

# SB 553 Medicaid Managed Care Implementation Working Group

## MCO Rate Setting Considerations for LTSS Services

Presented by:

John D. Meerschaert, FSA, MAAA  
Principal and Consulting Actuary

November 1, 2016



# Today's Agenda

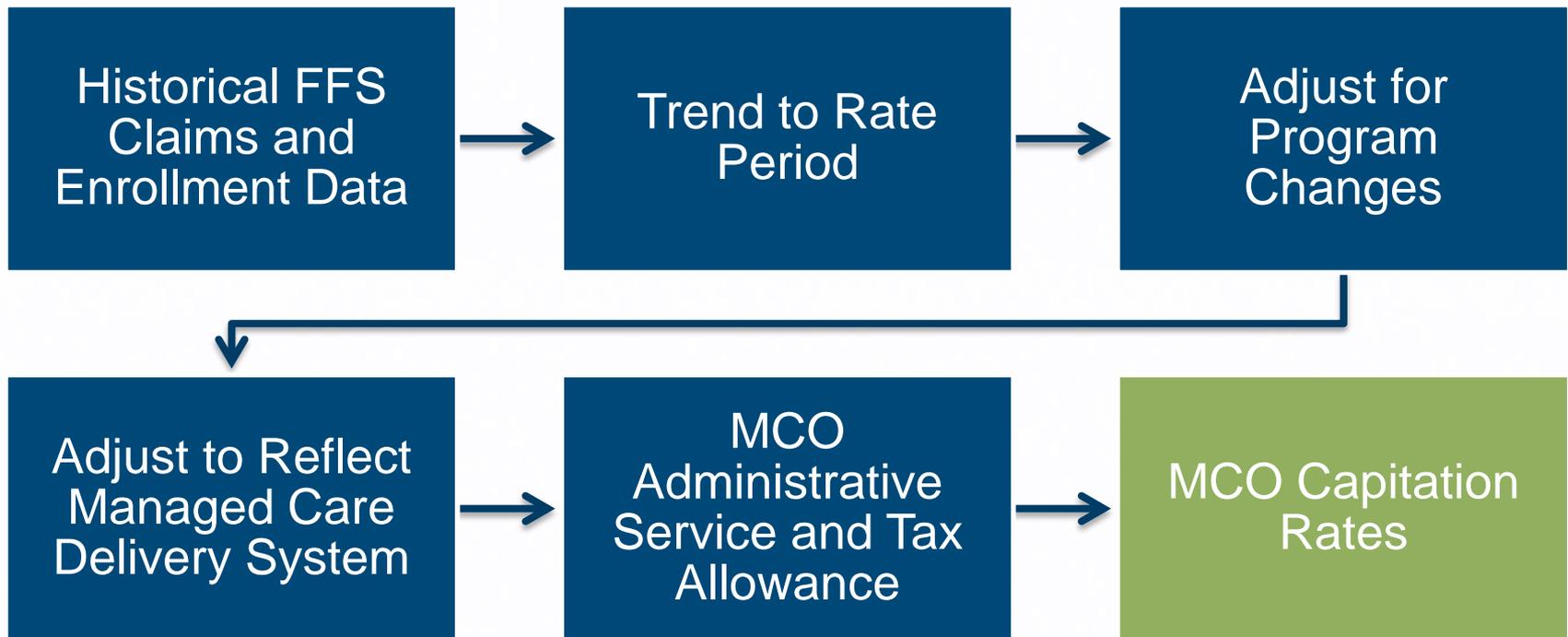
- Overview of Managed Care Rate Setting and the Actuary's Role
- MCO Rate Setting Considerations for LTSS Services
- Discussion

