

Government Human Services Consulting

January 25, 2011

State of California – Medi-Cal Rate Development for Seniors and Persons with Disabilities (SPD)

Recap of SPD Rate Development Process

- This is the fourth meeting with Medi-Cal health plans regarding the SPD rate development
 - August 12, 2010
 - November 19, 2010
 - December 3, 2010
 - January 25, 2010
- What follows will be a brief recap of previously covered materials. (Please refer to those meeting materials/presentations for additional detail)
- Then, we will review the major issues raised by the health plans.
- Finally, we will address these issues and provide an update on the rate development approach and assumptions.

Background

- Key information regarding the mandatory SPD transition
 - Aged and Disabled members that are Medi-Cal Only (i.e., non dual eligible members) will be mandatorily enrolled in managed care plans in Two-Plan and GMC counties
 - The effective date is currently scheduled to be June 1, 2011
 - Members will be phased into this mandatory enrollment based on their eligibility redetermination date (or month of birth) and the transition is currently scheduled to run for 12 months
 - All members will be given a choice of health plans
 - DHCS will attempt to assign members who do not “choose” a plan, based on their current provider relationships
 - Covered services will be the same as exists today in the Two-Plan and GMC models

Conclusions From FFS vs. MC Risk Assessment

- MC members have a higher disease burden in the majority (10/12) of the Two-Plan counties, indicating that FFS is not serving members with a higher disease burden.
- Both the FFS and MC programs have very similar disease conditions for their respective populations that are driving the overall health acuity within each program.

| Two-Plan Counties Combined CY2008-CY2009 | MC Risk Score Relative to FFS |
|--|-------------------------------|
| Alameda | 1.080 |
| Contra Costa | 1.122 |
| Fresno | 1.123 |
| Kern | 1.027 |
| Los Angeles | 0.946 |
| Riverside | 1.050 |
| San Bernardino | 1.031 |
| San Francisco | 0.939 |
| San Joaquin | 1.017 |
| Santa Clara | 1.034 |
| Stanislaus | 1.106 |
| Tulare | 1.126 |
| Two Plan Total | 1.015 |

Conclusions From FFS vs. MC Risk Assessment (continued)

- FFS members have a higher disease burden in both GMC Model counties.
- MC penetration rates are slightly higher in GMC versus Two-Plan.
- The Two-Plan and GMC combined results indicate that the MC population's acuity was 100.4% of the FFS population, showing that very similar risk is enrolled within the two population groups in aggregate.

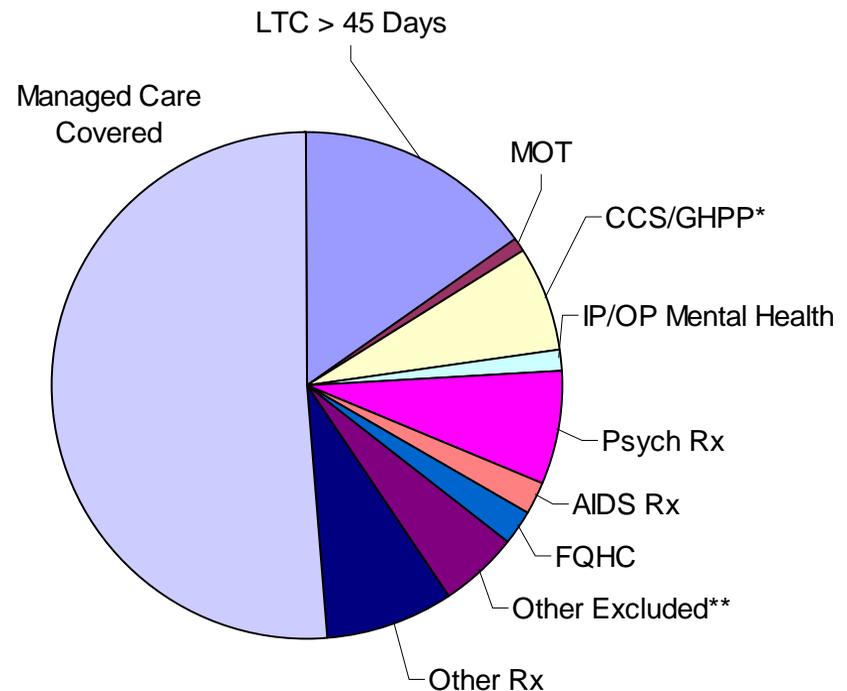
| GMC Counties Combined CY2008-CY2009 | MC Risk Score Relative to FFS |
|-------------------------------------|-------------------------------|
| San Diego | 0.905 |
| Sacramento | 0.985 |
| GMC Total | 0.945 |

