



## **Heritage Health Rate Development Narrative**

### **Background**

The base data and adjustments used for the populations currently enrolled in Physical Health or Behavioral Health managed care were derived using the assumptions in the latest (January 2016 – June 2016) Physical Health and Behavioral Health rate development. For populations not currently enrolled in managed care FFS data was used, and rating adjustments from a comparable population were applied to create the projected rates. Optumas will update the base data and re-evaluate all assumptions when updating the Heritage Health rates in the spring.

### ***Rating Regions***

Optumas analyzed the cost differences (inclusive of the new populations and services) across counties and used the results of this analysis as the basis of the rating region recommendation for the Heritage Health program. After discussing the results of the regional analysis with the State, Optumas proposed Rating Region 1 (RR1) and Rating Region 2 (RR2) as outlined on page 142 of the RFP.

### ***Covered Populations/Services***

The populations and services that are included in the draft Heritage Health rates are illustrated in the “Heritage Health Pre-Proposal Conference” presentation.

### **Base Data**

For the Physical Health acute care services, Optumas used SFY14 and SFY15 claims data from the existing Physical Health program, paid through September 30<sup>th</sup>, 2015.

For the Behavioral Health services, Optumas used claims data from the existing Behavioral Health program incurred from September 1<sup>st</sup> 2013 (the program’s inception) through June 30<sup>th</sup> 2015. The Behavioral Health data for the Foster Care population was unique; Optumas only used SFY15 incurral dates. When analyzing the FY14 and FY15 Foster Care data, FY14 was substantially different than FY15 and Optumas determined that FY15 was the most reasonable basis for predicting future Foster Care expenses. The current managed care entity described the change in Foster Care experience as variance in utilization for PRTF due to a decrease in requests for PRTF. After further discussions, it was determined that the utilization levels inherent in the FY2015 data was more indicative of future utilization patterns. The Behavioral Health data was paid through June 30<sup>th</sup> 2015.

For the populations and services that are being carved into Managed Care, such as the Pharmacy benefit or the acute care services for the LTSS population, Optumas used SFY14 and SFY15 FFS data, paid through September 30<sup>th</sup>, 2015.

**Figure 1. Data Sources**

<b>Populations</b>	<b>Services</b>	<b>Data Source</b>
Populations currently enrolled in Physical Health Managed Care	Physical Health and Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entities

Populations	Services	Data Source
LTSS Population	Physical Health Services	SFY14 and SFY15 FFS data
LTSS Population	Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entity
Non-LTSS Dual Population	Physical Health Services	SFY14 and SFY15 FFS data
Non-LTSS Dual Population	Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entity
Subsidized Adoption Population	Physical Health Services	SFY14 and SFY15 FFS data
Subsidized Adoption Population	Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entity
Women with Cancer Population	Physical Health Services	SFY14 and SFY15 FFS data
Women with Cancer Population	Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entity
Hospice Population	Physical Health Services	SFY14 and SFY15 FFS data
Hospice Population	Behavioral Health Services	SFY14 and SFY15 encounter data submitted by existing managed care entity
All Populations	Rx and Transplant Services	SFY14 and SFY15 FFS data

### **IBNR**

Optumas analyzed the claim payment lag by category of service through the incurred but not reported (IBNR) analysis. IBNR factors were developed and applied to the base data by category of service and data source. Completion patterns and assumptions for encounter data sets were discussed with current managed care entities to ensure reasonableness. IBNR factors can be found in the accompanying Excel document, titled “IBNR Assumptions by Source”.

### **Program Changes**

The State has implemented several program and policy changes that impacted the service costs that were not reflected in the base data. Optumas considered any prospective program change adjustments necessary to project the base to the contract period. Optumas and the State worked in partnership to determine the impact, shown within Figure 2 below, of the program changes on the projected capitation rate ranges:

