CY 2022 MCO Capitation Rate Development

Virtual Zoom Meeting

April 2, 2021 9:00 a.m.

Minutes

Date and Time of Meeting: April 2, 2021 at 9:00 AM

Name of Organization: State of Nevada, Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP), Mercer Government Human Services Consulting

Place of Meeting: Zoom Video/Call

Introduction:

- Katerina Lau (Lead Actuary with Mercer) welcomed everyone.
- Cody Phinney provided opening remarks, this is the opportunity for you to provide feedback in developing these rates for 2022. We appreciate your participation and feedback. As Katarina mentioned, please hold your questions to the end; the Division is trying to find a mechanism where we can have written questions related to this after the second round of questions.
- Katerina introduced the rest of the Mercer team.

General Rate Development:

- Tori Herren begins with the key stakeholders, Medicaid Agency, Health Plans and CMS. She said the goal of the states and their actuary when setting Medicaid managed care capitation rates, is to create an appropriate and reasonable reimbursement arrangement between the state and the MCOs for the transfer of risk and the provision of services as required in the managed care contract. She stated the Capitation rates should provide for all reasonable, appropriate, and attainable costs for covered services provided to enrolled population during a specific time period. It promotes cost containment and quality health outcomes as well as well-managed plan with the opportunity to earn a reasonable profit and to ensure tax dollars are being spent effectively. She continues with the general rate development components, base data, base data adjustments, medical trends, program changes, non-medical expenses, and risk adjustment.
    1. The base data is used to determine the appropriate data sources to be used as base data, the claims and eligibility may be from MMIS, encounters, or financials. Per CMS, based data must be Medicaid state plan services for Medicaid eligibility.
    2. Base data adjustments are to ensure membership reflected in the base data is representative of the managed care eligible population in the contract. IBNR medical expenditures, modifications to base data to ensure data consistency can include data blending of multiple sources or years, and unit cost normalization.

3. Medical trends accounts for non-problematic changes in overall cost resulting from unit costs and utilization changes, projects experience from the midpoint of the base data period to the midpoint of the contract, and relies on plan experience data as well as experience in other states, nationally, and regionally.
4. The program changes adjusts for programmatic change is not fully captured in the base data and may be a result of policy clarifications, legislative decisions, an items in the state budget, this may include benefit coverage changes, eligibility coverage changes, and provider payment and reimbursement rate changes.
5. Non-medical expenses --administration and care management expenses, assessments and premium taxes, underwritten gain (profit risk and contingency).
6. Risk adjustment accounts for the relative health status of enrollees, applied in budget in a neutral manner, redistributes the pie but does not resize the pie and can be applied prospectively or retrospectively.

- Tori continues with the 36 capitation rate Cells. There are 2 regions, Northern and Southern, and covers 3 populations such as TANF/CAP, Expansion, and Checkup.

Base Data:

- Katerina walks through the base data specifics. They will use the same base data used in the prior rate development. She said they are using pre-COVID based data for the rates, as it is more appropriate to use this period and adjust as necessary. The states data vendor provided a data extract for 3 years in early 2020. The few exclusions—encounters that were missing demographic information and if there were any ineligible age combinations (adult checkup member). Most of the data is for managed care enrollees. There's several excluded/carved out services. They are identified in the encounter data, and in the managed care contract. Wrap around service are paid through FFS not the managed care liability; but in 2022, those services will be carved back in. They will adjust for CCBHCs, day & residential habilitation and value-added services. Per federal regulation, we excluded adult IMD members. The main adjustment is IBNR; we continue to use the data they received last April. Through reviewing the MCOs encounter data, we discovered where there was some underreporting in the data we had. There were a few road bumps with the new MMIS system, which led to some under reporting where claims weren't submitted to MMIS or there were some details to work out where encounters were being erroneously excluded. Expenses that might not be captured in the encounter data itself, such as provider incentive payments, overpayments and out of system payments that get reported in the SDRs.

