

<b>STATE OF NORTH CAROLINA</b>  <b>Department of Health and Human Services</b>  <b>Division of Health Benefits</b>	<b>REQUEST FOR INFORMATION NO.</b> 30-DHB-110217-18-A2 – Managed Care Program Actuarial
	<b>Due Date/Time:</b> December 1, 2017 at 2:00 PM ET
<b>Refer ALL Inquiries to:</b> Ken Dahlin, Contract Specialist Telephone No. 919-855-4054 Fax No.: 919-733-5957	<b>Issue Date:</b> November 2, 2017  <b>Commodity:</b> 946-12, Actuarial Services
<b>E-Mail:</b> <a href="mailto:ken.dahlin@dhhs.nc.gov">ken.dahlin@dhhs.nc.gov</a>	<b>Using Agency Name:</b> NC Department of Health and Human Services, Division of Health Benefits (DHB)

This Managed Care Program Actuarial Request for Information (RFI) is available electronically on the NC Interactive Purchasing System (IPS) at <https://www.ips.state.nc.us/ips/>.

**The purpose of this RFI is to survey the market for information described herein and not to award a contract. Submission of a response does not create an offer, and no award will result by submitting a response.** The State recognizes that considerable effort may be required in preparing a response to this RFI. However, the Respondent shall bear all costs for preparing and submitting a response. Information obtained through this RFI process may be used to develop a future solicitation, such as a Request for Proposal (RFP).

Responses to Section III of this RFI will be received until **2:00 PM ET, December 1, 2017**.

**EXECUTION**

RESPONDENT NAME:	E-MAIL:	
STREET ADDRESS:	P.O. BOX:	ZIP:
CITY & STATE & ZIP:	TELEPHONE NUMBER:	TOLL FREE TEL. NO:
TYPE OR PRINT NAME & TITLE OF PERSON SIGNING:	FAX NUMBER:	
AUTHORIZED SIGNATURE:	DATE:	

**TO SUBMIT A RESPONSE:** It is the responsibility of the Respondent to have the RFI in this office by the specified date and time of opening. Address the envelope and clearly note the RFI number as shown below.

<b><u>DELIVERED BY US POSTAL SERVICE</u></b>	<b><u>DELIVERED BY ANY OTHER MEANS</u></b>
<b>RFI NO.</b> 30-DHB-110217-18-A2 NC Department of Health and Human Services Office of Procurement, Contracts, and Grants Attn: Ken Dahlin Hoey Building, Dorothea Dix Campus 2008 Mail Service Center Raleigh, NC 27699-2008	<b>RFI NO.</b> 30-DHB-110217-18-A2 NC Department of Health and Human Services Office of Procurement, Contracts, and Grants Attn: Ken Dahlin Hoey Building, Dorothea Dix Campus 801 Ruggles Drive Raleigh, NC 27603

## **Section I: Response Content and Instructions**

**A.** Please review all Sections of this RFI. Due to various deadlines, the Department will not have the opportunity to respond to questions about this RFI prior to the Due Dates. When responding, include the RFI's question numbers, subsections, and other identifiers to allow the Department to clearly understand the specific items being addressed. While the Department encourages Respondents to respond to all questions and items within this RFI, there is no obligation to do so. The Department reserves the right to contact any respondent and request additional information. Therefore, include the contact information for the individual(s) best suited to engage with the Department.

### **B. Instructions for responding to Section III: Questions for Respondents**

1. When submitting a response, include pages 1-9 of the RFI, with the EXECUTION SECTION on Page 1 completed and signed.

2. Number of Copies

The following copies are required to be provided to the Department as part of responses to Section III of this RFI:

- a) One (1) signed, original executed response;
- b) One (1) copy of the signed, original executed response;
- c) One (1) electronic copy of the signed, original executed response on CD, DVD, or flash drive marked **RFI 30-DHB-110217-18-A2**, and
- d) One (1) electronic copy of the signed, original executed response *redacted* in accordance with Chapter 132 of the North Carolina General Statutes (NCGS), the Public Records Act, on a separate CD, DVD, or flash drive marked **RFI 30-DHB-110217-18-A2 – Redacted**. For the purposes of this RFI, redaction means to edit a document by obscuring or removing information that is considered confidential and proprietary by the Respondent and meets the definition of Confidential Information set forth in NCGS §132-1.2. If the response does not contain Confidential Information, Respondent should submit a signed statement to that effect on **RFI 30-DHB-110217-18-A2 – Redacted**.

