

Governor's Commission on New Hampshire's Medicaid Care Management Program

Medicaid Managed Care Financial Considerations

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Today's Agenda

- Overview of Measuring Program Effectiveness
- General Step 2 Rate Setting Considerations
- Discussion

Overview of Measuring Program Effectiveness

Common Questions...

- *When should a state begin to measure a newly established managed care program?*
- *What should a state measure for managed care?*
- *What would the program have cost under the old FFS program?*

Reasons to Track Program Effectiveness

- States measure the effectiveness of their managed care programs in order to:
 - Understand the medical and administrative services they are purchasing
 - Track changes in the delivery of care, outcomes, and cost of health care
 - Administer pay for performance programs
 - Measure the attainment of policy objectives
 - Set future policy objectives

Program Effectiveness Tracking Loop



Program Effectiveness Tracking – Tradeoffs and Limitations

- Collecting data and developing reports can be time consuming and expensive
 - State staff and contractor time is a cost to the State
 - MCO staff time adds to administrative cost
 - Therefore, only measure what is valuable to understand
- No organization can simultaneously improve on every aspect of their operations
 - Choose to measure and incentivize what is most important
- Time lag between performance and the ability to measure that performance
- Avoid measures that are difficult to calculate or not credible for small populations

Examples of Quality Measures

- Healthcare Effectiveness Data and Information Set (HEDIS) measurements are commonly used as quality measures
 - Typically states use a subset of HEDIS measures
 - Customized measures can also be designed
- Measures typically address child and maternal health, chronic conditions, screenings, preventive visits, member satisfaction, and other measureable events
- Distinct behavioral health measures are usually included, such as:
 - Follow-up after hospitalization for mental illness
 - Initiation and engagement of alcohol or other drug treatment
 - Alcohol or other substance misuse screening

Examples of Quality Measures – LTSS

- Process-based measures, such as:
 - Percent of service plans developed in a timely manner
 - Care management staff turnover
- Outcome measures, such as:
 - Percent of residents experiencing one or more falls with a major injury
 - Percent of residents who had a catheter inserted and left in their bladder
- Quality of life measures, such as:
 - Member/family satisfaction
- Tennessee rewards nursing homes directly by adjusting their reimbursement for high quality
 - <https://www.tn.gov/assets/entities/tenncare/attachments/QuiltssFramwork.pdf>

