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Louisiana Medicaid
CCN Program
Actuarial Briefing

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Meeting Agenda

- DHH Opening Comments
- CCN - P (Prepaid Model) Premium Rates and methodology
- CCN – S (Shared savings Model) Savings Reconciliation methodology
  - Cost benchmarks
  - Case management fees
- Both Models – Risk Adjustment

Questions and Answers after each topic

CCN – P (Prepaid Model)
Rate S**etting**

Comparison to Draft Rates discussed in August 2010

- Key Similarities
  - Underlying Methodology is still Fee-for-Serve (FFS) based
  - Rate Cell structure and Risk Adjustment Approach
  - Covered Groups
  - Covered Benefits
- Key Differences
  - Base years for FFS data (changes many of the adjustments)
  - Regional Roll out schedule (results in different contract periods)
  - New FFS rate changes
  - Treatment of GME
  - Updated assumptions, notably trends
  - Competitive bid but rates will not be bid

We have not attempted a reconciliation to prior rates.

Roll out Schedule and First Rate Period (Page 1 of Certification)

- Phase 1 (January 1, 2012 – December 31, 2012)
  - New Orleans
  - North Shore (formerly known as Mandeville Region)
- Phase 2 (March 1, 2012 – December 31, 2012)
  - Baton Rouge
  - Thibodaux
  - Lafayette
- Phase 3 (May 1, 2012 – December 31, 2012)
  - Lake Charles
  - Alexandria
  - Shreveport
  - Monroe

Subsequent Rate Periods will be Calendar Years.

Base Data Development (Page 3 of Certification)

- State Fiscal Year (SFY) 2009 and SFY 2010 Eligibility Data
  - Adjusted enrollment records for retrospective changes in eligibility
- SFY 2009 and SFY 2010 FFS Claims Data with runout through August 2010
- Louisiana SFY runs from July 1st – June 30th

Adjustments are summarized in Certification Letter

Excluded Populations (Page 5 of Certification)

- Medicare Dually Eligible Individuals
- Home and Community Based Services Waiver Recipients
- *Chisholm* Class Members
- Individuals Receiving Medicaid Hospice Services
- Individuals Residing in Long Term Care Facilities (Nursing Home, ICF/DD)
- Individuals Receiving Services for Three Months or Less (Medically Needy Spend-down)
- Undocumented Immigrants Eligible for Emergency Services Only
- Enrollees receiving single service (family planning only)
- LaCHIP Affordable Plan

Excluded Services (Certification page 5)

Plans are required to provide all medically necessary services except for the following:

- Services provided through DHH's Early Steps Program
- Dental Services
- ICF/DD Services
- Hospice
- Personal Care Services (EPSDT and LT-PCS)
- Nursing Facility Services
- Pharmacy
- School-based Individualized Education Plan Services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures
- Home and Community-Based Waiver Services
- Specialized Behavioral Health
- Targeted Case Management Services

GME and FQHC (Page 4 and 6 of Certification)

- GME
  - GME component in hospital claims has been removed
  - State will pay the GME component to hospitals

- FQHC/RHC
  - Reimbursement to these entities shall be at the Prospective Payment System (PPS) rate
  - DHH will reconcile payments from the CCN-P to FHQCs/RHCs quarterly to ensure the full PPS rate is paid
  - If there is a shortfall, CCN-P is required to pay the difference

Rate Cells
(Page 7 of Certification)

<table>
<tr><td colspan="2">SSI</td></tr>
<tr><td>▪ 0 – 2 Months, Male and Female
▪ 3 – 11 Months, Male and Female
▪ 1 – 5 Years, Male and Female
▪ 6 – 13 Years, Male and Female</td><td>▪ 14 – 18 Years, Male and Female
▪ 19 – 44 Years, Male and Female
▪ 45+ Years, Male and Female</td></tr>
<tr><td colspan="2">Family and Children</td></tr>
<tr><td>▪ 0 – 2 Months, Male and Female
▪ 3 – 11 Months, Male and Female
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<tr><td>▪ Foster Care Children, All Ages</td><td>▪ Breast and Cervical Cancer, All Ages</td></tr>
<tr><td colspan="2">▪ Maternity Kickpayment</td></tr>
</table>

* Note age is calculated as of the beginning of the month.