**Figure 2. Program Changes**

Adjustment	Overview
<b>ASD Adjustment</b>	Beginning October 2015, the State is requiring the coverage of applied behavior analysis (ABA) and Behavioral Modification services for children with an Autism Spectrum Disorder (ASD) diagnoses. The State provided Optumas with the prevalence of ASD, which equated to 0.6% of Medicaid children having an ASD diagnosis. Optumas used this prevalence information, coupled with research and discussions with our internal clinician, to arrive at an estimated PMPM impact by cohort. The final Heritage Health rates will incorporate emerging program experience for this adjustment.
<b>DD Adjustment</b>	Beginning October 2015, the State is requiring coverage of ABA and Behavioral Modification services for children with a Developmental Disability (including Intellectual Disability) (DD). The State provided Optumas with the prevalence of DD, which equated to 0.7% of Medicaid children having a Development Disability. Optumas used this prevalence information and discussions with our internal clinician, to arrive at an estimated PMPM impact by cohort. The final Heritage Health rates will incorporate emerging program experience for this adjustment.
<b>Service Delivery Adjustments</b>	<p>NEMT Ambulance – This adjustment represents the addition of NEMT Ambulance services to the Managed Care program.</p> <p>Rx Dispensing Fee Change – This adjustment represents a change in the dispensing fee for non-independent pharmacies, from \$4.45 to \$2.50.</p> <p>Dual Integrated Care Savings - Individuals dually eligible for Medicaid and Medicare were previously not enrolled in physical health managed care. The non-nursing home level of need duals represent a significant opportunity for care savings. Inpatient utilization was reduced by 10%, Outpatient utilization was reduced by 15%, and Emergency Room utilization rates were reduced by 25%. The aggregate impact of these changes to the healthy dual population is a reduction of 5.4%.</p>
<b>Immediate Enrollment</b>	Beginning February 1, 2014, the State has implemented immediate enrollment in Medicaid managed care for newly eligible members. Enrollment is now effective back to the first day of the month that a health plan is chosen. Previously enrollment was effective the first day of the month following health plan selection. The impact of this program change was calculated by comparing the PMPM cost for members whom were in at least their second month of eligibility for the February to June 2014 time period to the PMPM cost for all members whom were eligible during that

Adjustment	Overview
	<p>period. The difference between these two PMPM costs would estimate the impact of immediate enrollment for those members who had enrolled in the Physical Health managed care program after the policy was implemented. This adjustment is somewhat mitigated because it is inherent in 17 of the 24 months of base data.</p>
<b>APR-DRG</b>	<p>On July 1, 2014 the State of Nebraska moved from using the AP DRG payment methodology to the APR DRG payment methodology for inpatient hospital claims. This change impacts all hospitals that are reimbursed on a DRG basis; this excludes hospitals reimbursed on a per diem basis such as Critical Access Hospitals (CAHs) and rehab facilities. The impact of this change was calculated by first re-pricing all impacted inpatient hospital claims in the SFY14 base data, at the AP DRG version 27 weights and SFY14 hospital rates specific to each hospital. This was done to ensure that the comparison between the AP DRG and APR DRG reimbursement would not be influenced by any contracting or payment differences between the MCO reimbursement and the State AP DRG fee schedule. Optumas then assigned an APR DRG and severity level to all inpatient hospital claims included in the analysis based on version 31 of the grouper. This was done by utilizing software from 3M who developed the APR DRG grouper. These claims were then re-priced using the APR DRG version 31 weights and SFY15 hospital rates. The final impact was calculated by comparing the percentage change from the SFY14 AP DRG re-priced amount to the SFY15 APR DRG re-priced amount for each category of aid and MCO.</p> <p>The transition to the APR DRG payment methodology was intended to be budget neutral at a global level, however it should be recognized that this may break down between health plans and especially between rate cells. The overall results do show that the impact is close to budget neutral in aggregate but does show increases and decreases by rate cell.</p>
<b>FQHC Rate Updates</b>	<p>Optumas calculated and applied an adjustment to account for FQHC APM rate changes. Optumas adjusted the FQHC rates inherent in the encounter data to be commensurate with the FQHC APM rates effective 1/1/16.</p>
<b>Prospective Behavioral Health Provider Increase</b>	<p>Beginning July 2014 and July 2015, the State has implemented a 2.25% provider increase. Optumas applied the 2.25% increase to all Behavioral Health services, with the exception of FQHC and RHC providers. The September-June 2014 data received three and a half 2.25% increases, while the July-June 2015 data received two and a half 2.25% increase.</p>