The electronic copies of the response must not be password protected.

### **C. Confidentiality**

1. As provided for in the North Carolina Administrative code (NCAC), including but not limited to 01 NCAC 05B .0210, 09 NCAC 06B .0103 and 09 NCAC 06B .0302, all information and documentation relative to the development of a contractual document for a proposed procurement or contract shall be deemed confidential in nature, except as deemed necessary to develop a complete contractual document. In accordance with these and other applicable rules and statutes, such material shall remain confidential until the award of a contract or until the need for the procurement no longer exists. Any proprietary or confidential information, which conforms to exclusions from public records as provided by North Carolina General Statutes Chapter 132, **must be clearly marked as such and reflected in the redacted copy submitted on RFI 30-DHB-110217-18-A2 – Redacted**. By submitting a redacted copy, the Respondent warrants that it has formed a good faith opinion, having received such necessary or proper review by counsel and other knowledgeable advisors that the portions marked confidential meet the requirements of Chapter 132 of the North Carolina General Statutes. The Respondent must identify the legal grounds for asserting that the information is confidential, including the citation to state law.
2. Except as provided in Section I.C.1 of this RFI, pursuant to NCGS §132-1, et seq., information or documents provided to the Department in response to this RFI are Public Record and subject to inspection, copy and release to the public unless exempt from disclosure by statute, including, but not limited to, NCGS §132-1.2. Redacted copies provided by Respondents to the Department may be released in response to public record requests without notification to the Respondent.

## **Section II: Introduction**

### **A. Purpose**

In September 2015, the General Assembly enacted Session Law 2015-245, directing the transition of Medicaid from a fee-for-service structure to a managed care structure. As the NC Department of Health and Human Services (DHHS) prepares to transition to Medicaid managed care, it will work with stakeholders and experts to refine program design and implementation approach.

The purpose of the Managed Care Program Actuarial RFI is for DHHS to solicit feedback from potential Medicaid managed care plans and other interested stakeholders on options and considerations related to Medicaid managed care design and implementation.

### **B. Background**

DHHS's proposed program design seeks to implement Medicaid managed care in a way that advances high-value care, improves population health, engages and supports providers, and establishes a sustainable program with predictable costs. DHHS's goal is to improve the health of North Carolinians through an innovative, whole-person centered, and well-coordinated system of care, which addresses both medical and non-medical drivers of health.

In Medicaid managed care, DHHS will remain responsible for all aspects of the North Carolina Medicaid and NC Health Choice programs. As directed by the General Assembly, DHHS will delegate the direct management of certain health services and financial risks to Prepaid Health Plans (PHPs). PHPs will receive a monthly capitated payment and will contract with providers to deliver health services to their members.

#### **1. Overview of Types of Managed Care Plans**

To ensure consumer choice, leverage the experience and commitment of Medicaid providers in North Carolina, and maximize opportunities for innovation, DHHS will contract with two types of PHPs:

- **Commercial Plans.** Under State law, three commercial plans will offer products statewide.
- **Provider-Led Entities.** Provider-led entities (PLEs) will offer up to twelve regional contracts in six regions. PLEs must cover a region in its entirety, and may bid for more than one region, provided the regions are contiguous.

PHPs will be required to meet minimum standards set by DHHS, but will also be given sufficient flexibility to innovate to improve quality and efficiency of care. PHPs will be responsible for establishing and maintaining an adequate network of providers to meet the health care needs of their beneficiaries by contracting with a diverse range of providers and establishing provider payment rates, subject to certain rules set by DHHS. To facilitate continuity as North Carolinians experience life changes that cause them to move across the coverage continuum, PHPs will be encouraged to participate in both Medicaid and the Health Insurance Marketplace.