Medical Rating Adjustments:

- Katerina continues-- using 2019 base period and 2020 rate period – used 36 months of data. Trends are typically expressed as an average trend factor. The trend is applied from the midpoint of the base period to the midpoint of the contract period by rate cell and category of service. For CY 2022, this will be July 1, 2019 to July 1, 2022. The trends are expressed as an annualized average rate and considers the impact of known programmatic changes adjusted for outside of the trend. Mercer is in several different states so we can leverage our capital across the firm, we can look at other states and national studies to be sure our trends make sense, of course with regional variances. Our base is pre-COVID, however we know that COVID-19 has had an impact in a variety of ways. We're also looking at enrollment, how long the public emergency might continue, etc. We are working closely across all the states, Mercer anticipates getting the most current information and uses their best judgement for utilization moving forward in 2022. There could be some downward pressure that could cause increases with other items such as increase in mental health.
- Janine Statt talks about pharmacy claims. Mercer looks at what they have done in other states, and reviews program changes. The mandatory FFS formulary is effective January 1, 2022. The MCOs must adopt and adhere to the state's current FFS pharmacy Preferred Drug List (PDL). The Pass-Through Pricing for PBM

will be effective January 1,2022 and the MCOs must contract with the PBMs using a pass-through pricing model.

- Brandon Odell continues with the medical rating adjustments. The Dental ASC, NICU/PICU, Short-Term IMD Repricing, and Assembly Bill 3.
    1. Dental ASC-Fee schedule increase of approximately 63% for dental ASC services effective April 2019. A percentage increase will be applied to applicable encounters for January through March 2019.
    2. NICU/PICU- Fee schedule increase of 25% for NICU services and 15% for PICU services effective January 2020. A percentage increase will be applied to increase the applicable encounters to CY 2019 base data.
    3. Short-Term IMD Repricing- Reprice short-term IMD stays to acute inpatient psychiatric/detox per diem reimbursement rates with corresponding average length of stay adjustment.
    4. Assembly Bill 3- Various fee schedule reductions effective August 15, 2020 pursuant to Assembly Bill 3. Pending legislative decision reinstate percentage decreases to applicable encounters in CY 2019 base data.
- Brandon stated the rating adjustment Mercer will make is short term IMD and a corresponding adjustment by the average length of stat. The last adjustment carrying forward to 2022 is AB3, that was passed last year with a 6% cut to providers in the state. This bill could be amended, changed, or appealed in its entirety this legislative session, and they will be watching what the outcome will be. He continues with the SMI population, Nursing Home Coverage, RTC Coverage, CCBHCs, and Legislative Session 81. They will reflect by adding in the member months and making any adjustments necessary to account for those people. For nursing home coverage- the timeframe has been changed to 180 days. Mercer will review the encounter data by adding this population in, and that will be reflected in the rates. The MCOs will be responsible for all costs but will evaluate the impact of this change. The services provided at CCBHC will be included in the managed care rates. Lastly, Mercer will evaluate any legislative changes which is anticipated to be at the end of May. In order to price the stop loss coverage, we project the inpatient encounters forward, adjusting for any hospital fee changes as well as trend; we aggregate by member who exceeds the threshold; the state is responsible for 75% of the costs, the MCOs, 25%. The Medical Rating Adjustments Credibility- applying weighting to rate cells with partial credibility. Full credibility is based on 36,000 base data member months. They then blend manual projected medical cost PMPMs with experience of credible rate cells. The manual rates development will include region factors as well as checkup manual rates that include a population factor when leveraging TANF/CHAP.

Non-Medical:

- Brandon continues through the presentation with Administrative Expenses which are the expected costs of MCOs to administer the program. The underwriting gain is a small portion of the total capitation rate to make the program a sustainable business venture for the risk-bearing MCOs. The assessments and premium tax are a non-medical load-- considers applicable taxes and fees (state premium tax). Mercer will look at other states regarding the administrative expenses. They reflect the 3% state premium tax in the rates. The utilization component of trend is on a case by case basis, not an incident rate of the population. Delivery case rate covers the delivery event itself with minimal coverage of pre- and post-natal care. Delivery case rate for VLBW is budget neutral to the state. Once payments are made, if they exceed the funded level, then the payments cease. If not, the remaining funds are dispersed to the MCOs. All the money will go to the MCOs regardless of the number of incidents. This has a separate cost pool.