Translating FFS Data - Updated

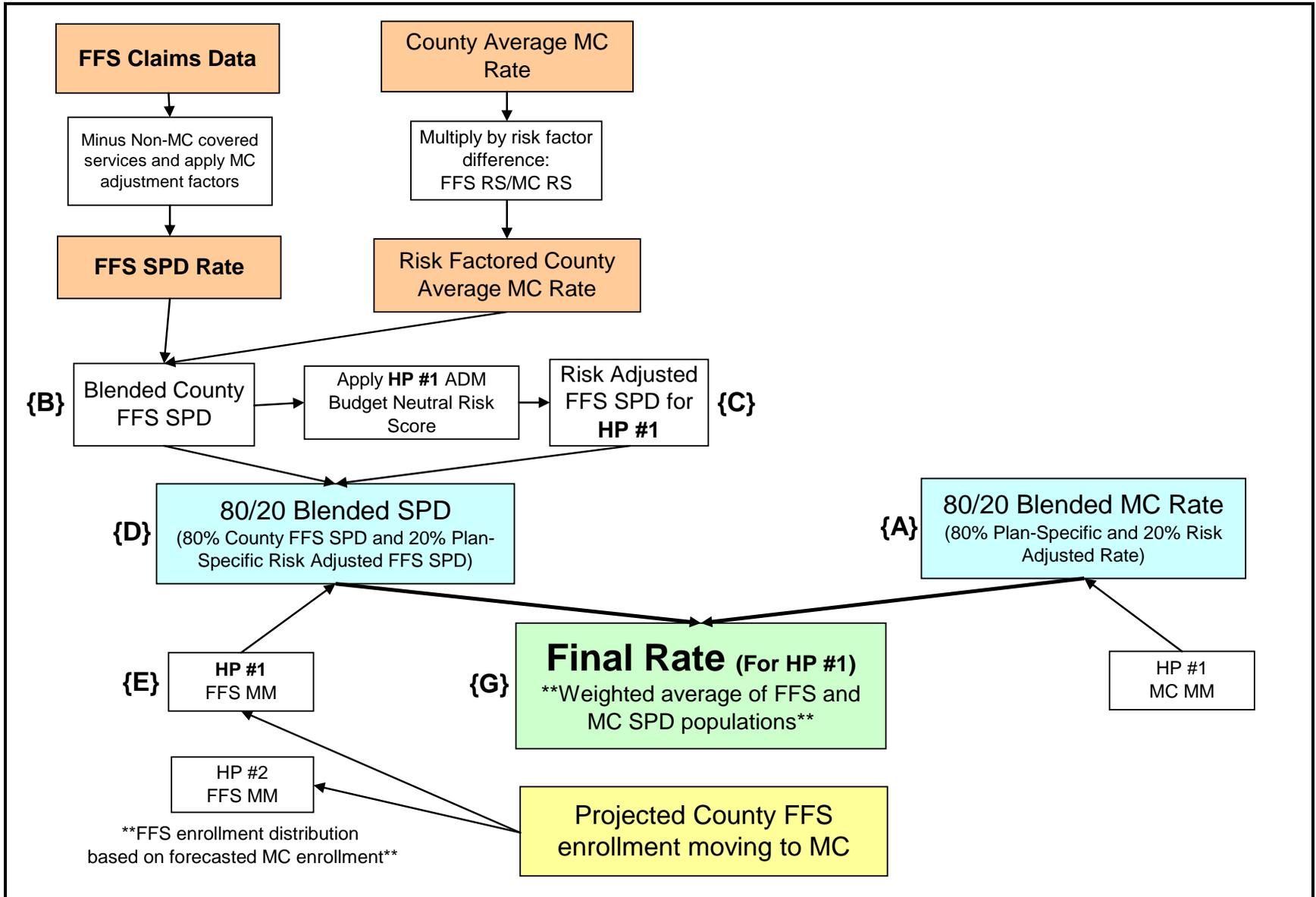
- Mercer pulled all calendar year 2008 and 2009 claims data for SPDs that were FFS enrolled. Much of the FFS data is for services that are not covered and/or is not otherwise a current fit for managed care rate development. The pie chart below is a graphical representation (sample only) of what portion of the FFS experience would translate to Managed Care “covered” services:

Two-Plan & GMC SPD Summary: Over 3 Months

| | |
|------------------------------|-------|
| All Raw FFS PMPM | \$996 |
| +3 Month FFS PMPM | \$962 |
| FFS less non-MC covered PMPM | \$495 |



SPD Rate Calculation Process Overview



Health Plan Feedback/Concerns

Concerns Expressed By Health Plans

- DHCS requested and did receive written feedback from the health plans regarding the SPD rate development approach and assumptions. The primary issues raised are summarized below in no particular order.
- **Issue #1**

The health plans have raised concerns about the level of managed care savings that can be achieved for this first rating period (Two-Plan 6/1/11 – 9/30/11, GMC 6/1/11 – 12/31/11). They have not said that no savings can be achieved in the rating period, just that less savings should be assumed for this first, shorter rate period.
- **Issue #2**

The health plans have raised concerns about the managed care savings assumptions for the pharmacy cost per unit. The plans pointed out that there is a transition period (3 months) wherein transitioning members will have the right to remain on their brand-name drugs if they request.

Concerns Expressed By Health Plans (continued)

- **Issue #3**

The health plans have suggested that DHCS pay at the top end (upper bound) of the actuarially sound rate range as opposed to paying at the lower bound of the rate range for the first year or two of the mandatory SPD roll-out.

- **Issue #4**

Health plans had questioned the validity of the Medicaid Rx results due to changes observed between the original and updated SPD acuity studies. The health plans want further explanation as to the reasons for the change in results.

Concerns Expressed By Health Plans (continued)

- **Issue #5**

One of the health plans has expressed concern as to the adequacy of the Medicaid Rx risk scoring for the current FFS SPD members. Specifically, their concern is that the FFS members may have higher risk than is being measured by the selected risk measurement tool (Medicaid Rx). Their assertion is that the risk in FFS is artificially low due to poor access to care and that the true level of risk of the transitioning members will be much higher after they are established with a managed care plan.

SPD Risk Scoring Discussion

SPD Acuity Study – Updated Results

- A question was raised regarding the changes in risk scores from the original to updated SPD acuity study results.
- Mercer feels strongly that the updated study results being applied in the development of capitation rates uses the most appropriate methodology and data sources available at this time.
- Changes between the original and updated study:
 - Base period changes
 - Medicaid Rx Model update
 - Inclusion of physician administered drugs

SPD Acuity Study – Updated Results

Original Study:

- Calendar Year (CY) 2008 as the base study period for the risk analysis.
- The original study used the Medicaid Rx model version 5.0 that was created using CY2001 to CY2002 national and Medi-Cal specific data (national data used for credibility when low observations appeared in the Medi-Cal data)
- No inclusion of physician administered drugs

SPD Acuity Study – Updated Results

Updated Study:

- Also used CY2008 as part of the base study period for the risk analysis. However, the following changes occurred within the CY2008 base data in the updated study:
 - Data were updated with at least six more months of encounter/claims processing lag (allowed more time for data to be submitted and processed) from the original study.
 - Included major data revisions for multiple health plans operating in multiple counties.
 - 7 Two-Plan Counties were affected by the data revisions.
- Therefore, the CY2008 data used in the updated SPD acuity study were more complete and better reflected the managed care risk than the results produced in the original study.