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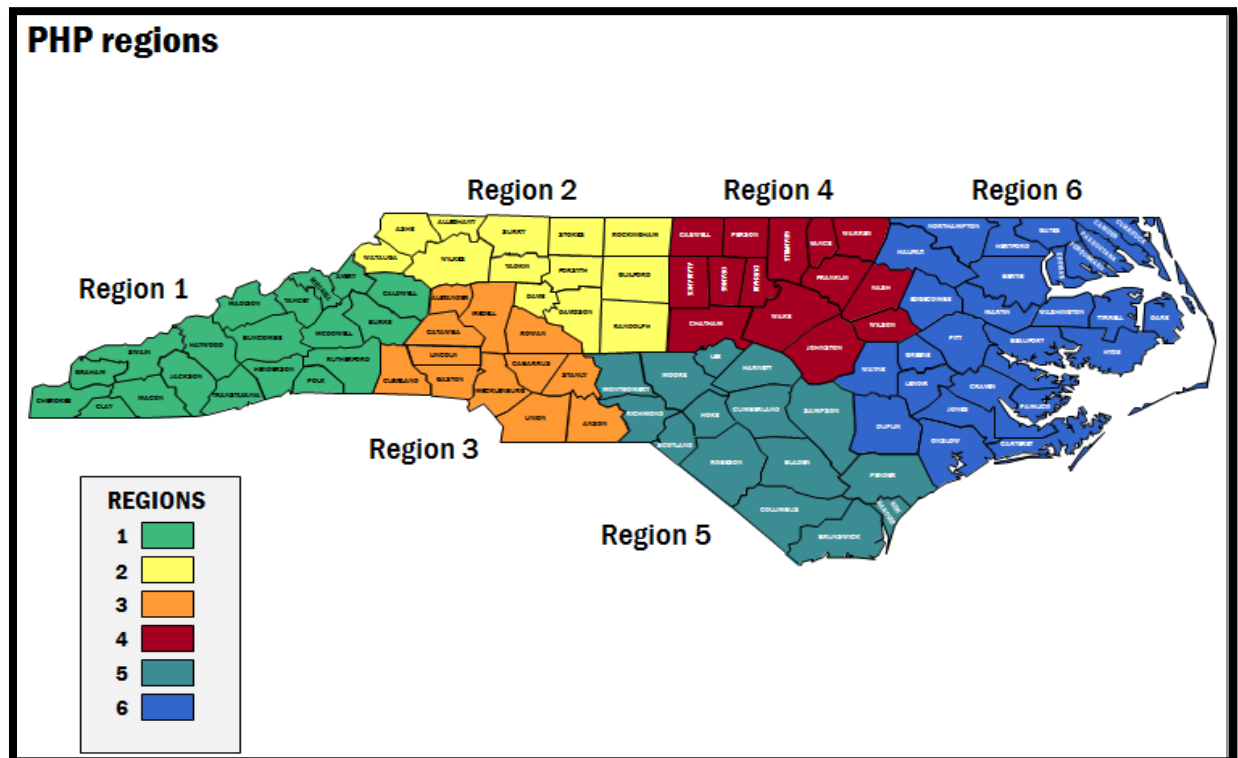
## 2. Regions

DHHS has defined six total regions within the state, as depicted in the figure below. Table 1 outlines the counties included in each of the six PHP regions. Figure 1 illustrates the PHP regions in map format.

**Table 1: List of Counties by PHP Regions**

PHP Regions	Counties
<b>Region 1</b>	Avery, Buncombe, Burke, Caldwell, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Madison, McDowell, Mitchell, Polk, Rutherford, Swain, Transylvania, Yancey
<b>Region 2</b>	Alleghany, Ashe, Davidson, Davie, Forsyth, Guilford, Randolph, Rockingham, Stokes, Surry, Watauga, Wilkes, Yadkin
<b>Region 3</b>	Alexander, Anson, Cabarrus, Catawba, Cleveland, Gaston, Iredell, Lincoln, Mecklenburg, Rowan, Stanly, Union
<b>Region 4</b>	Alamance, Caswell, Chatham, Durham, Franklin, Granville, Johnston, Nash, Orange, Person, Vance, Wake, Warren, Wilson
<b>Region 5</b>	Bladen, Brunswick, Columbus, Cumberland, Harnett, Hoke, Lee, Montgomery, Moore, New Hanover, Pender, Richmond, Robeson, Sampson, Scotland
<b>Region 6</b>	Beaufort, Bertie, Camden, Carteret, Chowan, Craven, Currituck, Dare, Duplin, Edgecombe, Gates, Greene, Halifax, Hertford, Hyde, Jones, Lenoir, Martin, Northampton, Onslow, Pamlico, Pasquotank, Perquimans, Pitt, Tyrrell, Washington, Wayne