Trend Factors
(Page 7 – 10 of Certification)

- Trend factors were updated based on new data and significant actuarial judgment
- Detailed tables are included in Certification (pages 8 – 10)
- Unit Cost trend is set to zero for many categories where the effect of fee schedule changes is considered a programmatic adjustment
- Programmatic changes are discussed in detail on pages 10 – 15 of certification. We also reverse engineered a capitation build up in Attachment B which includes columns for fee schedule changes
- Overall annualized trend factor is 3.67%

Data Smoothing
(Page 16 of Certification)

- 40/60 blend of SFY 2009 and SFY 2010 experience
- Some blending of regional and statewide data for rate cells with smaller enrollment. Details can be seen in Attachment B build up.

Managed Care Assumptions (Pages 16 – 20 of Certification)

- Detailed assumptions are included in the tables and in the Attachment B build up.
- Overall Impact is 14.69%
- This reflects our best judgment of what needs to be achieved in context of existing delivery system and recognizes that this is the first year of prepaid networks.

Administration and Planned Underwriting Gain (Page 20 of Certification)

- Overall assumed administrative cost of 10.0% of premium and planned underwriting gain of 1.8% of premium.
- Applied as a loading of 6.4% to the Maternity Kick Payment and 12.7% to the age/gender cells.

Resulting Rates (Attachment A to Certification)

- Rates are set out in Attachment A
- A detailed rate build up exhibit has been approximated in Attachment B.
- The attachments and all tables and references in the Certification reflect a single “target scenario”. Mercer used rate ranges to assure the actuarial soundness of the target scenario.
- Rates will be risk adjusted in an actuarially sound manner to reflect health risk differences between the Prepaid networks and the Shared Savings networks as well as between the individual Prepaid Plans in any region.

Q & A

CCN – S (Shared Savings Model)
Benchmarks and Rates

Comparison to discussion in August 2010

- Key Similarities
  - Underlying Savings Reconciliation Methodology
  - Benchmarks based on a PMPM Cell structure
  - Risk Adjustment of Benchmarks
  - Covered Groups
  - Covered Benefits
- Key Differences
  - Base years for FFS data (changes many of the adjustments)
  - Regional Roll out schedule (results in different contract periods)
  - New FFS rate changes
  - Updated assumptions, notably trends
  - Competitive bid but financial details will not be bid

We have not attempted a reconciliation to prior PMPMs.

Shared Savings Structure

- A Benchmark Cost is developed based on the expected Fee-for-Service (FFS) cost absent the network
- The benchmark cost is built up from specified PMPM amounts in age and gender cells
- Actual costs, including case management fees, are compared to the benchmark
- DHH retains the risk and pays claims on a FFS basis
- Savings are shared with 60% going to the network
- Savings are shared only if quality benchmarks are met
- CMS considers the savings payout to be an incentive and limits to 5%
- If there are no savings, plans will be required to pay back up to 50% of the management fee

Roll out Schedule
(Page 1 of Benchmark Letter)

- Phase 1 (January 1, 2012 – December 31, 2012)
  - New Orleans
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  - Monroe

Future benchmarks will be developed on Calendar Year basis

Base Data Development (Page 3 of Benchmark Letter)

- State Fiscal Year (SFY) 2009 and SFY 2010 Eligibility Data
  - Adjusted enrollment records for retrospective changes in eligibility
- SFY 2009 and SFY 2010 Fee-for-Service (FFS) Claims Data with runout through August 2010
- Louisiana SFY runs from July 1st – June 30th

Adjustments are described in detail in the Benchmark letter

Excluded Populations (Page 5 of Benchmark Letter)

- Medicare Dually Eligible Individuals
- Home and Community Based Services Waiver Recipients
- *Chisholm* Class Members
- Individuals Receiving Medicaid Hospice Services
- Individuals Residing in Long Term Care Facilities (Nursing Home, ICF/DD)
- Individuals Receiving Services for Three Months or Less (Medically Needy Spend-down)
- Undocumented Immigrants Eligible for Emergency Services Only
- Enrollees receiving single service (family planning only)
- LaCHIP Affordable Plan

Excluded Services
(Page 6 of Benchmark letter)

Plans are required to provide all medically necessary services except for the following:

- Services provided through DHH's Early Steps Program
- Dental Services
- ICF/DD Services
- Hospice
- Personal Care Services (EPSDT and LT-PCS)
- Nursing Facility Services
- Durable Medical Equipment (DME)
- Non Emergency Transportation
- School-based Individualized Education Plan Services provided by a school district and billed through the intermediate school district, or school-based services funded with certified public expenditures
- Home and Community-Based Waiver Services
- Specialized Behavioral Health including Rx
- Targeted Case Management Services

