

Department of Health Care Services
*Medi-Cal Managed Care
Rate Development Overview*

June 2015

Agenda

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Overview

- * The primary goals of DHCS' rate development process is to ensure that rates are reasonable and attainable, that it matches payment to risk, and to encourage quality and efficiency in our Medi-Cal health plans.
- * In general, DHCS uses actual health plan experience for the specified population in setting rates for the managed care populations and uses a combination of plan-specific and risk-adjusted county average experience for each plan's rates. As will be discussed in the second part of the agenda, when populations are new to managed care and/or new to Medi-Cal other data sources are necessary.
- * With some exceptions, such as for Rural Expansion counties, rates that are developed for Medi-Cal health plans have traditionally been county specific, such that even plans that are in multiple counties have separate rates for each county.

Overview

- * DHCS continues to work on improving our rate development processes to further the primary goals noted above and increase transparency. This has included rate development workgroups with representatives from health plans for both the Medi-Cal Expansion and Coordinated Care Initiative (CCI) rate development.

- * All managed care model types have rate years that align with the State Fiscal Year, effective 2014-15. Historically, the rate years for each model type have been as follows:
 - Two-Plan Model: October 1 – September 30
 - Geographic Managed Care Model: January 1 – December 31
 - County Organized Health System Model: July 1 – June 30



Federal and State Rate Setting Requirements

CMS Requirements For Medicaid Contracting Entities

As outlined in 42 CFR 438.6, CMS must review and approve all Prepaid Inpatient Health Plans (PIHP), Prepaid Ambulatory Health Plan (PAHP), Primary Care Case Management (PCCM), and Managed Care Organization (MCO) contracts.

- * Entities eligible for risk contracts: MCOs, Community Health Centers, certain Health Insuring Organizations (HIOs).
- * Risk (Capitation) contracts **must have actuarially sound rates.**
- * Documentation must be provided including actuarial certification and assurances that payments meet federal requirements.
- * Contracts with special risk provisions must be computed on actuarially sound basis (ex: risk sharing methods, reinsurance). Contracts with incentive arrangements may not pay more than 105 percent of the approved capitation for the covered population.

CMS Requirement for Actuarial Sound Rate Development

42 CFR 438.6(c)(4)(ii), effective August 13, 2002

Actuarially sound capitation rates means capitation rates that—

- * Have been developed in accordance with generally accepted actuarial principles and practices;
- * Are appropriate for the populations to be covered, and the services to be furnished under the contract; and
- * Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

CMS Rate Setting Checklist

A tool for use by CMS Regional Offices in approving rates for all capitated Medicaid managed care programs excluding the Program of All-Inclusive Care for the Elderly (PACE) capitated programs . Listed requirements include:

- * Overview of rate setting methodology
- * Actuarial Certification
- * Projection of expenditures – projection of expenditures under state’s previous year’s contract (or under its Fee For Service program if it did not have a contract in the previous year) compared to those projected under the proposed contract.
- * Other topics: risk contracts, limits on payments to providers, rate modifications, base year utilization and cost data, adjustments made to base year data, eligibility adjustments, etc.

Changes in Federal Review of Rates

- ❖ CMS is performing a more extensive analysis of the capitation rate packages sent forward for approval that include reviews by the federal Office of the Actuary (OOA). These approvals are required prior to rates being formalized in contracts and actual payment to plans for a given set of capitation rates.
- ❖ Managed Care Consultation Guides – 2014 (expansion rates only) and 2015. These guides outline critical elements to be considered as part of the rate development process and associated questions that should be addressed in addition to the traditional CMS checklist.

State Statutory Requirements

Rate setting process must follow CA Welfare and Institutions Code Section 14301.1 (a) through (n):

- * Medi-Cal must pay capitated rates to health plans participating in managed care.
- * Capitated rates must be developed using actuarial methods. Medi-Cal must utilize a county and model specific rate methodology to develop the rates.
- * The rate development process uses plan specific data that is submitted by the health plans to Medi-Cal.
- * If plan specific data is not available other substitutes can be used (similar health plans, county specific fee for service data, etc.)



Data Used for Rate Development

Data Used for Rate Development

Data specific to the Medicaid population must be used to develop rates. If data is not available, other types of data may be used and then adjusted to fit the Medicaid population. Data elements used in rate setting include:

- * Health plan specific encounter and claims data
- * Supplemental utilization and cost data submitted by the plan in Rate Development Template (RDT) format
- * Financial statement data specific to Medi-Cal operations.
- * Fee for service data and other add hoc data as needed

Data are compiled by category of aid (COA) group, by county, by plan and by 12 consolidated provider types or categories of service (COS).