# Overview of Managed Care Rate Setting and the Actuary's Role

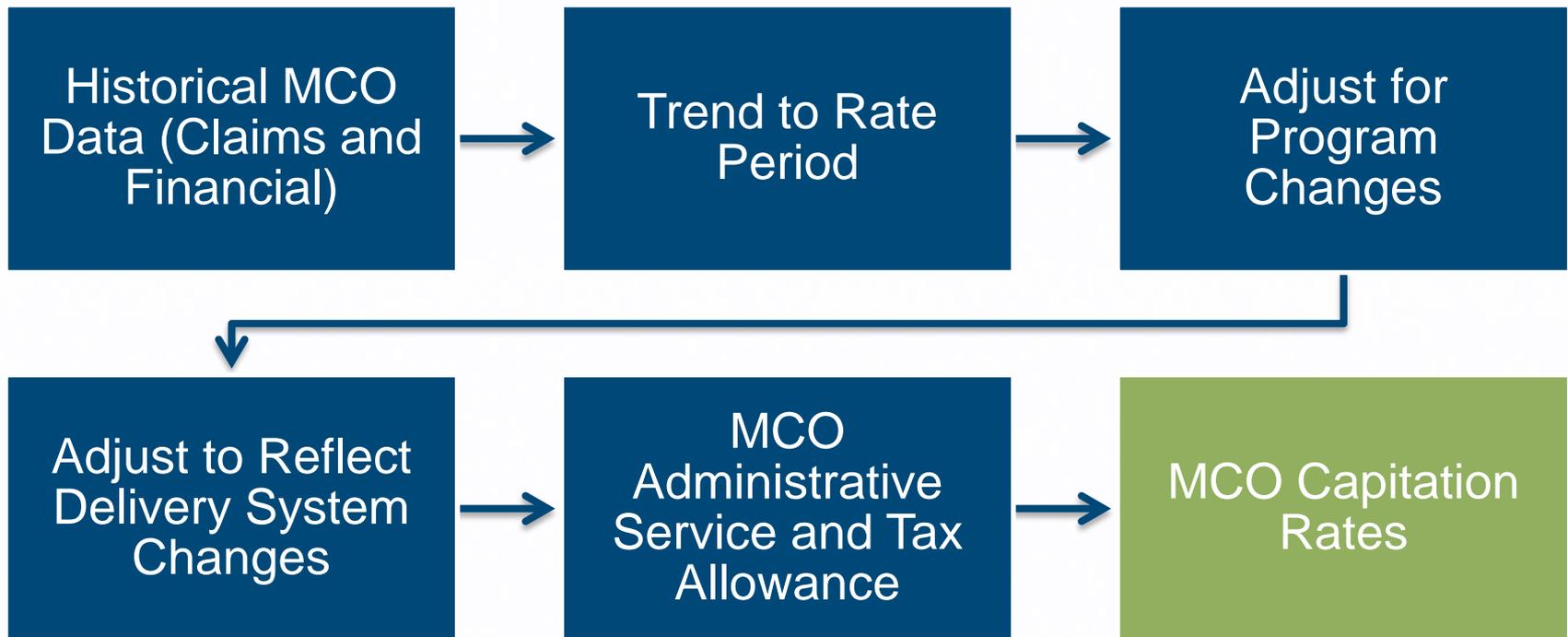
# High Level Managed Care Rate Setting Goals

- Set actuarially sound capitation rates that provide value to the State and compensate the MCOs fairly
- To an actuary, that means:
  - “Medicaid capitation rates are “actuarially sound” if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.” -- Actuarial Standards Board, Actuarial Standard of Practice #49

