NEW YORK STATE | Department of Health | Office of Health Insurance Programs

Managed Long Term Care Rate Development

Division of Finance and Rate Setting
March 22, 2018

Managed Care Rate Setting Goals

Review

Review existing methodologies for:

- Consistency
- Transparency
- Accuracy
- Actuarial Soundness

Analyze and Advise

Work collaboratively, onsite, and side-by-side with DOH, OMH, OPWDD, OASAS, and MCOs

- Deloitte provides analysis and advice regarding actuarial soundness
- DOH leadership makes rate setting decisions
- Rate setting goals:
  - ✓Timely – rates finalized prior to rate effective date
  - ✓Collaborative –rate setting approach that aligns with and supports state policy objectives
  - ✓Transparent – avoid “black box” methodologies
  - ✓Accurate

Certify

Deloitte certifies actuarially sound rates

- Consistent with Actuarial Standards of Practice and CMS requirements
- Capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs

Managed Care Rate Setting Principles

Capitation rates and rate setting methodology should be actuarially sound and follow all applicable actuarial standards of practice (ASOPs)

1

Capitation rates are reasonable and comply with all applicable laws

The capitation rates are developed in accordance with the relevant requirements of 42 CFR 438. The documentation is sufficient to demonstrate that the rate development process meets the requirements of 42 CFR part 438

2

Capitation rates must be certified as actuarially sound

The capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract for the time period and the population covered

3

The rate development processes are consistent with generally accepted actuarial standards of practice (ASOPs)

Relevant ASOPs include ASOP 1 (Introductory Actuarial Standard of Practice); ASOP 5 (Incurred Health and Disability Claims); ASOP 12 (Risk Classification); ASOP 23 (Data Quality); ASOP 25 (Credibility Procedures); ASOP 41 (Actuarial Communications); ASOP 45 (The Use of Health Status Based Risk Adjustment Methodologies); and ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification)

4

Plan payment rates should be within the certified rate range for the rate cell covered

Rates at any point within the rate range are certified to be actuarially sound and that the capitation rate for each rate cell should be within the certified rate range. Beginning with rate periods on or after July 1, 2018, actuaries must certify specific rates for each rate cell and it will no longer be permissible to certify rate ranges. States are able to increase or decrease the capitation rate in each cell up to 1.5 percent

Rate Setting Methodology Overview

Base Data 2016 MMCOR "Program Alignment"	Base Data Adjustments	Program Change Adjustments	Trend	Acuity Factor & Risk Adjustment	Spenddown/ NAMI	Admin, Taxes, and Profit

• 2016 Program Alignment Data:
  • MLTCOR
  • FIDAOR
  • MAPOR
• 2016 Supplemental OR
	• Runout on 2016 IBNR
	• Adjustment to separate the community and . NHT populations in the MMCORs
	• Historical home health recruitment & retention
	• Reinsurance
	• Provider Incentives
		• Minimum wage increases in 2018 and 2019
		• Managed care savings
		• Prospective home health recruitment and retention
			• Apply trend to base data from midpoint of the base period to midpoint of the rating period	• Apply plan specific risk adjustment to Community rate; NHT population is excluded from risk adjustment
				• Analysis relies on:
				  • Historical DOH risk adjustment model coefficients
				  • UAS assessments through June 2017
					• Separate adjustments for Community spenddown and NHT NAMI based on 2016 Supplemental OR	• Apply administrative and care management load
						• Incorporate applicable taxes
						• Apply profit load

MLTC Partial Capitation Base Data & Base Data Adjustments

For the April SFY2018-2019 rate setting period, the base data utilized was focused in CY2016

Community Base Data

- Base data relied upon the Calendar Year 2016 program alignment data by aggregating the MMCORs for the MLTC Partial Cap, MAP and FIDA programs
- Supplemental ORs were utilized to distinguish between the NHT and Community populations

Nursing Home Transition (NHT) Base Data

- Base data relied upon the Calendar Year 2016 Supplement ORs provided during 4Q2017

Community Base Data Adjustments

IBNR

- This adjustment reflects plan reported changes to the IBNR embedded in the MMCORs based on subsequent MMCOR reports, as well as additional adjustments to the reserve

NHT

- This adjustment separates the NHT and Community membership and costs from the combined MMCOR amounts
- This is based on 2016 Supplemental OR reporting provided in 4Q2017