**Figure 1: Map of PHP Regions.**



### 3. Implementation of PHPs

Both regional PLEs and statewide Commercial Plans must be licensed by the North Carolina Department of Insurance (NCDOI) and will be subject to NCDOI's solvency standards and financial oversight. Both types of plans must cover the same benefits and populations and must meet the same DHHS Medicaid managed care requirements. Those requirements include but are not limited to Medicaid managed care payment requirements, network adequacy requirements, program integrity requirements, grievances and appeals rules, cost sharing limitations, accreditation requirements and marketing restrictions.

### 4. Provider-led Entities as PHPs

Because only PLEs may compete at the regional level, it is important to ensure that they are affiliated or governed by providers. Thus, consistent with statute, PLEs will be required to comply with specific governance standards:

- North Carolina law specifies that a PLE must be controlled by individuals or entities, most of whom have as their primary business purpose the ownership or operation of one or more PHP contracts or Medicaid and NC Health Choice providers.
- Most of the entity's governing body must be composed of individuals who: are licensed in the state as physicians, physician assistants, nurse practitioners or psychologists, AND have experience treating beneficiaries of the North Carolina Medicaid program.

To protect against anticompetitive behavior, DHHS may require the following of Commercial Plans and PLEs:

- **Anti-exclusivity provisions:** DHHS may prohibit exclusivity provisions in contracts between PHPs and providers and may require providers that partially own or control a PHP to negotiate with rival PHPs in good faith if those rival PHPs seek to contract with them.
- **State review:** DHHS will have authority to review contracts between PHPs and providers and require modifications if any term is deemed anti-competitive.

These state-level rules will be in addition to applicable antitrust laws enforced by federal authorities, which prohibit entities from abusing their market power by engaging in anti-competitive conduct.

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## 5. Amendment from Session Law 2016-121

Section 2.(b) of Session Law 2016-121 amended Section 4.(2)b. of Session Law 2015-245 to read as follows:

*(2) Prepaid Health Plan. – For purposes of this act, a Prepaid Health Plan (PHP) shall be defined as an entity, which may be a commercial plan or provider-led entity, that operates or will operate a capitated contract for the delivery of services pursuant to subdivision (3) of this section. For purposes of this act, the terms “commercial plan” and “provider-led entity” are defined as follows:*

- a. Commercial plan or CP. – Any person, entity, or organization, profit or nonprofit, that undertakes to provide or arrange for the delivery of health care services to enrollees on a prepaid basis except for enrollee responsibility for copayments and deductibles and holds a PHP license issued by the Department of Insurance.*
- b. Provider-led entity or PLE. – An entity that meets all of the following criteria:*
  - 1. A majority of the entity’s ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more capitated contracts described in subdivision (3) of this section **or** Medicaid and NC Health Choice providers.*
  - 2. A majority of the entity’s governing body is composed of individuals who (i) are licensed in the State as physicians, physician assistants, nurse practitioners, or psychologists and (ii) have experience treating beneficiaries of the North Carolina Medicaid program.*
  - 3. Holds a PHP license issued by the Department of Insurance.*

DHHS has received questions from interested parties seeking its interpretation of the language added in Session Law 2016-121 and the operation of the highlighted “or” in Section 4.(2)b.1. DHHS reads this provision to designate two valid options for the structure of a PLE, i.e., 1) a PLE may have as its primary business purpose the ownership or operation of one or more capitated contracts **OR** 2) a PLE may have can have as its primary business purpose the ownership or operation of one or more Medicaid and NC Health Choice providers. Of course, the provisions of sub-subsections 2. And 3. also would apply to all PLE entities. DHHS intends to use the RFP process to require submission of a demonstration from all PLE respondents that the PLE has a significant level of involvement of North Carolina providers in leading and making decisions for the entity.