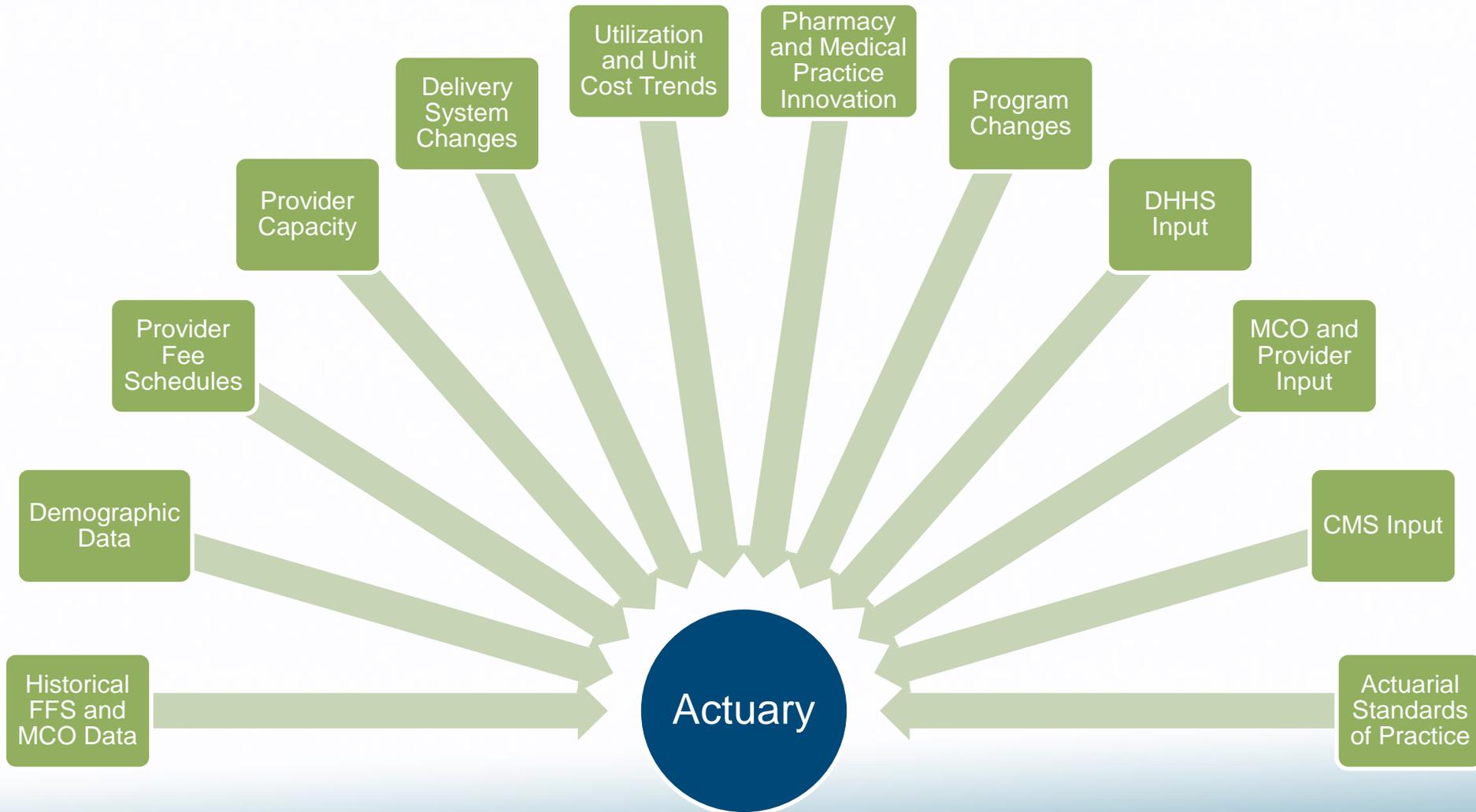
# Rate Setting for New Programs



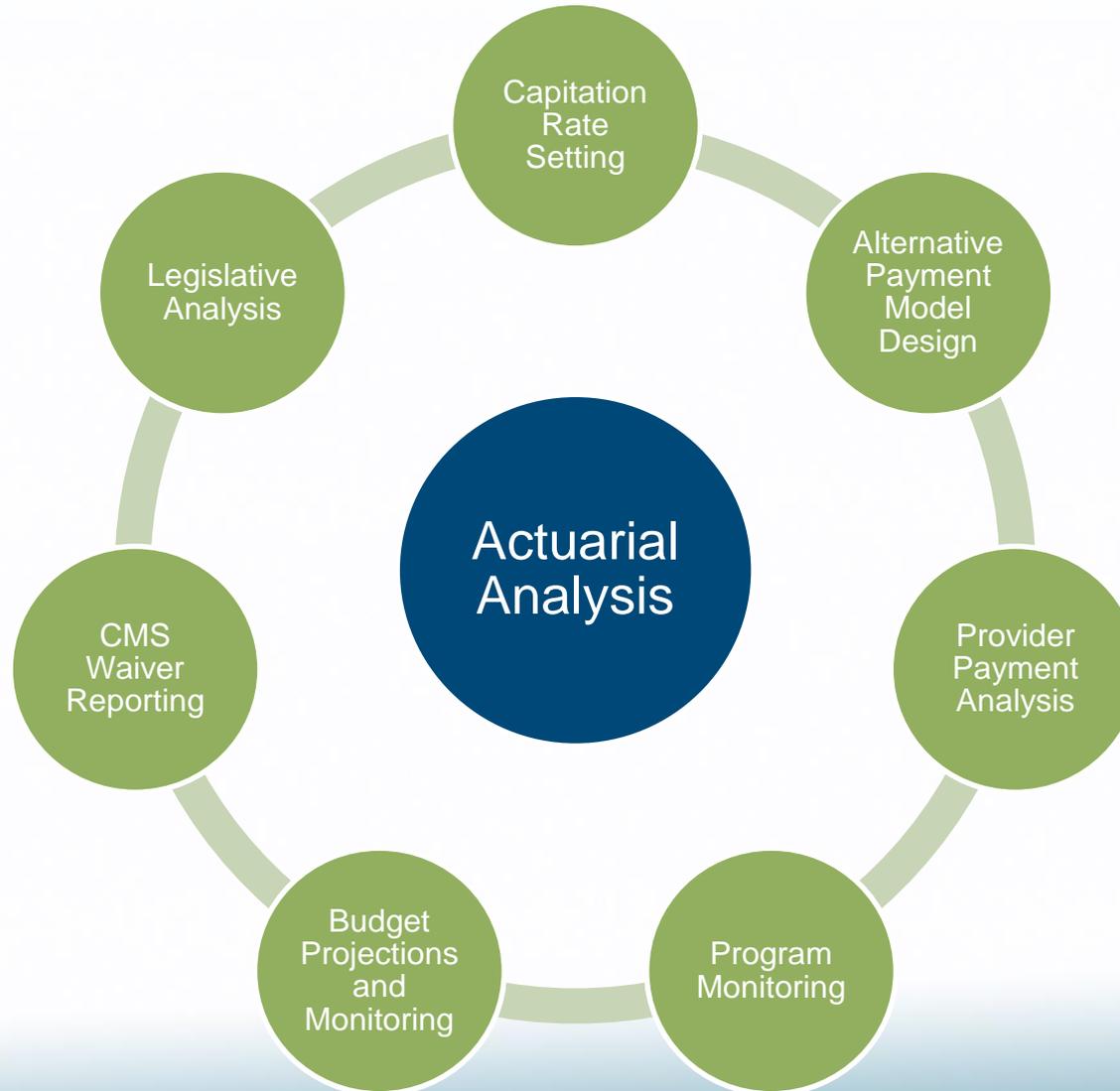
# Rate Setting for Established Programs



# Some of the Information We Use



# Interrelated Uses for Actuarial Analysis



# **MCO Rate Setting Considerations for LTSS Services**

# General Characteristics of Populations Using LTSS

## Nursing Facility Residents

- Individual meets nursing facility level of care based on functional status and resides in a nursing facility (NF)
- Generally higher cost to Medicaid compared to community residents
- Medicaid cost is relatively fixed (NF per diem)
- The NF per diem cost is most, but not all, of a member's Medicaid LTSS cost

## Community Residents

- Individual meets nursing facility level of care based on functional status, but lives at home or in an alternate community setting
- Generally lower cost compared to NF residents
- More variation in Medicaid cost among individuals – some people need more support to live in the community than others

# General Characteristics of Populations Using LTSS

- Program savings is primarily derived from supporting members in the community for as long as feasible and transitioning members from the NF back to the community if practical
- Simple **illustrative** example (not based on New Hampshire data)

Nursing Facility Residents  
• \$6,000 PMPM

Community Residents  
• \$2,000 PMPM

Population: 50% NF residents; 50% community residents

• Average PMPM =  $\$6,000 \times 50\% + \$2,000 \times 50\% = \$4,000$

Population: 47% NF residents; 53% community residents

• Average PMPM =  $\$6,000 \times 47\% + \$2,000 \times 53\% = \$3,880$

• Produces savings of 3% ( $(\$4,000 - \$3,880) / \$4,000$ )

# Observed Success in Transitioning NF Populations to the Community

- Review of other state MLTSS program data generally supports a 1% - 3% annual movement in the total population distribution from NF residents to community residents
