

Working Group on the Implementation Planning for the Incorporation of Nursing and Choices for Independence Waiver Services in the NH Medicaid Care Management Program

**Public Working Session
November 1, 2016
10:30 a.m. – 12:30 p.m.
Legislative Office Building, Rooms 210-211
Concord NH**

Agenda; Announcements

The agenda includes presentations on (1) Home Care Services for CFI; and (2) MCO Rate Setting for LTSS Services.

Home Care Services for “Choices for Independence” (CFI) Clients:

Gina Balkus, CEO, Granite State Home Health Association; Click [here](#) to view slide deck.

The Granite State Home Health Association represents 39 home care agencies in the state, 32 of which provide services to Medicaid beneficiaries enrolled in the CFI waiver program

CFI is a Medicaid waiver program for adults in need of long term care services who meet financial and clinical eligibility requirements. Clients eligible for nursing homes can choose to receive (1) Mid-level care (residential care/dementia care); Home support services which include, but not limited to, adult day care, personal emergency systems, personal care services, non-medical transport and case management; and (3) Home health care services which include RN visits, home health aides, and homemaker services. DHHS authorizes the type and units of service; case managers arrange the array of services.

Expenditure limitations are based on average aggregate costs. Mid-level care cannot exceed 60% of the nursing home costs; Home services cannot exceed 50% of nursing home costs; and unless waived by the Commissioner, no individual whose costs exceed 80% of nursing home costs are eligible for mid-level or home services.

CFI home care services include skilled nursing visits, home health aide/LNA visits, personal care services, and homemaker services. Licensed LNAs and unlicensed personal care service providers do many of the same tasks, though clients with increased medical needs are seen by a supervised LNA. CFI pays a higher rate for LNA services .

Over 2,525 CFI clients receive home health; 466 receive CFI mid-level care; and over 4,187 reside in nursing homes. In SFY 2015, CFI expenditures for skilled nursing and home health aide visits were \$8.8 million; personal care service provider services cost \$24.5 million. In recent years, there has been a trend away from skilled services to personal care services. Rate setting for home care services is based on RSA 126-A:18-a, which requires annual updates. The rate setting methodology rules have expired and are not utilized. Concern was raised as how future rates will be set as LTSS transitions to managed care. Presently RN rates are \$95/visit compared to \$162 cost per visit; home health aide rates are \$31/visit vs. cost of \$66/visit.

Major public policy concerns: current payment rates do not allow home health agencies to pay competitive wages and cover operational costs. This affects their ability to recruit and retain workers. Home care agencies have been subsidizing low CFI rates with Medicare margins, but federal cuts make this a less viable strategy. The continuation of current CFI rates will reduce access to services.

To assure continued availability of services, DHHS must conduct the statutorily required updates of CFI home health rates. Under Step 2, we need a review process to ensure that clients are getting care that is appropriate to their medical needs.

Q: Has an assessment of workforce needs been undertaken in various areas of the state?

A: Though not done on a geographic basis, a vacancy survey was conducted in July. The RN vacancy rate was 9% with 1,125 missed visits per week (5 visits per day, 5 days a week). Home health agencies need more LNAs and PSPs. Agencies will be surveyed again in January. Geographic factors will be added. Commissioner Meyers requested the survey be made available to DHHS.

Q: What is your perspective on the amount of care needed?

A: The level of care required by clients at home is increasing. However, data is not available on how many clients are receiving services for longer blocks of time.

Comment: It would be interesting to know clients' need for assistance with ADLs as compared to those of NF residents.

Q: What is the reason for stable number of CFI clients? Demand? Budget constraints?

A: This is surprising. She doesn't know how many clients are in the pipeline – the eligibility process can take several months. This is really a question for the Department

F/U Q: Is there a waitlist?

A: The question was noted.

Q: Because of the expenditure limitations, when you got a rate increase for skilled nursing, if caps are not lifted, how do rates increase and expenditures caps relate? A concern would be that fewer services get delivered because the newer, higher reimbursement would squeeze out services previously subsidized by low wages.

A: Not sure. This is a budgetary question for the Department.

F/U Q: Was money left on the table?

A: Gina requested information from the Department.

F/U Comment: Unintended consequences should be considered, e.g. as wages are increased, perhaps the cap should be as well.

MCO Rate Setting Considerations for LTSS Services

John Meerschaert, Principal and Consulting Actuary, Milliman; Click [here](#) to view slide deck.

Overview of Managed Care Rate Setting and the Actuary's Role: The goal of managed care rate setting is to set actuarially sound capitation rates that provide value to the State and compensate the MCOs fairly. To be actuarially sound, costs include, but are not limited to, expected LTSS benefits, health benefit settlement, administrative expenses, cost of capital, and government-mandated assessments, fees, and taxes. (From Actuarial Standard of Practice #49 - how rates should be set and factors that should be considered in the rate setting process.) This is reinforced in the new CMS rule.

Rate setting for new programs is based on historical fee-for-service expenditures and enrollment data for this population. The data is trended to the rate period and adjusted for program changes and to reflect the managed care delivery system. Rate setting for established programs starts with historical

MCO data trended forward and adjusted for delivery system changes. Costs can go up or down, as could be the case as of July 1, with the new SUD benefit.

The actuary's job is to collect information from many sources, including demographic data, provider fee schedules, provider capacity, delivery system changes, utilization and unit cost trends, pharmacy and medical practice innovation, DHHS input, CMS input, etc. The goal is to set the baseline in order to project a reasonably sound capitation rate.