## 6. Standard Plans and Tailored Plans

Pending legislative authorization, DHHS intends to permit PHPs to develop and offer two types of products: Standard Plans and Tailored Plans.

- **Standard Plans** are proposed to serve most Medicaid and NC Health Choice enrollees, including adults and children. They will provide integrated physical health, behavioral health, and pharmacy services at the launch of North Carolina’s Medicaid managed care program.
- **Tailored Plans** are proposed to be specifically designed to serve special populations with unique health care needs. North Carolina is considering launching a Behavioral Health and Intellectual/Developmental Disability Tailored Plan (Behavioral Health I/DD Tailored Plan) no later than two years after the launch of Medicaid managed care. The plan will provide integrated physical health, behavioral health, I/DD, and pharmacy services to enrollees with Serious Mental Illness, Substance Use Disorder, and/or I/DD needs. In future years, DHHS may create additional Tailored Plans for other high-needs populations, such as individuals dually eligible for Medicare and Medicaid.

## **7. Populations in Managed Care**

Most Medicaid and NC Health Choice populations will be mandatorily enrolled in PHPs, although not simultaneously. There may be limited exceptions to mandatory enrollment for certain populations who may be better served outside of Medicaid managed care. These populations may be either exempt—meaning that they may choose to enroll in either fee-for-service or Medicaid managed care—or excluded—meaning they must remain enrolled in fee-for-service. All excluded populations will receive health benefits outside of PHPs.

Pursuant to Session Law 2015-245 as amended by Session Law 2016-211, excluded populations include but are not limited to beneficiaries dually eligible for Medicaid and Medicare, PACE beneficiaries, and medically needy beneficiaries. Exempt populations include members of federally recognized tribes.

## **8. Delayed Mandatory Enrollment for Special Populations**

The transition of high-need populations to Medicaid managed care requires special care and planning to ensure that provider relationships and care regimens transition smoothly. DHHS believes that certain targeted populations with complex health care needs should be allowed more time to make the transition to Medicaid managed care. This would mean phasing in mandatory enrollment of some vulnerable populations after the Medicaid managed care program is fully established. DHHS will work with the General Assembly on this proposed phase-in. During the transition period, to avoid care disruption, special populations will continue to have access to their existing provider networks.

## **9. Additional Background**

Additional background and detail about the proposed program design may be obtained from North Carolina's Proposed Program Design for Medicaid Managed Care paper which is linked in the footnote below. The paper includes additional details about the proposed program design, including details around excluded and exempted populations, delaying mandatory enrollment for special populations, and Standard and Tailored Plans.

## **10. Attached Reference Materials**

- **Appendix A – Proposed PHP Capitation Rate Setting Methodology:** This document summarizes the state's proposed rate-setting methodology and outlines the process for developing actuarially sound capitation rates for the new managed care program. The purpose of this document is to help health plans, providers, elected officials, advocates, Medicaid and Health Choice beneficiaries and other stakeholders understand the process that will be used to determine initial and future year capitation rates.

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### **Section III: Questions for Respondents**

#### **A. Size of the Pools**

DHHS is committed to helping PHPs achieve the enrollment necessary to ensure viable risk pools and economies of scale while ensuring adequate choice for members in each region. Refer to DHHS' RFI-Managed Care issued concurrently to this RFI and North Carolina's Proposed Program Design for Medicaid Managed Care paper<sup>1</sup> for details and questions relating to the enrollment, initially and ongoing, of these populations.

1. What is a minimum number of covered lives to ensure a viable risk pool and economies of scale for:
  - i. Regional Provider-led Entity?
  - ii. Statewide Commercial Plan?
2. What is the maximum number of covered lives or market share within a region to ensure member choice and sustainable competition for:
  - i. Regional Provider-led Entity?
  - ii. Statewide Commercial Plan?

#### **B. Capitation Rate Setting Methodology**

Appendix A includes DHHS' proposed PHP capitation rate setting methodology.

1. Please share any questions or comments on the proposed methodology.

#### **C. Administrative Component of PHP Capitation Rate**

DHHS will ensure that capitation rates are set in accordance with actuarially sound principles and incorporate reasonable administrative costs. An important component of plan payments will be to understand ongoing administrative needs and how those needs may change with the size of the program.