SPD Acuity Study – Updated Results

Updated Study (continued):

- CY2009 data were also used to match the base period used for rates (January 1, 2008 through December 31, 2009)
- The CY2009 data showed increased acuity in managed care compared to CY2008.
- Using CY2008 in conjunction with CY2009 data contributed to changes from the original SPD acuity study.

SPD Acuity Study – Updated Results

Updated Study (continued):

- Medicaid Rx Model Update
 - The version 5.2 model includes updates to the mapping logic to reflect more recent practice patterns and new NDCs that have recently emerged in the market (released June 2010).
 - Version 5.2 uses more recent and robust data spanning from CY2001 to CY2005.
 - Since more observations appeared in the Medi-Cal data, less reliance was placed on the national dataset (previously used to supplement the Medi-Cal data where there were low observations).
 - Moving to the updated model contributed to the changes in risk scores from the original SPD acuity study.

SPD Acuity Study – Updated Results

Updated Study (continued):

- Medicaid Rx Model Update
 - Since the original study was performed, the State and Mercer had implemented the use of physician administered drugs into the Medicaid Rx model as an additional method for flagging disease conditions.
 - Mercer incorporated this change into the SPD acuity study as well, which would have an impact on the results.
 - Note that the same Medicaid Rx version 5.2 model applied in the updated SPD acuity study was used to adjust (20%) the capitation payments for the contract period 10/11 rates.

Medicaid Rx – evaluating FFS versus managed care

- Another concern had been expressed regarding the adequacy of the Medicaid Rx risk scoring for the current FFS SPD members.
- One assertion was that the risk in FFS is artificially low due to poor access to care and that the true level of risk of the transitioning members will not be known until after they are established with a managed care plan.
- Mercer has examined this issue in a variety of ways. No substantial evidence to support the assertion has been found.
 - FFS versus managed care utilization
 - Risk analysis of other populations
 - FFS SPD enrollment duration
 - Other enrollment considerations

Medicaid Rx – evaluating FFS versus managed care

- FFS versus Managed Care Pharmacy Utilization
 - The FFS SPD members as a group (across all Two-Plan and GMC counties), have higher pharmacy utilization than the managed care SPD population.
 - This higher utilization does not support the theory that these members have an access to care problem relative to managed care.
- Risk analysis of other populations
 - Mercer examined the risk scores of SPD members in San Luis Obispo, Merced, and Sonoma Counties before and after the implementation of mandatory managed care in each County.
 - The risk scores for these counties did not show an increase after the establishment of managed care in a manner that supports the stated concern.

