NC Department of Health and Human Services

Medicaid Managed Care Capitation Rate Development

Julia Lerche, FSA, MAAA, MSPH
NC Medicaid - Chief Actuary and Policy Advisor

Medical Care Advisory Committee (MCAC) Meeting
June 14, 2019

PHP Payment Structure

Risk Adjusted Per Member Per Month (PMPM) Capitated Payments

- Under managed care, PHPs will get a fixed payment per member per month to cover the projected costs of covered services for the populations served. PHPs bear the risk of utilization and costs being different than what is assumed in the capitation rates.
- The Department will make per member per month capitation payments to the PHPs based on the number of members in each rate cell multiplied by the applicable risk adjustment factor.

ABD (all ages)	TANF, Newborn (ages <1)	TANF, Child (ages 1–20)	TANF, Adult (ages 21+)

Maternity Event Payment

- A maternity event payment will be made by DHHS to the PHPs for each qualifying birth event.
- This payment covers prenatal, delivery and postpartum care for the mother.

Utilization Based Directed Payments (pending CMS approval)

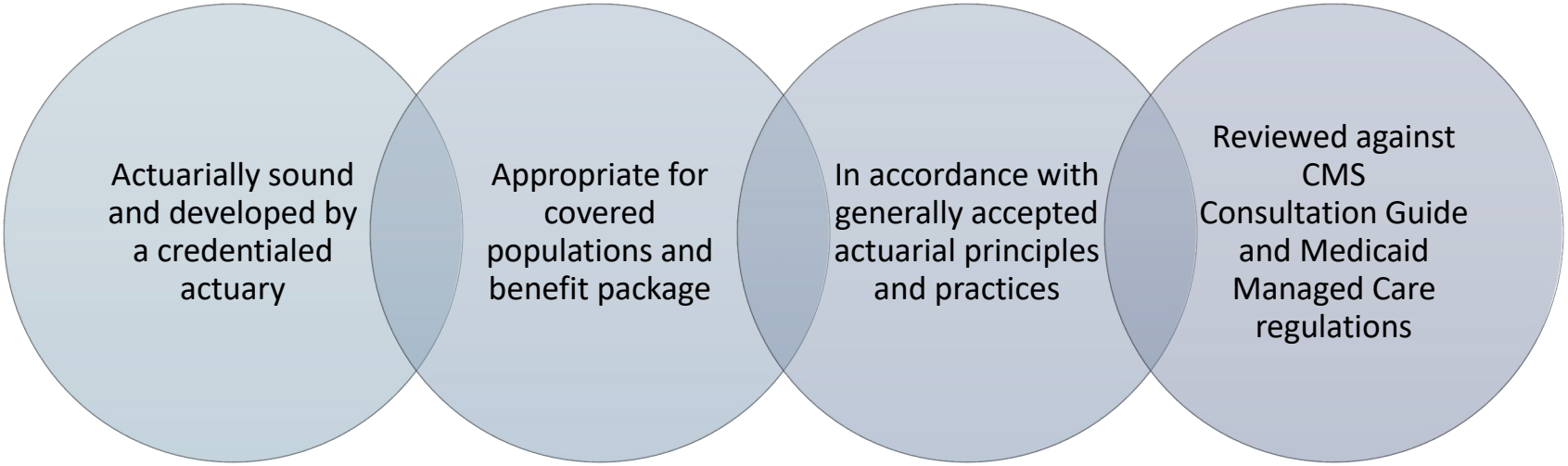
- PHPs will be required to make additional utilization-based payments to certain providers, include public ambulance providers, local health departments, hospitals owned by UNC Health Care and Vidant Medical Center, and certain faculty physician groups associated with the University of North Carolina and East Carolina schools of medicine.

Healthy Opportunities Pilots (future years)

- If the PHP covers a region that includes a Healthy Opportunities Pilot, the PHP will be eligible to receive payments from the Department, up to a PHP-specific capped allotment, to fund pilot services delivered to the PHP's members. These payments were not considered in the capitation rates.