Category of Aid (COA)

- * Adult
- * Child (including former Health Families Program)
- * ACA Optional Expansion
- * Aged/Disabled Medi-Cal Only
- * Disabled Dual Eligible
- * Aged Dual Eligible
- * Breast and Cervical Cancer Prevention and Treatment (BCCPT)
- * Long Term Care (LTC) Medi-Cal Only
- * Long Term Care (LTC) Dual Eligible
- * AIDS Medi-Cal Only
- * AIDS Dual Eligible
- * Maternity

Categories of Service (COS)

- * Inpatient Hospital Services (I/P)
- * Outpatient Facility Services (O/P)
- * Emergency Room Facility Services (ED or ER)
- * Long Term Care Facility Services (LTC)
- * Physician Primary Care Services (PCP)
- * Physician Specialty Services (SPEC)
- * Federally Qualified Health Centers (FQHC)
- * Other Medical Professional Services (OTHER)
- * Pharmacy (RX)
- * Laboratory and Radiology (LAB and RAD)
- * Transportation (now part of All Others)
- * Home and Community Based Services (HCBS – due to CCI)
- * Mental Health – Outpatient (MHOP)
- * Behavioral Health Treatment (BHT)
- * All Others



Base Data Adjustments

Base Data Adjustments: Smoothing

Typically programs are large enough to have credible base data for rate setting purposes. However, there are a number of MCO Category of Aid (COA) groups for which there is concern over specific COA group credibility. In those instances, the actuaries analyze data and information on a more aggregate level to overcome any excessive variation brought on by small membership or extraordinary (high or low) utilization or unit costs. Adjustments are made via a budget-neutral relational modeling process and no dollars are gained or lost.

Base Data Adjustments: Trend and Program Changes

Adjustments are also made for changes in utilization, medical cost inflation, trend, program changes or other items that are expected to change in the rating period.

- * **Trend** – Trend is an estimate of the change in the overall cost of medical services over a finite period of time. Trend factors are necessary to estimate the expenses of providing health care services in a future period.
- * **Program changes** - adjustments recognize the impact of benefit, rate or eligibility changes that took place during or after the base data period. Program changes are incorporated in the development of the rate ranges retroactively and prospectively.

Program Change Examples

- * Community-Based Adult Services (CBAS)
- * Annual LTC rate adjustments
- * AB 97 Provider payment reduction
- * Blood Factor Drug Carve-Out
- * Hepatitis C Carve-Out
- * Mid-level mental health services incorporation into managed care

Rate Cell Development

Once adjustments to the data have been completed rate cells are created for the population. The rate cells are divided according to:

- * Eligibility category
- * Age
- * Gender
- * Locality region
- * Risk adjustments used (if any)
- * Dividing the population into risk categories helps to better quantify the risk and uncover any problems.
- * Other payment methods that are used for chronic or high-cost members are also be isolated and examined.



Efficiency Adjustments

Efficiency Adjustments

- * DHCS currently incorporates two efficiency adjustments into the Medi-Cal managed care rate-setting with respect to pharmacy purchasing practices (Maximum Allowable Cost Pricing Adjustment) and Potentially Preventable Hospital Admissions (PPA).
- * Details concerning the methodologies can be found at the following link:
http://www.dhcs.ca.gov/dataandstats/reports/Documents/MCD_Fin_Rpts/CA_DHCSAllPlanMtgPres_072111.pdf

Efficiency Adjustment: MAC Pricing

- * Beginning with the 2011-12 rating period, an adjustment occurs to the managed care base data at the plan specific level that relates to effectiveness of each MCO's pharmacy cost management through a MAC avoidable cost analysis.
- * To identify potentially avoidable costs due to reimbursement inefficiencies, Mercer utilizes prior pharmacy period RX data and reviewed the reimbursement contracting for generic products.
- * Each RX claim was compared against a benchmark Medicaid MAC list for the same timeframe to create a potential cost savings amount for each claim.

Efficiency Adjustment: MAC Pricing

- * To calculate the cost savings amount, a derived paid amount which utilized the unit price from the benchmark MAC list is calculated for each claim and subtracted from the actual paid amount on each claim.
- * The total cost savings for each claim is then combined and aggregated for each MCO to calculate the total cost savings for each MCO.
- * In instances where the actual paid amount was less than the derived paid amount (negative cost savings), the negative amount was counted against the cost savings amount.

Efficiency Adjustment: Potential Preventable Admissions

- * DHCS utilizes an adjustment to the managed care inpatient base data that analyzes levels of inefficiency and/or potentially avoidable expenses present in the health plan encounter data.
- * Potentially preventable hospital admissions were identified in Prior Year Medi-Cal health plan encounter data using criteria from the Agency for Healthcare Research and Quality (AHRQ) Guide for Prevention Quality Indicators (PQI) and Pediatric Quality Indicators (PDI). Additional exclusions for enrollment duration and risk are made as part of the analysis.