  - Movement depends on state-specific conditions
- At some point, mature programs reach a steady-state between NF residents and community residents
- Some programs report much larger transition percentages, but reported percentages can be influenced by eligibility changes and waiver service expansions (i.e., increases in the number of “waiver slots” available)

# LTSS Rate Setting Levers

Mix of nursing facility residents and community residents

Utilization of services

Unit cost contracts between MCOs and providers

Access to services – before and after managed care

DHHS program changes

State policy priorities

Constraints placed on MCOs by DHHS

CMS regulations

Actuarial soundness requirement and Actuarial Standards of Practice

# LTSS Rate Setting Levers

## Mix of NF residents and community residents

- What is the current mix under the FFS program?
- Potential for moving part of the population from NF to community setting
- Availability of community services

## Utilization of services

- NF resident utilization is generally fixed (30 days per month)
- Community resident utilization of services can vary significantly based on member needs
- What is the most efficient use of services to successfully support a member in the community?

## Unit cost contracts between MCOs and providers

- Will MCOs contract with NFs and other providers at the Medicaid fee schedule, or something different?
- Potential for alternate payment methods?

# LTSS Rate Setting Levers

## Access to services – before and after managed care

- Current and future availability of community services
- Impact of workforce development efforts
- Relationship between provider payment rates, provider operating costs, capacity, and access to services

## DHHS program changes

- Any change to Medicaid eligibility, benefits, or other program design features may impact MCO rates

## State policy priorities

- What are New Hampshire's policy objectives?
- How do those policy objectives impact program cost?