Federal Capitation Rate-Setting Requirements

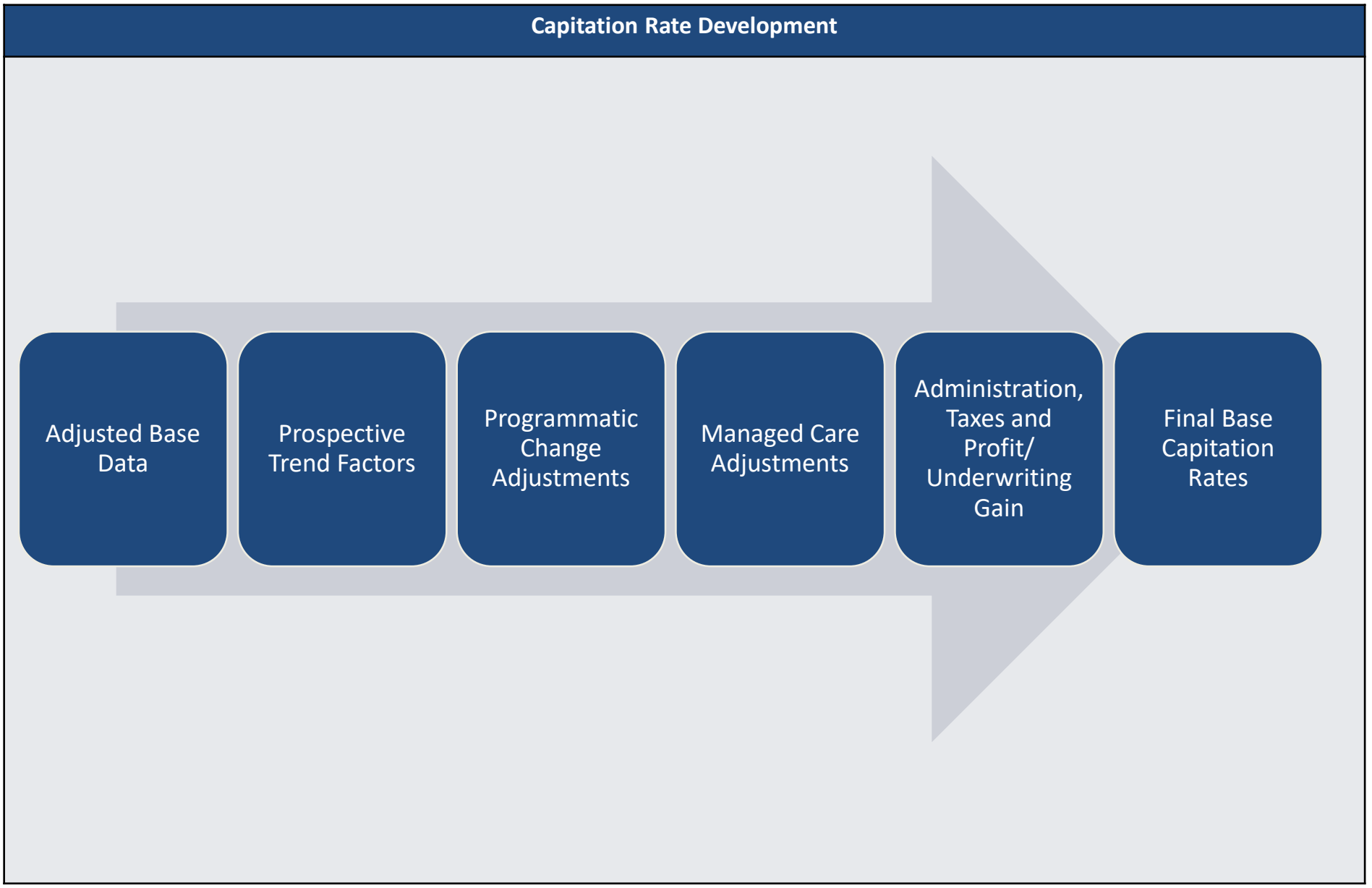
In accordance with the Centers for Medicare and Medicaid Services (CMS) regulations (42 CFR 438.4), rates must be:



"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."