Capitation rate setting can be used in many ways for different purposes (i.e., interrelated uses for actuarial analysis) including legislative analysis to determine the impact on rates, provider payment analysis.

Q: How often are rates adjusted?

A: CMS requires rates be adjusted annually.

Comment: Rates have historically changed more frequently due to program changes. The current MCO contracts are full risk contracts, so unless the state makes changes to the program, it is expected that the rate is unchanged for the year.

MCO Rate Setting Considerations for LTSS Services: The characteristics and differences between nursing facility residents and community residents using LTSS were discussed. However, both groups meet the nursing facility (NF) level of care. NF costs are baked into a predictable NF per diem. Community residents are generally a lot less expensive than NF patients, though there is a lot of variation within the group. Program savings are derived from gradually increasing the populations receiving services in the community and transitioning members from NFs back to the community. An example was used to demonstrate program savings by reducing the population utilizing NF services under managed care. Review of other state MLTSS program data supports a 1%-3% annual shift in the distribution from NF residents to community residents. This can be achieved by delaying admissions to NFs.

Many factors (rate setting levers) affect rates, whether higher or lower. These include (1) mix of NF residents and community residents (current mix vs. success at transition based on availability of community services); (2) utilization of services (NF is a fixed 30 days/month; community resident utilization varies based on member needs and the most efficient use of services); (3) unit cost contracts between MCOs and providers; (4) access to services before and after managed care, impact of workforce development, and the relationship between provider payment rates, operating costs, capacity, and access to services; (5) DHHS program changes (e.g., eligibility, benefit); (6) state policy priorities; (7) constraints placed on MCOs by DHHS (e.g., provider reimbursement rates); (8) CMS regulations; and (9) actuarial soundness requirement and actuarial standards of practice.

Q: How have you been able to model the current mix between NF and community programs, as it varies from state to state?

A: States set the rates and let the program play out. They may update the mix between NF and community residents more often than annually.

Q: How accurately can you forecast rates for the state?

A: In Florida, the legislative target was a 3% mandated transition. Florida achieved 1-2%. It's more of an art than a science. That's why rates are adjusted annually.

Q: Where do you obtain data on the "relationship between provider payment rates, provider operating costs, capacity, and access to services?"

A: We look at each provider and the operational costs behind the services. If that relationship is flawed, simply moving to managed care does not solve those issues. The actuary's job is to take those factors and build a model.

Q: Does that mean that inadequate rates are figured into the rates?

A: There is no obligation to look at downstream reimbursement rates to determine if they're sound from the provider's point of view. If there's evidence, the model will be reviewed.

Q: Which rate setting lever is the wild card when building a model that's consistent? Are there factors that are difficult to control for?

A: It's most difficult to identify changes in the delivery system, e.g., workforce. In addition, we're using data that's a year old to determine rates one year from now.

Q: Is there a threshold volume (e.g., population size or service units) that produces a robust result?

A: The fixed NF costs and the basket of CFI services are relatively fixed. The level needed for LTSS is a lot lower than acute care.

Q: When looking at expense data, do you use billed or paid amount?

A: We look at the amount Medicaid is responsible for - paid amount.

Q: With whom should the discussion regarding historical data be held?

A: Commissioner Meyers said the discussion will be with the Department through the SB 553 implementation workgroup; which is why this process is different than before. There will be workgroups to delve into different aspects of implementation including rate setting. The direction given to Milliman will be informed by the next Governor and Legislature as well.

Q: Within the DD population, which is exclusively community-based, one could argue that savings have been achieved, so how will the state address cutting costs?

A: Input from the advocacy community will help to inform a level set for savings as well as inform coordinated care on the medical side that could result in savings.

Q: How does Florida look at rate setting for those individuals who have sudden medical events such as brain injury or stroke?

A: The actuary looks at the population; not the individual. From a rate setting point of view, it doesn't matter who these people are. Once tracked over time, it can be built into the risk adjustment model.

There are three main approaches to setting MCO capitation rates for LTSS populations:

1. Pay separate rates for NF residents and community residents. This option is being utilized less.
2. Pay a blended rate to encourage MCOs to maintain more members in the community. Most states use this approach which provides a strong financial incentive to maintain members in the community if their cost is lower than in a NF.
3. Pay a single rate for all LTSS users using a functional-based risk adjustment to appropriately pay each MCO for the acuity of their members. This requires timely and consistent data on member functional status. Wisconsin and NY are the only states using this approach. See Milliman's research papers at <http://www.dhhs.nh.gov/sb553/index.htm>, on the DHHS SB 553 website page.

Nursing facilities currently receive Medicaid payments from three sources: NF per diem payments, Medicaid Quality Incentive Payments (MQIP), and Proportionate Share Payments (ProShare). DHHS will consider the impact of the new CMS managed care regulation on MQIP and ProShare funding and will consider how funding will be structured.

Other rate setting structure considerations include rate cell structure, potential risk mitigation programs, and pay-for-performance programs that can be layered on top of rate structures.

Q: In 2014, \$53 million in federal match pass through payments was paid to county NFs. How will these payments be addressed under the new federal managed care rule?

A: Commissioner Meyers responded that the CMS final rule prohibits pass through payments by 2020. It is not yet known whether MQIP and ProShare will be considered as prohibited pass through payments. The Department is carefully considering how to structure these payments.

Q: We have not heard mention of quality of life issues. Will people be able to access activities that impact their quality of life? If not, they will receive care exclusively at home without the ability to participate in the community.

A: Yes, quality is important.

Next Meeting: Tuesday, Nov 15th, 10:30am-12:00pm at the Legislative Office Building, Rooms 210-211.