Efficiency Adjustment: Potential Preventable Admissions

- * The analysis represents a conservative approach to identifying and quantifying potentially unnecessary expenditures utilizing the AHRQ definitions for PQI and PDI and their specific exclusions (i.e. deaths, transfers to other facilities, etc.).
- * Additionally, only individuals meeting specific Medicaid Rx risk score criteria and enrollment durations by PQI/PDI in the same Medi-Cal health plan are considered for the analysis.
- * A benchmark methodology was utilized in order to apply an adjustment factor based on a PPA level that has been achieved by high performing Medi-Cal health plans.



Risk Adjustment

Risk Adjustment

- * Prior to the 2009-10 rate year, DHCS set plan specific rates without a component that was based on risk-adjusted county averaging in Two-Plan and Geographic Managed Care Model counties. Since COHS counties only have a single plan in the county, risk adjusted county averaging does not occur.
- * Beginning in that first year 2009-10, DHCS moved away from 100% plan specific rate setting to a rate development process that was partially plan specific and partially county average risk adjusted. The county average risk adjustment components are utilized only for the Adult, Child, and SPD Medi-Cal only rate categories. The table below shows the percentage split for each rate year:

	Plan Specific	Risk Adjusted County Average
Rate Year 2009-10	80%	20%
Rate Year 2010-11	80%	20%
Rate Year 2011-12	75%	25%
Rate Year 2012-13	65%	35%
Rate Year 2013-14	60%	40%
Rate Year 2014-15	55%	45%
Rate Year 2015-16	50%	50%

Risk Adjustment

- * The risk adjustment is done using Medicaid RX Version 5.2 software developed by UC San Diego.
- * The model uses pharmacy encounters to assign individual acuity factors that are aggregated for a plan specific risk score.
- * The risk-adjustment process includes experience data only for individuals who have at least six months of total Medi-Cal eligibility within each 12-month study period.
- * Additional information can be found at the following link:
http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Fin_Rpts/CA_RA_ROverview_4-1-09.pdf
- * DHCS is currently developing plans to move toward further use of risk adjusted county averaging.
- * Our methodology for maternity reimbursement as a supplemental payment is also a method of risk adjustment.
- * Under the Coordinated Care Initiative (CCI), there are additional components of risk adjustment being utilized.



Risk Mitigation

Supplemental (“Kick”) Payments

- * **Maternity Supplemental Payment.** Instituted to ensure that payment matches risk given significant historical variance in delivery/birth rates among health plans. Payment is on delivery event that generates a vital record. One blended payment combines caesarean and vaginal deliveries which varies by county only.
- * **Hepatitis C Supplemental Payment.** Given significant uncertainty in utilization of newer high cost drugs for Hepatitis C treatment (ex: Solvoldi), DHCS implemented a monthly statewide supplemental capitation payment that is disbursed based on a weekly rate. Payment is triggered by specific prescriptions dispensed and paid for by the plan. The actuarial soundness of this supplemental payment is regularly monitored and as new drugs enter the market.
- * **Behavioral Health Treatment (BHT) Supplemental Payment.** Effective September 15, 2014, Medi-Cal managed care plans have responsibility for provision of BHT services for individuals diagnosed with Autism Spectrum Disorder. Due to lack of experience and uncertainties inherent within the BHT benefit, it was determined that a kick payment was the most appropriate mechanism to match payment to risk. Supplemental payments were developed for two age bands: ages 0-6 and ages 7-20. For 2014-15, supplemental payments were developed on a statewide basis, while 2015-16 payments are on a county specific basis.

Risk Corridors and Other Strategies

In addition to supplemental payment structures, DHCS has instituted risk corridors and other strategies to address uncertainty in new programs and populations to managed care including for:

- * Optional Expansion population – MLR corridor
- * Coordinated Care Initiative (CCI)
 - * Risk Corridors – generally for managed long term care services supports
 - * Rate Recasting – On a time limited basis, rates are “recasted” based on actual enrollment for full duals rates only



Rate Range

Rate Range

- * In the past and for the upcoming rate period (2015-16) the final rates developed by DHCS include an actuarial “rate range.”
- * The differences between the lower and upper bound of the rate range relate to different assumptions regarding trend, administration, and profit/risk/contingency.
- * Generally, DHCS pays plans at the lower bound of the actuarial rate range.
- * However, public providers (such as county hospitals) have worked with health plans and DHCS to provide the non-federal share utilizing intergovernmental transfers (IGTs) to increase the capitation rates to the upper bound. These arrangements are approved on an annual basis, retroactively.
- * For most rate range arrangements, per statute, the transferring entity is also assessed a 20% administrative fee.



Questions?