March 2015 Actuarial Standard of Practice No. 49, "Medicaid Managed Care Capitation Rate Development and Certification"

Rate Setting Overview



Key Considerations for Capitation Rate Development

Provider Reimbursement Considerations

Rate Floors for Certain Provider Types

- DHHS has established rate floors at 100% of the Medicaid fee-for-service (FFS) rate for in-network physicians, physician extenders, hospitals, and nursing facilities.
- Capitation rates assume the FFS levels will be used as the payment level for these providers with additional consideration of unit cost trends.

Reimbursement for Services Historically Covered by LME/MCOs

- The base encounter data experience from the LME/MCOs reflects provider-negotiated rates for LME/MCO BH services that will be covered under the Standard Plan.
- No adjustments other than trend are being made in the capitation rate development to alter the historical LME/MCO provider rates.

FQHC/RHC Providers

- The capitation rates assume similar reimbursement levels as FFS for FQHC/RHC providers, with anticipated wrap payments as required.

Historical Cost Settlements

- DHHS has historically cost settled certain providers in the FFS program. For some of these providers (including LHDs and public ambulances) these payments will be reimbursed outside of the prospective PMPM rates, but through the PHPs, based on utilization of specific services.
- The capitation rates assume continuation of reimbursement consistent with current fee schedules for cost settled providers.

Hospital Reimbursement Considerations

Hospital Reimbursement

- Historically, DHHS has reimbursed hospitals using a mix of claims payments and supplemental payments.
- Federal rules for Medicaid managed care do not allow for continuation of North Carolina's supplemental payments to hospitals in their current form.
- To ensure similar reimbursement levels to hospitals under managed care, most supplemental payments are being incorporated into base rates in the fee-for-service program, which will then serve as the basis for a limited-duration rate floor under managed care.
- Final capitation rates will reflect the final hospital base rates and payment requirements developed in collaboration with the NC Health Care Association.
- As PHPs will not be required to reimburse hospitals for GME or DSH payments, capitation rates exclude GME and DSH considerations as DHHS will make these payments directly to eligible hospitals.

Managed Care Assumptions

Overview

- PHPs are expected to impact levels of medical cost and utilization through care management:
  - Encouraging the use of preventive services so that acute conditions are not exacerbated to the point that requires a visit to the Emergency Room or hospitalization.
  - Reducing non-emergent use of the Emergency room through member education and viable alternatives (e.g., extended hours for doctor's offices, after-hours urgent care clinics, or even nurse advice lines).
  - Hospital discharge planning to ensure a smooth transition from facility-based care to community resources, and minimize readmissions.
- An analysis was performed to assess the managed care opportunity for medical services based on the following:
  - Comparison of NC FFS statistics to other state Medicaid managed care experience with consideration that NC experience is impacted by the current PCCM program.
  - Managed care efficiency analyses based on NC historical FFS experience (Potentially Preventable Admissions, Inpatient Hospital readmissions, Low Acuity Non-Emergent).
  - Pharmacy considerations under managed care related to clinical management.
- It is assumed that it will take approximately three years for each population to fully realize the expected changes to utilization, with 75% of utilization impact being achieved during the first 12 month period (less for the first short contract year).

Non-Benefit Expense Considerations

Methodology and Considerations

- The Non-Benefit load includes the following considerations:
  - General administrative costs, including program management, administrative operations and utilization management personnel
  - Care management
  - Profit/Underwriting Gain
  - Premium Taxes
- General administrative and care management components were modeled based on expected costs necessary to administer the requirements of the RFP, and developed as a PMPM not as a percent of premium
- Non-personnel costs primarily consist of IT systems, annual rent and utilities as well as the necessary equipment and supplies required to operate a business (e.g., computers and cell phones)

Non-Benefit Expense Considerations

Care Management

- Care management is an integral part of DHHS' health care strategy.
- Care management is a team-based, person-centered approach which partners with care coordination, focused more on administrative coordination.
- Care management was modeled based on expected staff to client ratios and assumption of 22% of population requiring CM.
- Advanced Medical Home (AMH) contracting and Local Health Departments (LHD) payment requirements were modeled as they will be utilized for care management.
- Other contract and staffing requirements include PHP screening and support to beneficiaries with high unmet social needs

Profit/Underwriting Gain and Premium Taxes

- Profit/Underwriting gain provides compensation to the PHP for the assumed risk (1.25% cost of capital, 0.5% risk margin).
- The capitation rates include 2.02% for NC insurance premium taxes, pending legislation.
- The rates currently do not include consideration for the Federal Health Insurer Provider Fee. It is DHHS intent to reimburse PHPs for this fee should it be applicable in a future contract period.