Adjustment	Overview
<b>PRTF Program Change</b>	Optumas calculated and applied an adjustment to account for cost settlements made outside of the MMIS system to two Psychiatric Residential Treatment Facilities. Optumas adjusted the PRTF rates inherent in the encounter data to be commensurate with these cost settlements.
<b>MST/FFT Carve-In</b>	Effective July of 2016 Multisystematic Therapy (MST) and Functional Family Therapy (FFT) will be covered benefits. Optumas added the anticipated expense for these services into the Heritage Health rates. The expense was projected using provider information, case rates, and anticipated provider caseloads. Optumas developed these assumptions with the help of our internal clinician.
<b>Behavioral Health Copay Adjustment</b>	Beginning January 2014, the State implemented a \$2.00 copay for certain services. Since this change was implemented within the base data period, Optumas only needed to adjust September-December 2013 to reflect the copay policy change. The January 2014 – June 2015 base data already reflected the copay implementation, so no adjustment for this time period was necessary.
<b>Physical Health Copay Adjustment</b>	The State currently imposes copays on several Medicaid populations. While MCOs are not required to charge copays, the State reimburses the MCOs as if they did impose copays. The impact of this program change was calculated by adjusting reimbursement as necessary to reflect full collection of copays.
<b>Benefit Limits</b>	The State currently imposes limits on chiropractic visits, rehab visits, hearing aids, and eyeglasses for Medicaid FFS. The impact of this program change was calculated by removing any utilization and corresponding cost from the SFY14-15 base data for any of the services listed above that exceeded the FFS utilization limit.

### Trend

Trend factors were applied to estimate the change in utilization rate (frequency of services) and unit cost (pure price change, technology, acuity/intensity, and mix of services) of services over time. These trend factors were used to project the costs from the base period to the future contract period. Trends were developed on an annualized basis and applied by major category of service (COS) (e.g., inpatient, outpatient, etc.) and category of aid (e.g. AABD, Family, etc.). Trend values can be found in the accompanying Excel file, titled “COS and COA Trends”.

Physical Health and Pharmacy trends were applied for a total of 36 months from the midpoint of the July 2013 – June 2015 base (6/30/2014) to the midpoint of the contract period (7/2/2017).

With the exception of Foster Care, Behavioral Health trends were applied for a total of 35 months from the midpoint of the September 2013 – June 2015 base (7/31/2014) to the midpoint of the contract period (7/2/2017). Foster Care trends were applied for a total of 30 months from the midpoint of the July 2014 – June 2015 base (12/30/2014) to the midpoint of the contract period (7/2/2017).

### **Non-Medical Loading**

The non-medical load measures the dollars associated with components such as administration, profit, and quality improvement (QI) and are expressed as a percentage of the capitation rate. Optumas utilized reported administrative and profit levels in the financials submitted by the current managed care entities to develop the non-medical load. Experience in other states and similar programs on both a PMPM and percentage basis were also reviewed to ensure reasonableness.

Nebraska State Statute 78-831 requires all contracts and agreements relating to the medical assistance program governing at-risk managed care service delivery for behavioral health services entered into by the Department on or after July 1, 2012, shall:

- (1) Provide a definition and cap on administrative spending that (a) shall not exceed 7% unless the implementing department includes detailed requirements for tracking administrative spending to ensure (i) that administrative expenditures do not include additional profit and (ii) that any administrative spending is necessary to improve the health status of the population to be served and (b) shall not under any circumstances exceed 10%.

The detailed non-medical loading assumption by each subcategory is included in slide 15 of the rate presentation.

### **UNMC Supplemental Payment**

The University of Nebraska Medical Center (UNMC) providers are reimbursed at commercial fee levels. Since the MCOs contract at levels more commensurate with Medicaid reimbursement, a supplemental payment is required to be paid to UNMC by each MCO to make these providers whole. The State includes this supplemental payment as part of the capitation rates, which is then paid by the MCOs to UNMC.

Optumas received a list of UNMC provider IDs from the State as well as the MCOs. These lists were used to identify claims and services attributed to a UNMC provider. The State also provided the most recent UNMC fee schedules, which were used to calculate the difference between the UNMC fee schedule and the UNMC reimbursement inherent in (a) the FFS data for currently un-managed populations and (b) the MCO encounter data for populations currently enrolled in managed care. The difference between the adjusted reimbursement and the reimbursement reflected in the FFS and encounter data at current utilization levels is the amount paid as a supplemental rate to UNMC.