

STATE OF LOUISIANA RATE-SETTING METHODOLOGY FOR MANAGED LONG-TERM SUPPORTS AND SERVICES (MLTSS) PROGRAM

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Agenda

- Overview of the Centers for Medicare and Medicaid Services (CMS) requirements
- Managed care rate development:
 - Overview
 - Rate development methodology
 - Base data
 - Trend
 - Program changes
 - Managed care efficiency adjustments
 - Non-Medical expenses — care management
 - Non-Medical expenses — administration
 - CMS rate certification
 - Other considerations

Overview of CMS Requirements

- In accordance with CMS regulations (42 CFR 438.6(c)):
 - “Rates must be actuarially sound” and developed by a credentialed actuary:
 - Appropriate for covered populations and benefit package.
 - In accordance with generally accepted actuarial principles and practices.
 - Actuarial certification reviewed against CMS Rate-setting Checklist and 2015 Managed Care Consultation Guide recently released by CMS.
 - The American Academy of Actuaries Practice Note, August 2005, “Actuarial Certification of Rates for Medicaid Managed Care Programs,” which proposes the following definition of actuarial soundness:

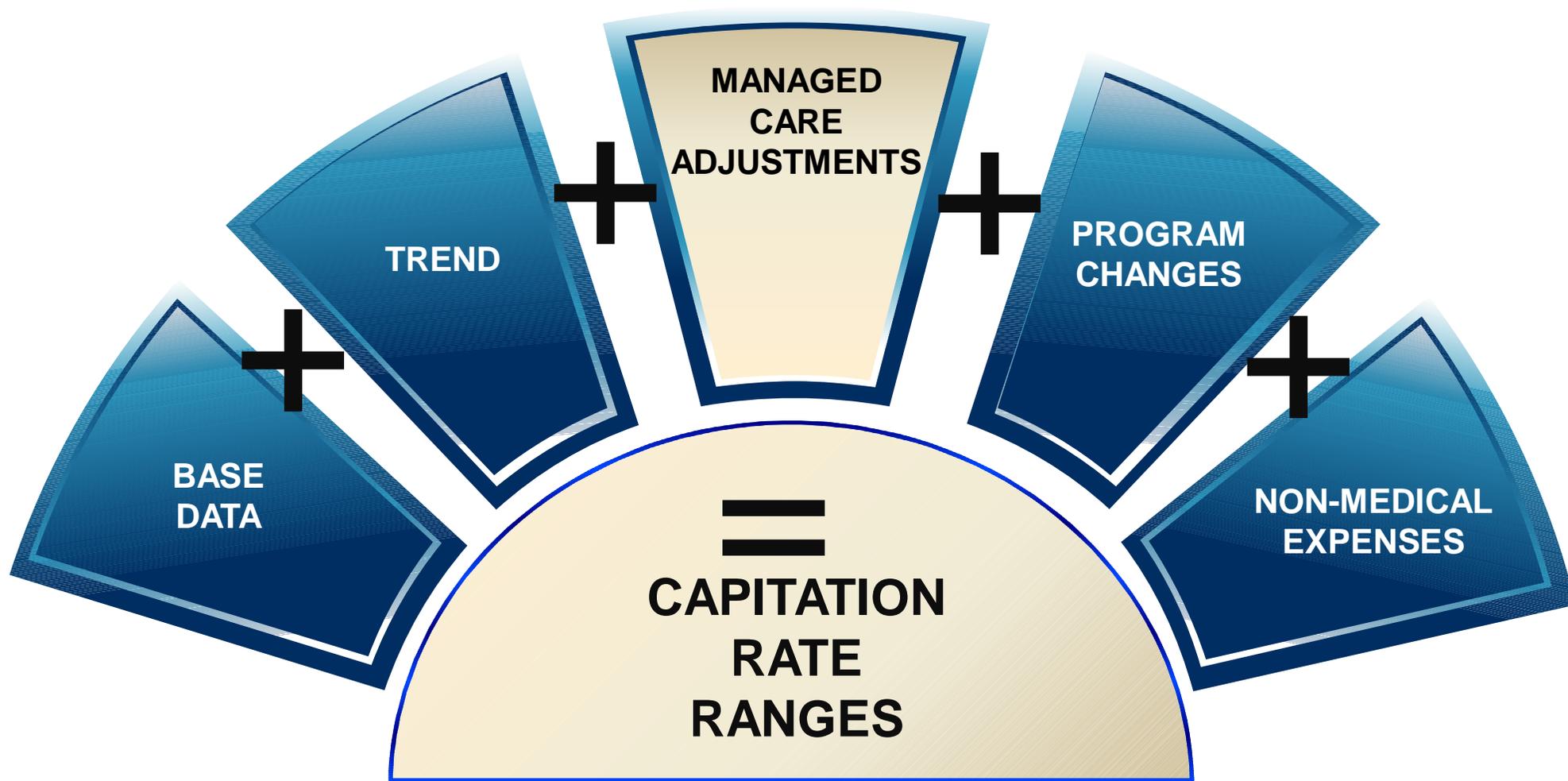
“Medicaid benefit plan premium rates are “actuarially sound” if, for business in the state for which the certification is being prepared and for the period covered by the certification, projected premiums, including expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income, provide for all reasonable, appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, any state-mandated assessments and taxes, and the cost of capital.”