Other Contract Provisions:

- Katerina talks about the Deliver Case Rate (Maternity Kick Payment). The delivery case rate is triggered by a qualifying delivery event. This is projected separately from other capitated services but adjusted for

applicable program changes and trends. The development uses the same data sources and general methodology as capitation, grossed up for non-medical expenses and premium tax. She continues with the low birth weight risk pool. The VLBW supplemental payment is triggered by qualifying VLBW event, up to the funded level. The risk pool is funded by the reduction to PMPM capitation rates for TANF/CHAP under 1 rate cells. This grossed up for non-medical expenses and premium tax and the remaining funds, if any, are distributed to the MCOs. The division will provide further guidance for the quality withhold. The inpatient/professional payment are the payments that don't flow through capitation. These are assessed and paid outside of the capitation. The new directed payment-CCBHCS will transition over to managed care and are priced at the state plan rate. These will be paid out on actual utilization and performance measures by the CCHBC.

Risk Adjustment:

- Brandon Horman gives an overview of the current application to the risk adjustment. The risk adjustment measures the relative acuity of the populations enrolled in each of the MCOS- dependent on accurate and complete encounter data reporting. On average, the risk adjustment will result in increased funding to the MCOs with the higher risk population and reduced funding for the MCOs with the lower risk population. The risk adjustment will utilize the most current version of the CDPS+Rx model (national weights). The current application risk adjustment is applied retrospectively on an annual basis. CY2020 risk adjustment will use encounter data submitted on or before March 31, 2021. A final schedule of risk-adjusted rates is produced for each MCO, along with additional information generated from the CDPS+Rx process. The rate cells with no risk adjusted include, TANF/CHAP and Check Up under 1 (and VLBW) as well as delivery case rate (Maternity Kick Payment). In the current application of risk adjustment, it's applied retroactively. The final reconciliation amounts are not known until after the measurement period. For CY 2020 encounter data submitted through March 2021 is included in this adjustment. For 2022 risk adjustment, it will include all2022 encounters submitted through March 2023 will be used in the risk adjustment calculation. The final schedule of adjusted rates is produced for each MCO. DHCFP and Mercer expects to use the same methodology used last year going forward. For CY21 and CY22 rates, there aren't large changes planned. Any changes made will be known to the MCOs.

Comments/Questions in Chat:

FROM CHAT: (text in red indicates response)

From RPA to Everyone: 09:12 AM
What is unit cost normalization? Katherina Lau - unit cost normalization: this is a general overview, not NV specific. In some programs, it might be necessary to adjust base data to normalize for varying contracted reimbursement levels.

From RPA to Everyone: 09:15 AM
Is it necessary / done in NV? Katherina Lau – No.

From Toni Inserra to Everyone: 09:18 AM
Have you excluded cost-based services such as Critical Access Hospital and Rural Health Clinics? Katherina Lau - certain services are excluded from managed care. We only include experiences that were included under the managed care contract.

From Randy Brock to Everyone: 09:23 AM
With the SMI population becoming mandatory, will the State consider adding a SMI rate cell? Can you provider FY2019 FFS spend on SMI members? Also, can you provider FFS spend with CCBHCs? Katherina

Lau – no separate rate cell for 2022. SMI members were voluntary and now moved to managed care. This change is limited to adults; these members were mandatory due to expansion. We do not have the spend numbers for FFS with CCBHCs. Mercer will provide details on the impact as they add them in. It will depend on PPS rates for 2022 and projected utilization levels.

From Lynam Ben to Everyone: 09:26 AM
Is encounter data for base period "re-priced" or does unit cost reflect negotiated rates between MCOs and providers? Katherina Lau - The encounter data is not re-priced; it reflects the encounters that were submitted. One nuance is there are sub-capitated arrangements and we received shadow prices; but we use the paid amount to develop the base data.