Other

- Historical home health recruitment & retention
- Reinsurance
- Provider incentives
- Other medical expense write-ins

NHT Base Data Adjustments

IBNR

- No IBNR adjustment was applied to the NHT-specific population

NAMI

- This adjustment removes NAMI from the base NHT medical expenses
- This relies on the NAMI amounts reported in the 2016 Supplemental ORs

Other

- No other base data adjustments were applied to the NHT-specific population

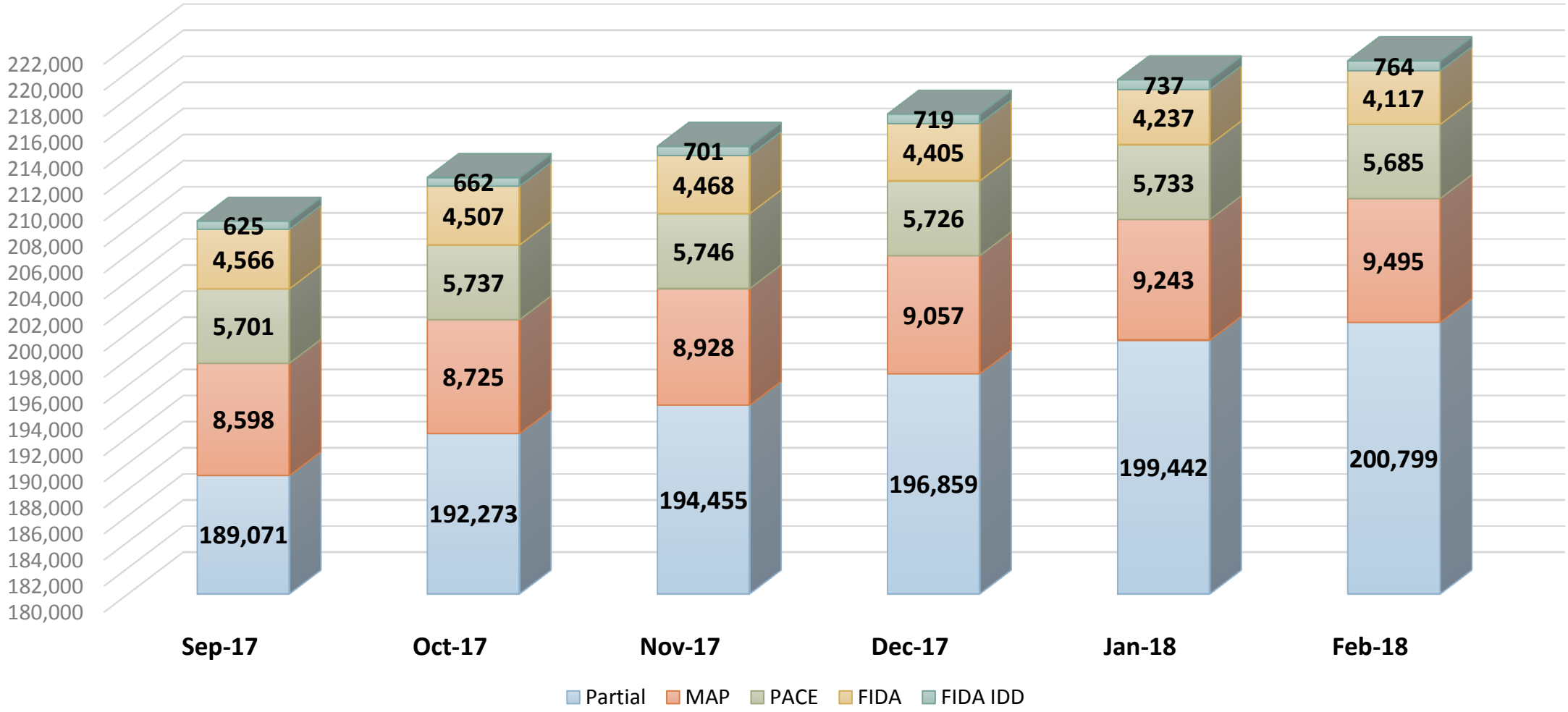
Comparison of Base Period Data

SFY 17-18 vs. SFY 18-19 Base Data

	SFY 17-18 Base Data	***SFY 18-19 Base Data***
Community		
Community Base	• CY2014 and CY2015 MMCOR, weighted 50/50	• CY2016 MMCOR
Mandatory Enrollment Phase-In	• Phased in during the CY2014 and CY2015 base period	• Complete for all regions in CY2016 MMCOR data
FLSA, Home Care Worker Wage Parity, Minimum Wage	• Phased in during the CY2014 and CY2015 base data • Associated program change adjustments were incorporated	• FLSA & Home Care Wage Parity is complete in base CY2016 MMCOR data • Minimum Wage phase in is not yet complete in the CY2016 MMCOR data and thus requires a program change adjustment
NHT Exclusion	• Relied on the CY2015 Supplemental OR to separate the Community and NHT populations in the CY2015 MMCOR	• Relied on the CY2016 Supplemental OR to separate the Community and NHT populations in the CY2016 MMCOR
NHT		
NHT Base	• 2012 FFS Data	• CY2016 Supplemental OR managed care experience
Nursing Home Transition Phase-In	• Phased in throughout 2015; as such, a full year of managed care experience was not yet available	• Fully reflected for all regions in the CY2016 base data period; a full year of managed care experience is available
NAMI	• FFS base data was net of NAMI	• CY2016 Supplemental OR managed care experience informs NAMI

Current MLTC Statewide Enrollment

Total Enrollees in MLTC: 220,860 (As of 2/1/2018)



*Based on 2017 and 2018 enrollment reports

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Minimum Wage Reconciliation

- Funding to support compliance with increases in Minimum Wage is currently being paid in Managed Care Rates.
- The Department has implemented the first phase of the reconciliation process – surveys of Home Care Providers were conducted in the Fall of 2017 which collected information associated with minimum wage costs. The Department is also collecting supplemental Minimum Wage reports from Managed Care Plans.
- The Department intends to reconcile prior rate adjustments to the actual costs determined through the Home Care surveys.