Illustrative Build-up of PHP Capitation Rates

PHP Capitation Rate Development (Illustrative)	
Projected FFS Medical Services (including historical PCMH and LHD payments)	$350.00
Managed Care Savings	$(25.00)
General Administrative Costs	$15.00
Care Management Costs	$11.00
UW Gain (1.75%)	$6.50
State Premium Taxes (2.02%)	$7.50
PMPM/Payment	**$365.00**

Comparison of Draft and Final Rates

	Draft Rates (Released with RFP)	Final Rates (Pending)
Base Data	Blend of SFY 2016 and SFY 2017 experience	SFY 2018
Covered Population	Based on initially proposed Standard Plan vs. Tailored Plan eligibility	Based on updated Standard Plan vs. Tailored Plan eligibility and better matched to operational approach
Benefit Package	No changes were assumed	Updated to include benefit changes such as adult optical, anticipated addition of peer supports to state plan, and SUD/IMD waiver
Provider Reimbursement	Proxy methodology for revised hospital reimbursement	Final hospital base rates; updated primary care physician fee schedule and nursing facility rates
Contract Year	Assumed July 2019 – June 2020	Regions 2 & 4: Nov 2019 – June 2020 Other Regions: Feb 2020 – June 2020 Final rates will reflect reduced managed care impact, additional trend and seasonality
Number of PHPs	Assumed four statewide and four regional plans	Four statewide plans and one regional plan

Risk Adjustment

Risk Adjustment

Overview

- Goals of Risk Adjustment
  - Help match payment to risk by estimating PHP variations in health care expenses based on the different demographic characteristics and disease conditions for the populations in each PHP.
  - PHPs with lower acuity populations will have base capitation rates adjusted down and PHPs with higher acuity populations will have base capitation rates adjusted upward so the weighted average of the budget neutral risk scores is equal to 1.0.
  - Discourage PHPs from avoiding enrolling higher risk individuals.
- DHHS will use the Chronic Illness and Disability, and Pharmacy Payment System (CDPS+Rx) model for risk adjustment process, calibrated to North Carolina data.
- Risk adjustment will apply to the ABD, TANF Child and TANF Adult rate cells.
- Maternity Event payments will not be risk adjusted because the specific payment is already a form of risk adjustment. Newborns are also not risk adjusted due to the lack of historical data.
- Risk adjustment will be evaluated separately by region.

Medical Loss Ratio

Medical Loss Ratio (MLR)

Key Concepts

- MLR is the portion of a PHP's premium revenues used to pay claims costs and costs for improvement in healthcare quality.
- As required by state law, the minimum MLR threshold for PHPs is 88%.
- MLR is measured retrospectively after the end of the contract year.
- PHPs with a MLR below 88% must provide a rebate to the state (shared with federal government) or invest in community-based health related resources in lieu of a rebate.
- The capitation rates are developed independent of MLR requirements, rates are not developed based on a target MLR.

Federal MLR Formula

$$\text{MLR} = \frac{\text{Incurred Claim Costs} + \text{Health Care Quality Improvement Costs}}{\text{Premium Revenues Excluding Amounts for Taxes/Assessments/Fees}} + \text{Credibility Adjustment}$$

State Modifications

- Adjustments to numerator:
  - Include expenditures for all community reinvestment activities that tie to state's quality strategy
  - Exclude payments to related entities that violate requirement that PHPs reimburse related providers no more than non-related entities
- Adjustments to numerator and denominator:
  - Exclude expenditures related to increased directed payments (University of North Carolina, Vidant, local health departments, public ambulance and Social Determinants of Health pilots)

Questions?