From Randy Brock to Everyone: 09:36 AM
Can Mercer provide details on how they will adjust rates for changes in the PDL? Janine Statt – Mercer will review the encounters against the state FFS PDL and analyze any shift in brand preferred drugs and therapeutic classes and adjust the assumptions for the base to be more reflective of the current PDL in an environment assuming it would have been in place for CY 2022. This will be provided in the final rate presentation.

From Mike Schramm: What has Mercer determined is the appropriate Administrative expense % and what has Mercer determined is the expected Underwriting Gain %? Both of those are things that we will address once the rates are developed completely. Those percentages depend on both the total projected benefit expenses as well as the projected administrative expenses. They will be provided in the final rate development presentation.

From Kindle Craig to Everyone: 09:49 AM
Will these slides be shared after the presentation? Sarah Bellemare -The presentation is available here: http://dhcfp.nv.gov/Public/AdminSupport/PublicNotices/

From Sarah Hunt to Everyone: 09:55 AM
What is the process for the receiving delivery payment and Very Low Birth Weight payment? Also, how will the directed payment and the CCBHC payment be made? Seeking to understand process. Cody Phinney– payments are currently being made through manual transactions. Regarding the VLBW payments, those are submitted to us from the current plans and we pay manual transactions on those.

From Jayson Chatelain:
Did you review CY 2019 runout encounters after 3/31/2020 to validate IBNR assumptions? Katherina Lau– we will look at the more recent data we have available to us to determine if the adjustment that we made 2021 continues to be the appropriate adjustment to use for 2022.

From Susan Priestman:
Will the recording be available? Cody Phinney – we will ask purchasing to make both the slides and the recording available with the materials that they distribute.

From Russ Elbel to Everyone: 10:02 AM
What legislative appropriation impacts, if any, will influence the budget pool / rates? Katherina Lau – To be determined as we do not have final legislative action available to us yet. We will do our best to include many of the program changes that they are aware of and we deem to have material impact on the rates.

FROM PHONE:
Rick Pattenson (AmeriHealth Caritas) – can Mercer make available the average relativity to provider payments from Medicaid for various service types? Katherina Lau– I don't think we would provide that. We would defer to the state.

Is that something Mercer looks at? Katherina Lau– It is not one of our standard analyses included here.
One last comment on it, for new entrants to the market obviously it is very important to understand ballpark where that is to appropriately contract with providers to be consistent with the revenue rates you develop. Cody Phinney– we will take your question back and review it. I am not aware that we have that information at this point.

Nathan Berra (AETNA) – The presentation mentions 85% MLR, but the RFP says any Medicaid rate cell below 85% will require a rebate. Can you clarify how MLR remittances are determined and if it is at the program or rate cell level? Katherina Lau –Mercer develops the rates to reasonably achieve at least an 85% MLR but I will leave it to the state to speak on the contractual language and process. Cody Phinney– We will get you an answer to your question, but not in this venue. Please watch for the second round of questions – this will be the mechanism used to answer questions.

Kevin Mitby-Manning (SilverSummit) – In the past, there's a risk corridor for specialty drugs in 2020, since there's a global corridor for COVID, is there a plan to have a specialty drug risk corridor for 2022 and beyond? Katherina Lau– I'll leave it to the state to speak on the contractual language and process. Cody Phinney– we have been discussing whether we want to go back to that risk corridor for specialty pharmacy. At this point, we don't expect to do that; however, I am going to reserve the right to provide additional responses in writing.
You mentioned in your trend development you would have COVID considerations, but would you consider at least providing what your trend assumptions are absent of COVID, and then explicitly stating whatever COVID adjustments you would be making? Katherina Lau – I do anticipate that we would delineate and give you a good sense of how we adjusted for COVID.
Impact of moving to the State PDL could be different depending on the transition rules so we ask that you consider the transition rules when coming up with the PDL adjustment. Janine Statt - Transition of care and continuity of care are items that we review and will be considered.

FROM CHAT:
From Russ Elbel to Everyone: 10:08 AM
The RFP stated the availability of a data book. Will that be provided and what data will be provided within it? Cody Phinney – yes, the data book will be provided. I cannot speak to what exactly will be contained in it at this time. We are aware that it was erroneously not made available already, but we are working to correct that as soon as possible.