# LTSS Rate Setting Levers

## Constraints placed on MCOs by DHHS

- What limitations are placed on the MCOs in the managed care contract (e.g., mandated provider reimbursement rates)?
- How do those limitations impact program cost?

## CMS regulations

- DHHS must comply with the new CMS Medicaid managed care regulation
- Potential impact of Medicaid waivers
- CMS reviews and approves all MCO rates

## Actuarial soundness requirement and Actuarial Standards of Practice

- CMS requires all MCO rates to be actuarially sound
- Actuaries must comply with Actuarial Standards of Practice

# General LTSS Rate Setting Structure

- Generally, there are three main approaches to setting MCO capitation rates for populations needing LTSS services

Pay separate rates for NF residents and community residents

Pay a blended rate to encourage MCOs to maintain more members in the community

Pay a single rate for all LTSS users, but use functional-based risk adjustment to appropriately pay each MCO for the acuity of their enrolled members

- MCO rates for LTSS are generally built up separately from MCO rates for medical and behavioral health services
  - Ultimately the rates may be combined into one payment to the MCO

# Pay Separate Rates

- Pay separate rates for NF residents and community residents
  - Best match of MCO payment to living arrangement for each member
  - Does not provide a financial incentive to maintain more members in the community
    - Once a member costs more than the average community resident, the financial incentive is to move that member to a NF (contrary to program savings and quality goals)
  - Sometimes, a “transitional” payment is made for members moving between living arrangements to provide a financial incentive
    - Transitional payment set in between NF resident and community resident payment
    - Paid to the MCO for a 3-6 month period of time if:
      - Member moves from community to NF
      - Member moves from NF to community
  - CMS does not look favorably on this approach

# Pay a Blended Rate

- Pay a blended rate to encourage MCOs to maintain more members in the community
  - First, set separate capitation rates for NF residents and community residents
  - Set an MCO-specific blending percentage to develop an average rate paid for all members
    - Start with the “current” mix of NF residents and community residents for each MCO to recognize differences among the MCO populations
    - May or may not include a transition target that assumes a higher percentage of each MCO’s population will be community residents in the contract year
    - Lock in the blending percentage for the contract year
  - Provides a strong financial incentive to maintain members in the community if their cost in the community is lower than in a NF
  - Most states use this approach

# Pay a Single Rate and Risk Adjust

- Pay a single rate for all LTSS users, but use functional-based risk adjustment to appropriately pay each MCO for the acuity of their enrolled members
  - Requires timely and consistent data on member functional status
  - Each MCO's rate is based on their enrolled population's risk score based on statistical modeling of the impact of factors such as:
    - ADLs and IADLs
    - Behavioral health conditions
    - Medication use
    - Health related services (dialysis, tube feeding, etc.)
    - Other factors
  - Wisconsin and New York currently use this approach
  - See Milliman research papers posted on SB 553 website:
    - <http://www.dhhs.nh.gov/sb553/index.htm>

# MQIP and ProShare Payments

- NFs currently receive Medicaid payments from three sources:
  - NF per diem payments (i.e., the “budget neutral rate”)
  - Medicaid Quality Incentive Payments (MQIP)
    - MQIP is funded by the Nursing Facility Quality Assessment (NFQA) tax revenues
  - Proportionate Share Payments (ProShare)
    - ProShare is funded based on available contributions from participating Counties
  - Currently per diem rate is paid prospectively and retrospective adjustments are made for MQIP and ProShare
- DHHS will consider the impact of the new CMS Medicaid managed care regulation on how MQIP and ProShare funding will be structured

# Other Rate Setting Structure Considerations

- Rate cell structure
  - Rates can vary by age, gender, and Medicare eligibility status (if warranted)
- Potential risk mitigation programs
  - Risk sharing
  - Risk pools
  - Reinsurance
- Pay for performance programs

# Caveats and Limitations

- This document is intended to be used by the New Hampshire DHHS in a presentation to the SB 553 Medicaid Managed Care Implementation Working Group on MCO rate setting considerations for LTSS services. This information may not be appropriate for other purposes.
- This information should not be relied upon by anyone other than DHHS. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work. This information assumes the reader is familiar with the Medicaid program, Medicaid populations, and Medicaid financing in general.
- This presentation is intended to be informational only. It does not include any recommendations specific to the New Hampshire Medicaid program.
- This presentation and its use is subject to the contract between DHHS and Milliman signed on November 16, 2012.

# Discussion