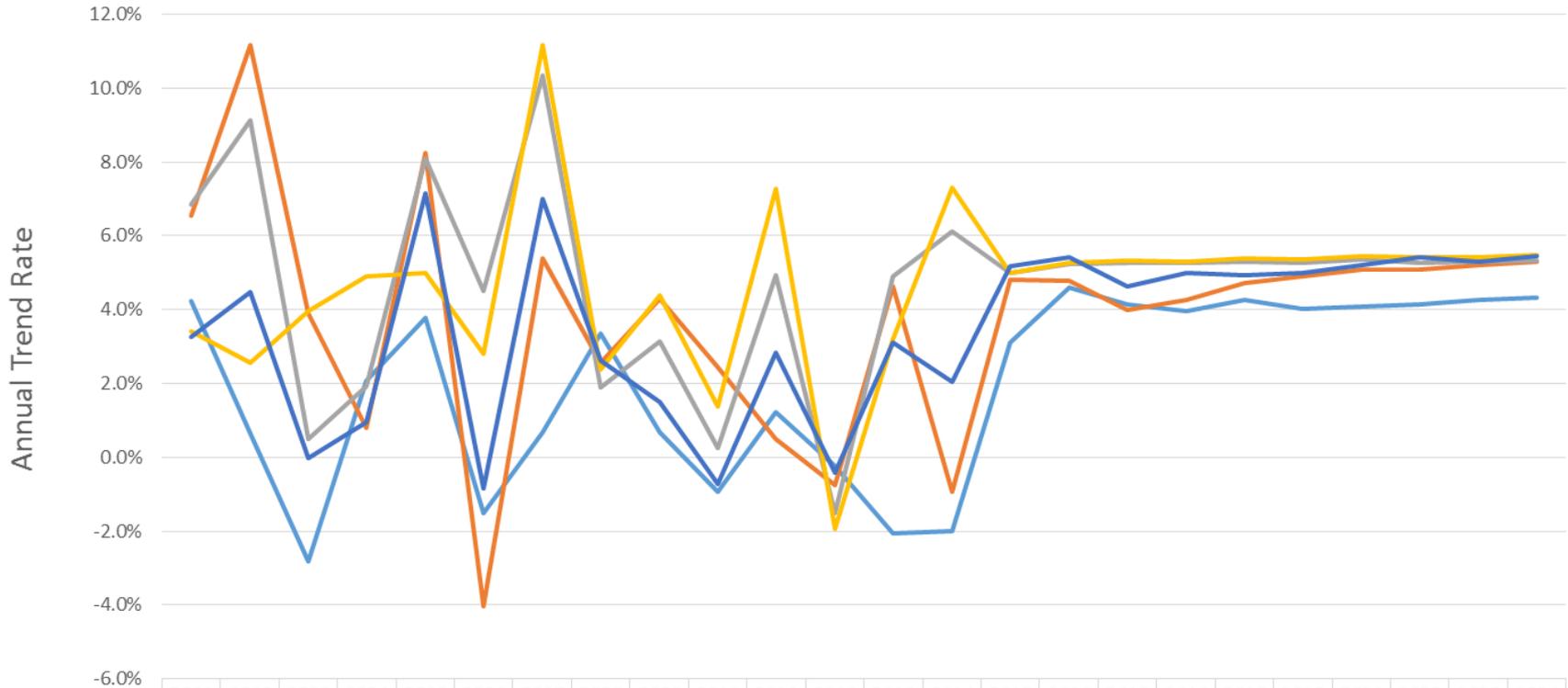
Examples of Operational Measures

- Members enrolled in a patient-centered medical home
- Members assigned to a care coordinator
- Members receiving a health risk assessment
- Resolution of member grievances and appeals
- Timeliness of answering member calls
- Timeliness of claim payment
- Timeliness and accuracy of encounter data submission
- Timeliness of mandatory report submission

Examples of Financial Measures

- Quarterly financial summary information
 - Florida Achieved Savings Rebate (ASR) report is an example of a very comprehensive quarterly financial reporting template
 - Some other states use a less detailed template
- Enrollment by MCO and population
- Medical loss ratio (MLR), administrative cost ratio (ALR), and gain/loss reporting
- Medical expenditures and utilization rates by category of service and population
- Managed care rate changes compared to CMS national Medicaid expenditures per enrollee trends (see next slide) or other trend benchmarks

National Medicaid Benefit Expenditures per Enrollee Annual Trend Rates From Table 19 - 2015 Actuarial Report on the Financial Outlook for Medicaid Published by the CMS Office of the Actuary



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
— Aged	4.2%	0.7%	-2.8%	2.1%	3.8%	-1.5%	0.7%	3.4%	0.7%	-0.9%	1.2%	-0.2%	-2.0%	-2.0%	3.1%	4.6%	4.1%	4.0%	4.3%	4.0%	4.1%	4.1%	4.3%	4.3%
— Disabled	6.5%	11.2%	3.9%	0.8%	8.2%	-4.0%	5.4%	2.6%	4.3%	2.4%	0.5%	-0.7%	4.6%	-0.9%	4.8%	4.8%	4.0%	4.3%	4.7%	4.9%	5.1%	5.1%	5.2%	5.3%
— Children	6.8%	9.1%	0.5%	1.9%	8.1%	4.5%	10.3%	1.9%	3.1%	0.3%	4.9%	-1.5%	4.9%	6.1%	5.0%	5.2%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%	5.3%
— Adults	3.4%	2.6%	4.0%	4.9%	5.0%	2.8%	11.2%	2.4%	4.4%	1.4%	7.3%	-1.9%	3.2%	7.3%	5.0%	5.3%	5.3%	5.3%	5.4%	5.4%	5.5%	5.4%	5.4%	5.5%
— Average of all enrollees	3.3%	4.5%	0.0%	1.0%	7.2%	-0.9%	7.0%	2.6%	1.5%	-0.7%	2.9%	-0.4%	3.1%	2.1%	5.2%	5.4%	4.6%	5.0%	4.9%	5.0%	5.2%	5.4%	5.3%	5.5%

Public Links to Examples of State Reporting

- Florida's Medicaid plan reporting requirements (including the ASR quarterly financial reporting template):
 - http://www.fdhc.state.fl.us/medicaid/statewide_mc/report_guide_2016-01-01.shtml
- Oregon's Health System Transformation Coordinated Care Organizations Performance Reports
 - <http://www.oregon.gov/oha/Metrics/Pages/HST-Reports.aspx>
- Iowa's quarterly performance report for its new Medicaid managed care program (implemented in 2016):
 - https://dhs.iowa.gov/sites/default/files/IowaMedicaidManagedCare_Year1_Qrtr1.pdf
- Ohio quality measures – Appendix M of the following document:
 - <http://www.medicare.ohio.gov/Portals/0/Providers/ProviderTypes/Managed%20Care/Provider%20Agreements/ManagedCare-PA-201609.pdf>