From Jayson Chatelain to Everyone: 10:12 AM
Will there be adjustments for the transition of members to different MCOs in Jan 2022? Cody – can the caller repeat the question? Katherina Lau– there will be adjustments for the movement of members in terms of risk adjustment because risk adjustment is done retrospectively. I'm not sure what else the questioner is asking.
With the MCOs applying and accepted through the RFP process a large portion of the membership will move Jan 2022. Will that impact the carrier rates? Katherina Lau – in terms of capitation rate development, we don't anticipate that we would make particular adjustments for that, but again that movement will be captured in the retrospective risk adjustment process so the final rate paid to the MCOs will vary based off of the movement of members, it's just done retrospectively.

From Russ Elbel to Everyone: 10:14 AM
Will there be continuity of care period for movement of members? Cody Phinney – what there will be is the continuation of our transition of care requirements that do include some continuity of care aspects.

From Kevin Mitby-Manning:
When you develop admin for the rates, will it vary for each contractor, such as north vs. south or statewide? Katherina Lau– we do not expect that we would vary the admin loads by plan; it will be program wide. It's still

TBD on how exactly we will be applying the non-medical in terms of variation by rate cell, but we do want to explore the option for some fixed variable across the different rate cells. It is still an aspect that is under way in terms of our methodology development.

From Jayson Chatelain to Everyone: 10:16 AM
What is the timing of the risk adjustment settlement payments? Bradley Horman- It does take Mercer a few months to be able to go through the full risk adjustment process as stated in the presentation. At the end of the measurement period, we do allow for three more months for submission of encounters. Fred Gibison– I think Brad must have gotten locked up on internet space so I will finish his thought - after the run out period for the study period it takes us a few months to complete the process then review the results with the State. Probably the earliest that any risk adjusted rates or risk adjustment factor results would be available for the CY 2022 period would be some time in the summer of 2023, probably towards the end of summer. It does vary based on how long it takes and what's happening with the program at that particular time.

From Russ Elbel to Everyone: 10:18 AM
Are there any directed payments within the rates? The slides cover those outside of the rates, but are there any within the rates? Katherina Lau - In 2022, the only anticipated directed payment that is included in capitation is the CCBHC fee schedule for the PPS rate.

From Jayson Chatelain to Everyone: 10:18 AM
The cap rate history provided in the RFP showed a change for Sep 2020. Do those rates include the P4P withhold? Katherina Lau– Katherina Lau - No, in 2020 the P4P withhold was canceled for the year so the September 2020 rates do not include a withhold.

From Susan Priestman:
Which Providers would be eligible for incentive payments, are theses based on Medicare? Katherina Lau – I am not entirely sure what the questioner is referring to. There are the directed payments for quality incentive or bonus payments that are prescribed by the Division for CCBHC. I am not sure what other incentive payments the questioner might be asking about. Cody Phinney – I am wondering if that question is specific to the directed payments that we are working to implement but I can't tell from the question.

LAST CALL FOR QUESTIONS:

Cody Phinney – I want to recognize that this is a challenging process but the more questions we get, the better this program is going to be so please don't hesitate to share your questions with us. We really appreciate all your participation.

How should follow up questions make their way to the State? Cody Phinney – I very much appreciate everyone's time and attention. It is our intention to alter slightly our instructions on round 2 of the questions and indicate that those can include both follow-ups to round 1 and follow-ups to this presentation today. We will provide that in the answers to the round 1 questions as well. That is one additional mechanism to ask questions and provide comments on this information as you think about it. We really appreciate that this is a very challenging timeline. It is for us as well and we are dedicated to trying to get all the information in both directions that is possibly available.

Presentation ended at 10:24.
An Audio (CD) version of this meeting is available through the DHCFP Compliance office. For more detailed information on any of the handouts, submittals, testimony and or comments, please contact Jenifer Graham at jenifer.graham@dhcfp.nv.gov or (775) 684-3685 with any questions.