Managed Care Rate Development Overview

- Managed care rate development is the process by which a per member per month (PMPM) rate, or premium, is developed for the prospective contract period, based on historical data, assumptions for projected trend, efficiencies from the management of care, the impact of program and policy changes, and non-medical expenses.
- The PMPM represents the rate paid by the State to the contractor (managed care organization) for the members and services covered at-risk by the contractor under the contract with the State; PMPMs are established for defined eligibility groups, often referred to as rating groups or rate cells.

Managed Care Rate Range Development

Rate Development Methodology



Managed Care Rate Range Development Base Data

- Mercer will typically review at least two years of data to establish the base data, which would be published in a Data Book; this Data Book would represent the covered populations and covered services enrolled in the MLTSS program.
- In developing the base data, Mercer reviews anomalies in the data between the two years in order to establish a credible base; this may include blending of the various years of base data for some or all populations and services.
- Various adjustments will be applied to each of the data sources to be consistent with the expected service costs during the contract period, which would also be described in the Data Book.

Managed Care Rate Range Development Trend

- Trend is the projection of utilization and unit cost changes over time.
- Trend sources:
 - Known fee schedule changes during the historical base data period and following the base data period up to the contract period.
 - Annual trend exhibited in the FFS and encounter data (regression analysis).
 - Trend information supplied by the State and trends in other Louisiana managed care programs.
 - National trend indices (CPI, etc.).
 - Trends in other state Medicaid programs.

Managed Care Rate Range Development Program Changes

- Through discussions with the State, program changes are identified which may only be partially reflected in the data or not reflected for those changes that occur after the base data period.
- New program changes are identified for any changes to the covered populations or covered services that may commence with implementation of the MLTSS program. Examples of program changes include:
 - Fee schedule changes.
 - Changes to the benefit package:
 - Addition or subtraction of benefits.
 - Modifications to the fiscal responsibility for certain services (e.g., services converting from State-only funding to Medicaid funding).

Managed Care Rate Range Development

Managed Care Adjustments

- The review for managed care adjustments could include a review of unit costs, as well as utilization for the MLTSS programs.
- Unit cost review: Provider contracting requirements around State-mandated fees as well as any willing provider requirements could impact this review.
- Utilization data review: Mercer actuaries and clinicians will analyze the utilization data to determine whether there are opportunities for increased efficiency, such as management of inpatient readmissions and pharmacy costs. In cases where management of high utilization is expected under managed care, consideration will also be made for utilization of other services, like Outpatient and HCBS waiver services, to achieve such results.
- Experience with care management within the Bayou Health and LBHP programs will also be considered.
- For MLTSS programs, this review for initial rates will include consideration of transition requirements, which will be outlined in the RFP.

Managed Care Rate Range Development

Non-Medical Expenses – Care Management

- Under MLTSS, plans will be required to maintain staffing that complies with specific case load contract requirements for all populations.
- Mercer actuaries and clinicians will review the requirements and develop an adjustment as necessary to reflect the additional cost for the LTSS plan care management staff.
- The adjustment may consider:
 - Salary, benefit, and travel cost information for care management staff.
 - Care management staffing ratios and estimated number of individuals.
 - Case management experience in other programs.

Managed Care Rate Range Development Non-Medical Expenses – Administration

- Review the components of the administrative allowances:
 - Review factors including overall program enrollment, reporting requirements, organizational requirements of the contract, and typical staffing needs.
 - Review available managed care data from the Bayou Health and LBHP programs.
- These items are consistent with CMS allowance for administrative costs.
- Will consider withhold and profit/contingency, along with State- and Federal-mandated taxes.

Managed Care Rate Range Development

CMS Rate Certification

- Rate certification letter will be sent to CMS to document compliance to actuarial soundness, CMS managed care rate setting checklist, and 2015 Managed Care Consultation Guide.
- CMS will also review the final contracts between the State and contractors for final federal approval.
- Mercer will work with our CMS experts to ensure the appropriate documentation is provided to CMS.
- Mercer will also be available to address questions from CMS on the rate package.

Managed Care Rate Range Development Other Considerations

- Along with development of the capitation rates, consideration will be made for risk mitigation for at least the initial phase of program implementation.
- For example, medical loss ratios (MLR) are used in the LBHP and Bayou Health programs to protect against excessive MCO profits and hold the MCOs accountable.
 - The MLR represents the share of total MCO payments spent on health benefits.