Medicaid Rx – evaluating FFS versus managed care

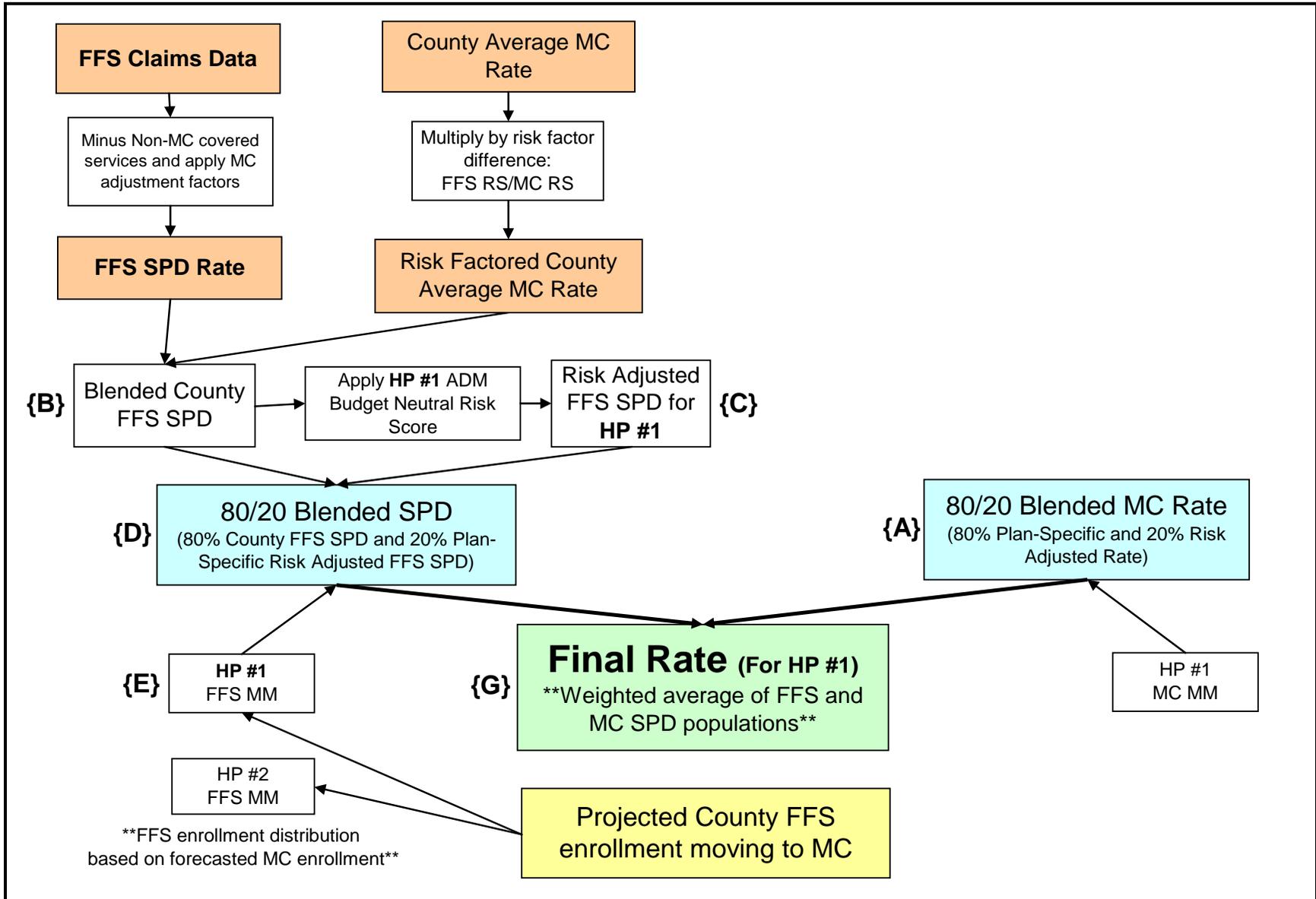
- Risk analysis of other populations (continued)
 - Mercer examined the risk scores of SPD members from another state (New Jersey) that has already completed a transition from voluntary to mandatory managed care enrollment.
 - Similar to what was observed in the Medi-Cal Counties, the risk scores in that state did not increase with mandatory enrollment into managed care in a manner that supports the concern regarding access to care.
- SPD FFS enrollment duration
 - The FFS SPD group that will be transitioning to mandatory managed care is a well established population.
 - For example, 80% of these members have been eligible and enrolled in Medi-Cal FFS for at least 12 months (90% for at least 10 months).

Medicaid Rx – evaluating FFS versus managed care

- Enrollment policy considerations
 - A theory exists where members who exercise their right to choose a health plan tend to have higher health acuity (i.e., more sick).
 - Higher acuity members are more concerned about their health conditions and are more likely to make an enrollment choice based on the available providers (particularly specialists) and facilities within a given network.
 - For the Medi-Cal program, SPD members must make a choice to be enrolled into managed care.
 - Conversely, if a member does not make a choice, their enrollment will default into the FFS program.
 - Medi-Cal's enrollment policy helps to explain why Medi-Cal SPD members opting into voluntary managed care have higher acuity relative to FFS than typically observed in states with differing enrollment policies.