List of Oregon's Quality Measures

- **Access to care (CAHPS survey)**
- **Adolescent well-care visits**
- **Alcohol or other substance misuse screening (SBIRT) - all ages**
- Alcohol or other substance misuse screening (SBIRT) - ages 12-17
- Alcohol or other substance misuse screening (SBIRT) - ages 18+
- All-cause readmissions
- **Ambulatory care: emergency department utilization**
- Ambulatory care: avoidable emergency department utilization
- Ambulatory care: outpatient utilization
- Appropriate testing for children with pharyngitis
- Cervical cancer screening
- Child and adolescent access to primary care providers
- Childhood immunization status
- Chlamydia screening
- **Colorectal cancer screening**
- Comprehensive diabetes care: HbA1c testing
- Comprehensive diabetes care: LDL-C screening
- **Controlling high blood pressure**
- **Dental sealants on permanent molars for children - all ages**
- Dental sealants on permanent molars for children - ages 6-9
- Dental sealants on permanent molars for children - ages 10-17

Items in **bold red text** are used as incentive metrics for Oregon's Coordinated Care Organizations (CCOs)

List of Oregon's Quality Measures

- **Depression screening and follow-up plan**
- **Developmental screening in the first 36 months of life**
- **Diabetes HbA1c poor control**
- Early elective delivery
- **Effective contraceptive use among women at risk of unintended pregnancy - ages 18-50**
- Effective contraceptive use among women at risk of unintended pregnancy - ages 15-17
- Effective contraceptive use among women at risk of unintended pregnancy - all ages
- **Electronic health record (EHR) adoption**
- **Follow-up after hospitalization for mental illness**
- Follow-up care for children prescribed ADHD medication (initiation phase)
- Follow-up care for children prescribed ADHD medication (continuation and maintenance phase)
- Health status (CAHPS)
- Immunization for adolescents
- Initiation and engagement of alcohol or other drug treatment (initiation phase)
- Initiation and engagement of alcohol or other drug treatment (engagement phase)
- Low birth weight
- Medical assistance with smoking and tobacco use cessation: Advised to quit
- Medical assistance with smoking and tobacco use cessation: Medications to quit
- Medical assistance with smoking and tobacco use cessation: Strategies to quit

Items in **bold red text** are used as incentive metrics for Oregon's Coordinated Care Organizations (CCOs)

List of Oregon's Quality Measures

- **Mental and physical health assessments for children in DHS custody**
- Obesity prevalence
- **Patient-centered primary care home (PCPCH)**
- PQI 01: Diabetes short-term complication admission rate
- PQI 05: Chronic obstructive pulmonary disease or asthma in older adults admission rate
- PQI 08: Congestive heart failure admission rate
- PQI 15: Asthma in younger adults admission rate
- PQI 90: Prevention quality overall composite
- PQI 91: Prevention quality acute composite
- PQI 92: Prevention quality chronic composite
- **Prenatal and postpartum care: timeliness of prenatal care**
- Prenatal and postpartum care: postpartum care rate
- Provider access questions from the Physician Workforce Survey
- **Satisfaction with care (CAHPS)**
- Tobacco use prevalence (CAHPS)
- Well-child visits in the first 15 months of life

Items in **bold red text** are used as incentive metrics for Oregon's Coordinated Care Organizations (CCOs)

General Step 2 Rate Setting Considerations

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

DHHS policy priorities

Limitations placed on MCOs by DHHS

CMS regulations

Actuarial soundness requirement and Actuarial Standards of Practice

LTSS Rate Setting Considerations

- The monthly cost for a NF resident is relatively fixed
 - Overwhelming majority of Medicaid costs for NF residents are related to the NF per diem
- PMPM cost for community residents is also relatively stable, and may increase as more services are needed to support a member in the community
- Program savings is derived from supporting members in the community for as long as feasible and transitioning members from the NF back to the community if practical

General LTSS Rate Setting Structure

- There are generally two approaches to setting MCO capitation rates for populations needing LTSS services
 1. Setting separate rates for NF residents and community residents
 - Some states pay MCOs using separate rates for NF residents and community residents (weakest financial incentive)
 - Some states pay a blended rate to encourage MCOs to maintain more members in the community (stronger financial incentive)
 - Most states use this approach
 2. Setting a single rate for all LTSS users and using functional-based risk adjustment to appropriately pay each MCO for the acuity of their enrolled members (strongest financial incentive)
 - Requires timely data regarding each member's functional status
 - Wisconsin and New York currently use this approach

Caveats and Limitations

- This document is intended to be used by the New Hampshire DHHS in a presentation to the Governor's Commission on New Hampshire's Medicaid Care Management Program on the general financial framework for Medicaid managed care programs. 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 New Hampshire Medicaid program and Medicaid populations and 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