Community First Choice Option (CFCO)

- **Effective July 1, 2018**, the following CFCO service will be included in the Benefit Package and be available to CFCO eligible enrollees:
  - Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL) skill acquisition, maintenance, and enhancement
- **Effective January 1, 2019**, the following CFCO services will be included in the Benefit Package and be available to CFCO eligible enrollees:
  - Assistive Technology (beyond scope of Durable Medical Equipment)
  - Community Transitional Services
  - Moving Assistance
  - Home-Delivered/Congregate Meals
  - Environmental Modifications
  - Vehicle Modifications
  - Social Transportation
- Please direct any comments or questions to CFCO@health.ny.gov

MLTC VBP Financial Considerations for Plans

The performance adjustment is based on the **Potentially Avoidable Hospitalization (PAH)** measure

The Office of Quality and Patient Safety (OQPS) calculates the measure for each plan; it is risk adjusted across plans

Funding distributed in the rates based on plan membership

Partially Capitated

- **$10 million Stimulus** Incentive for plans to transition to VBP; allocation by per member per month (paid SFY 2017-18)
- **$50 million for VBP Performance Adjustment** for plans; based on PAH measure (paid SFY 2020-21)
- **Penalties** assessed based on conversion to VBP levels 1, 2 and 3

Fully Integrated

- **$1 million Stimulus** Incentive for Fully Capitated plans to transition to VBP (paid SFY 2017-18)
- **Performance Adjustments** information will be forthcoming
- **Penalties** assessed based on conversion to VBP levels 1, 2 and 3

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2018-2019 Executive Budget – MLTC Summary

- Administration Rate Reduction/Regulation Relief
- Increase Access to ALP Service
- Limit the number of LHCSA (Licensed Home Care Services Agencies) that Contract with MLTC Plans
- Require Continuous 120 days of CBLTC for Plan Eligibility
- Implement a UAS Score of 9 for MLTC Eligibility
- Prohibit Community-Based Long Term Care Provider Marketing and Restrict Referring Providers from being Servicing Providers
- Restrict MLTC Members from Transitioning Plans for 12 Months After Initial Enrollment
- Authorization vs. Utilization Adjustment for MLTC
- Limit MLTC Nursing Home Permanent Placement Benefit to Six Months
- Social Adult Day Health Benefit Efficiency Savings

Questions

- Questions regarding MLTC rate-setting can be submitted via e-mail to:

  MLTC Bureau Mail Log – mltcrs@health.ny.gov