Capitation Rate Updates

SPD Rate Calculation Process Overview



Managed Care Adjustment Factor Updates

- The managed care adjustment factors and their development were reviewed following the December 3, 2010, meeting.
- Two types of changes were implemented:
 - Some of the assumed managed care impacts of the category of service factors were lessened (utilization and unit cost)
 - County-specific managed care unit costs were also utilized in the refined level of unit cost factors (now county-specific)

FFS SPD Rate Development Approach

- Managed Care Adjustment Factors (midpoint):

SPD Expansion - Two-Plan & GMC Managed Care Midpoint Factors

| Managed Care Factors | 12/3/2010 Factors Statewide | | Initial New Factors Statewide | | Change from Original | | Final New Factors County Averages | | Change from Original | |
|----------------------------|--------------------------------|-----------|----------------------------------|-----------|----------------------|-----------|--------------------------------------|-----------|----------------------|-----------|
| | Utilization | Unit Cost | Utilization | Unit Cost | Utilization | Unit Cost | Utilization | Unit Cost | Utilization | Unit Cost |
| Inpatient Hospital | 0.600 | 1.050 | 0.750 | 1.050 | 0.150 | 0.000 | 0.750 | 1.069 | 0.150 | 0.019 |
| Outpatient Facility | 0.800 | 1.050 | 0.875 | 1.050 | 0.075 | 0.000 | 0.875 | 0.851 | 0.075 | (0.199) |
| Emergency Room | 0.600 | 1.050 | 0.750 | 1.050 | 0.150 | 0.000 | 0.750 | 1.091 | 0.150 | 0.041 |
| Long-Term Care | 0.350 | 1.200 | 0.400 | 1.200 | 0.050 | 0.000 | 0.400 | 1.391 | 0.050 | 0.191 |
| Physician Primary Care | 1.400 | 0.800 | 1.250 | 0.875 | (0.150) | 0.075 | 1.250 | 0.793 | (0.150) | (0.007) |
| Physician Specialty | 1.050 | 1.000 | 1.050 | 1.000 | 0.000 | 0.000 | 1.050 | 0.965 | 0.000 | (0.035) |
| FQHC | 1.000 | Varied | 1.000 | Varied | 0.000 | N/A | 1.000 | 0.523 | 0.000 | N/A |
| Other Medical Professional | 1.400 | 0.800 | 1.250 | 0.875 | (0.150) | 0.075 | 1.250 | 1.053 | (0.150) | 0.253 |
| Pharmacy | 1.100 | 0.600 | 1.100 | 0.650 | 0.000 | 0.050 | 1.100 | 0.650 | 0.000 | 0.050 |
| Laboratory and Radiology | 1.050 | 1.052 | 1.050 | 1.050 | 0.000 | (0.002) | 1.050 | 1.050 | 0.000 | (0.002) |
| Transportation | 0.750 | 1.050 | 0.750 | 1.050 | 0.000 | 0.000 | 0.750 | 1.050 | 0.000 | 0.000 |
| All Other | 1.000 | 1.000 | 1.000 | 1.000 | 0.000 | 0.000 | 1.000 | 1.000 | 0.000 | 0.000 |

FFS SPD Rate Development Approach

- Two-Plan Lower Bound Costs:

| COS | SFY 10-11 Two-Plan | FFS Two-Plan Projected/Adjusted | PMPM Difference | |
|--------------|--------------------|------------------------------------|-----------------|--------------|
| | PMPM | PMPM | Dollars | Percentage |
| Facility | \$212.03 | \$221.31 | \$9.28 | 4.4% |
| Professional | \$77.53 | \$82.09 | \$4.57 | 5.9% |
| Pharmacy | \$106.08 | \$163.69 | \$57.61 | 54.3% |
| "Other" | \$25.65 | \$33.74 | \$8.10 | 31.6% |
| | \$421.28 | \$500.83 | \$79.55 | 18.9% |

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