PMPM Category Groupings for Benchmark (Page 7 of Benchmark letter)

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Trend Factors
(Page 7 – 10 of Benchmark Letter)

- Trend factors were updated based on new data and significant actuarial judgment
- Detailed tables are included in Letter (pages 8 – 10)
- Unit Cost trend is set to zero for many categories where the effect of fee schedule changes is considered a programmatic adjustment
- Programmatic changes are discussed in detail on pages 10 – 13 of Letter. We also showed a PMPM build up in Attachment B which includes columns for fee schedule changes
- Overall annualized trend factor is 3.39%

Data Smoothing
(Page 13 of Letter)

- 40/60 blend of SFY 2009 and SFY 2010 experience
- Some blending of regional and statewide data for rate cells with smaller enrollment. Details can be seen in Attachment B build up.
- Large claims are smoothed out by excluding amounts over $100,000 for any recipient in any year from the reconciliation.

Resulting Benchmark PMPMs (Attachment A to Letter)

- Rates are set out in Attachment A
- A detailed PMPM build up exhibit has been approximated in Attachment B.
- Rates will be risk adjusted in an actuarially sound manner to reflect health risk differences between the Prepaid networks and the Shared Savings networks as well as between the individual Shared Savings networks in any region.
- Mercer and DHH will reconsider Benchmarks after Fiscal 2011 claims are available and may adjust if they appear too low or too high.

Case Management Fees (Page 7 of Fee Letter)

- Case Management Fees have been established as:
  - TANF/LaCHIP $13.31 PMPM
  - SSI-related $19.66 PMPM
- $1.50 of these amounts will be paid directly to the PCPs with remainder going to networks
- Only the network share ($11.81 or $18.16) will be included in the savings reconciliation.
- Build up of the network share by service is shown on page 6 of Fee letter

Q & A

Risk Adjustment
Both Models

Risk Adjustment Overview

- Risk adjustment measures the relative acuity of the populations enrolled in each of the CCNs
- Risk adjustment will result in increased funding to the CCN-Ps with a higher risk population and reduced funding for the CCN-Ps with a lower risk population
- Risk adjustment will impact the shared savings calculation through higher benchmarks for the CCN-Ss with a higher risk population and lower benchmarks for CCN-Ss with a lower risk population
- ACG (Johns Hopkins) model will be used initially to measure health risk
- Starting in the fourth month of the implementation in a geographic area, rates and benchmarks will be risk-adjusted
- Health risk of the members and the CCNs will be measured on a semi-annual basis

Highlights of ACG Risk Adjustment Model

- DHH selected the Adjusted Clinical Groups (ACGs) diagnosis-based system, developed by Johns Hopkins University, to assess the health risk of each Medicaid member
- The ACG model uses ICD-9-CM or ICD-10-CM diagnoses codes documented on FFS claims or encounter data to assign members into approximately 100 mutually exclusive ACG categories based on pattern of morbidity, age, and gender
- ACG model excludes diagnoses associated with laboratory, radiology services and durable medical equipment from disease classification
- In most situations, only one diagnosis code is required to classify a member into a disease condition
- A tentative decision has been made to require two or more instances of supporting diagnosis codes to classify select chronic conditions

Using claims/encounter data

- Members will be assigned to an ACG category based on twelve months of experience data (referred to as the measurement period)
- July 2010 through June 2011 claims data with 6-months of run-out (through December 2011) will likely be used for the initial risk adjustment
- Data quality and completeness can significantly impact the risk scores
- As part of risk adjustment, claims/encounter data will be examined for data quality and completeness to identify potential gaps in data
- If claims/encounter data are not sufficiently complete for risk adjustment, other data source e.g. pharmacy data may be considered in the future

Determining individual risk scores

- Using the data within the twelve-month measurement period, members will be assigned to an ACG category
- The cost weight associated with the assigned ACG category will serve as the individual's risk score, which represents the expected health care costs to care for the individual member relative to the overall population
- Members must have at least six months of eligibility during the twelve-month measurement period to receive a risk score
  - Six-month criteria does not require continuous eligibility