1. What are the anticipated non-medical costs needed to administer a program across 100,000 lives?
2. Provide the estimated administrative costs separately for the following cost categories: (a) start-up activities (stated in dollars), (b) ongoing fixed costs (stated in dollars), and (c) ongoing variable costs (stated as a PMPM).

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<sup>1</sup> [https://files.nc.gov/ncdhhs/documents/files/MedicaidManagedCare\\_ProposedProgramDesign\\_REVFINAL\\_20170808.pdf](https://files.nc.gov/ncdhhs/documents/files/MedicaidManagedCare_ProposedProgramDesign_REVFINAL_20170808.pdf)



**D. Maternity Kick Payments**

DHHS is planning to pay a maternity kick payment for costs associated with a delivery event. The kick payment will be a one-time cost paid to PHPs to cover a defined pregnancy/delivery episode; note that the kick payment is made alongside the monthly capitation payment. DHHS is planning to structure the kick payment to include costs for the delivery event along with prenatal and postpartum care (similar to the current global maternity payments structure). Please provide feedback on the questions below and consider in your answer how the kick payment structure can best promote and incentivize positive health outcomes and support value based purchasing:

1. DHHS is planning to include prenatal and postpartum care, what is the optimal window of coverage around the delivery event (e.g., 5 months prior to and 60 days after the delivery)?
2. Are there other elements that DHHS should consider in the kick payment structure?
3. Do you anticipate any challenges regarding accurate financial reporting associated with a prenatal/delivery/postpartum kick payment structure?

**E. Reinsurance Requirement**

DHHS is planning to require PHPs to purchase reinsurance to mitigate the financial impact of high-costs for certain members.

1. What minimum threshold for costs or attachment point should DHHS establish for this coverage?
2. Are there any reinsurance market dynamics in terms of availability of coverage that DHHS should be aware of as we finalize the requirements?

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Medicaid Transformation  
*Proposed PHP Capitation Rate Setting Methodology*

*November 2, 2017*

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# 1 PURPOSE

As a part of the State of North Carolina (State) Medicaid (NC Medicaid) transformation initiative, the North Carolina Department of Health and Human Services (DHHS) has developed a rate-setting methodology to outline the process for developing actuarially sound capitation rates for the new managed care program as proposed in the Medicaid Managed Care Proposed Program Design published in August 2017<sup>1</sup>. The purpose of this document is to help stakeholders understand the process that will be used to determine initial and future year capitation rates.

## 2 RATE-SETTING METHODOLOGY

### 2.1 Overview

The rate-setting methodology is based on generally accepted actuarial principles and best practices and approaches from other State Medicaid managed care programs. The rate-setting process and related documentation comply with the Centers for Medicare and Medicaid Services (CMS) regulations outlined in 42 CFR 438.4 and was developed in accordance with applicable law and regulations, including Actuarial Standards of Practice (ASOPs). The process was developed in a way that supports the financial-related objectives of the new managed care program to:

1. Advance high-value care, and
2. Establish a sustainable program with predictable costs.

The capitation rates are meant to provide a reimbursement structure that will match payment to the expected financial risk of the managed care program designed for the State's Medicaid and NC Health Choice populations. Under managed care, the capitation payments will be made by the State to the Prepaid Health Plans (PHPs) who will administer the contractually-required services to the populations covered under the program. Capitation payments differ from fee-for-service (FFS) payments where the State pays providers for each service rendered. Under capitation payments, a monthly payment for each member is made to a PHP to cover a defined set of services. Under managed care, PHPs will contract and reimburse providers for services rendered to their enrollees.

The rate-setting process is the means for determining the per member per month (PMPM) capitation payments the State will pay to the PHPs for each beneficiary enrolled in the program, regardless of the amount of future services that beneficiary receives. Generally, this process involves summarizing historical claims and eligibility data that represent the covered populations and services and projecting future medical claims costs on a per member per month basis into the rating period. Consideration for administrative allowances and underwriting gain or risk margin will be added to the expected medical costs to arrive at the base capitation rates for each rate cell<sup>2</sup>.