Assigning members and their risk scores to CCNs

- CCN enrollment data at a point in time (snapshot) will be used to assign members and their corresponding risk scores to a CCN
- The selected snapshot will generally be the month proceeding the payment period
- For initial risk adjustment, December 2011 enrollment data will be used to assign members to CCNs for payment periods from January to June 2012
- Some members do not have a calculated risk score (unscored members)
  - Less than six months of eligible months within the measurement period to calculate a risk score
  - New to Medicaid (no experience within the measurement period)
- Since the health risk of unscored members is unknown, they will be assigned the average health risk of the population

Calculate raw CCN risk scores

- Risk scores of individual enrolled members will be aggregated and averaged to determine the CCN risk score
- Table below contains a limited example based on ten members

Members	CCN A
1	0.9700
2	1.7100
3	0.1600
4	2.6710
5 (Unscored)	1.2790
Raw (Average) Risk Score	1.3580

Members	CCN B
6	1.6420
7	0.9500
8	0.8500
9 (Unscored)	1.2790
10 (Unscored)	1.2790
Raw (Average) Risk Score	1.2000

- Based on the above example, the overall population's (All CCNs) risk score is 1.2790, which was used for the unscored members

Calculate raw CCN risk scores

- Risk scores of CCNs that have a small number of enrollees may be unstable and have low credibility
- CCN risk scores will be calculated for each geographic area for the following consolidated groups:
  - Families and Children Ages 1 through 18
  - Families and Children Ages 19 and older
  - SSI Ages 1 through 18
  - SSI Ages 19 and older
  - Foster Care Children
  - Breast and Cervical Cancer
- CCNs that have less than 50 enrollees in the consolidated group will be assigned the average population risk score
- Maternity and newborns premiums and benchmarks will not be risk-adjusted

Calculate CCN relative risk scores

- Calibrate CCNs risk scores for easier interpretation
  - Average population is 1.0000
  - Higher risk population is greater than 1.0000
  - Lower risk population is less than 1.0000
- Divide CCN raw risk scores by the All CCNs raw risk score, except for voluntary populations that will be divided by All CCNs and FFS.
- Below is an example of the relative risk score calculation for family and children ages 19 and older, assuming an equal size of enrolled population for each CCN

	CCN A	CCN B	All CCNs
Raw Risk Score	1.3580	1.2000	1.2790
Relative Risk Score	1.0618 (1.3580 / 1.2790)	0.9382 (1.2000 / 1.2790)	1.0000

- This step is commonly referred to as a Budget Neutrality adjustment

Determine inherent risk

- The underlying age-gender premium and benchmark PMPM structure inherently allows for some risk variation
- Risk variation that is accounted for by age and gender rate cells are called “inherent risk”
- Below is an example of the determination of inherent risk for family and children ages 19 or older within a geographic area, with an evenly distributed population size for each CCN

Rate Cells	Universal Prepaid Rate	Membership Distribution		
		CCN A	CCN B	All CCNs
F&C Females 19-44	$300.00	80%	84%	82%
F&C Males 19-44	$250.00	10%	8%	9%
F&C Females 45+	$425.00	6%	5%	6%
F&C Males 45+	$455.00	4%	3%	4%
Composite Rate		$308.70	$306.70	$307.70
Inherent Rate Risk		1.0032	0.9968	1.0000

Calculate CCNs final risk score accounting for inherent risk

- To avoid duplicative-adjustment of health risks when CCN relative risk scores are used in combination with age-gender rate cells, the relative risk risk scores will be modified to only account for the incremental effect of health status
- Below is an example of the calculation of the final risk score for family and children ages 19 and older

	CCN A	CCN B	All CCNs
Relative Risk Score	1.0618	0.9382	1.0000
Inherent Risk	1.0032	0.9968	1.0000
Final (Adjusted) Risk Score	1.0583 (1.0618 / 1.0032)	0.9413 (0.9382 / 0.9968)	1.0000 Dollar Weighted

Apply CCN final risk scores

- Premium rates and PMPM cost Benchmarks that vary by age and gender are then risk adjusted using the CCN final risk scores
- Below is an example of the application of final risk scores to the prepaid rate for family and children ages 19 and older within a geographic area, assuming an equally distributed population within each rate cell:

Rate Cells	Example Unadjusted Prepaid Premium Rate	CCN A Final Risk Scores	CCN A Final Risk Adjusted Prepaid Rate
F&C Females 19-44	$300.00	1.0583	$317.49
F&C Males 19-44	$250.00	1.0583	$264.58
F&C Females 45+	$425.00	1.0583	$449.78
F&C Males 45+	$455.00	1.0583	$481.53
Composite Rate		1.0583	$378.34

Q & A

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