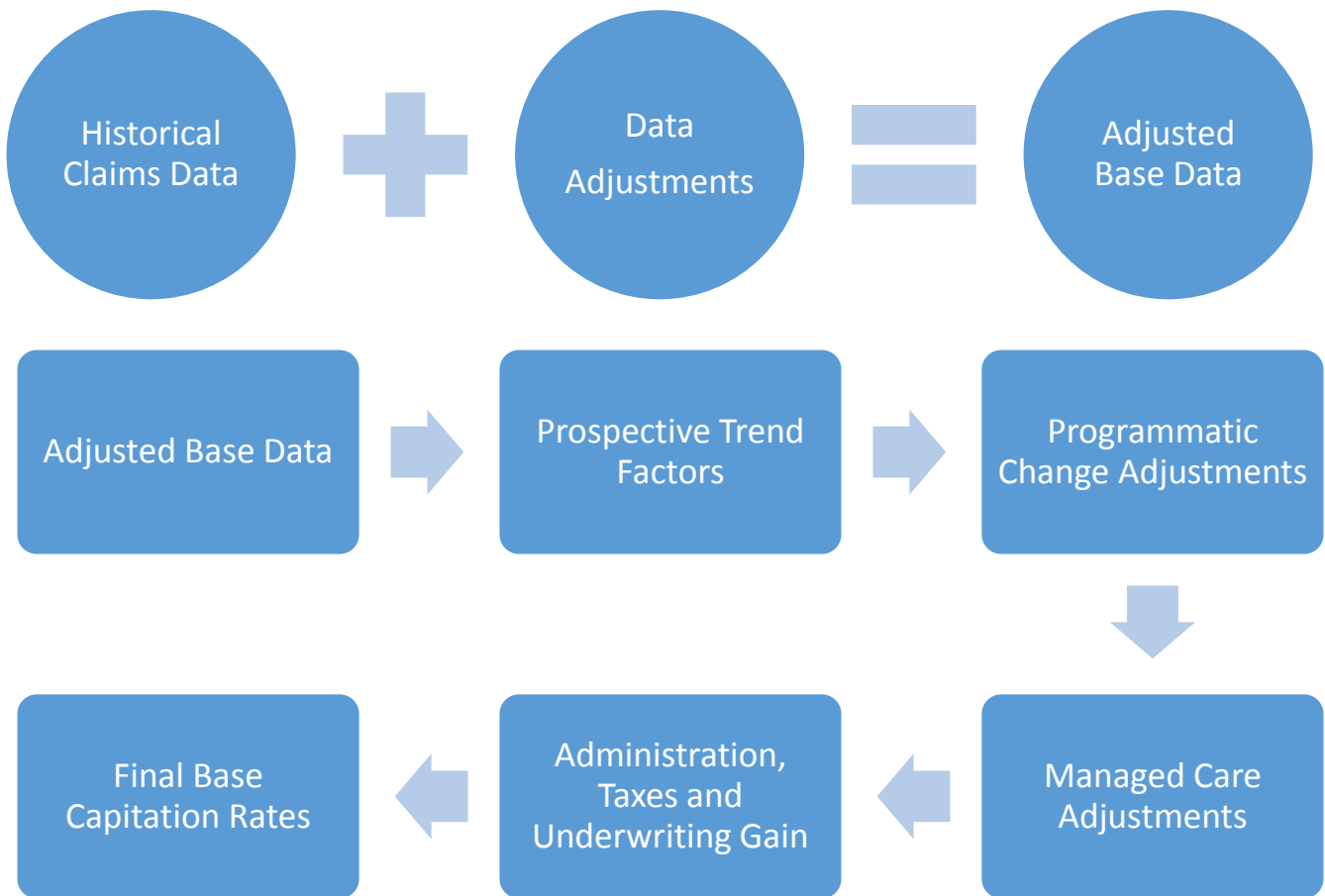
DHHS's overall rate-setting approach will be based on the foundational steps outlined below. DHHS has refined the approach to best match the proposed Medicaid managed care program design and North Carolina's health care landscape.

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<sup>1</sup> [https://files.nc.gov/ncdhhs/documents/files/MedicaidManagedCare\\_ProposedProgramDesign\\_REVFINAL\\_20170808.pdf](https://files.nc.gov/ncdhhs/documents/files/MedicaidManagedCare_ProposedProgramDesign_REVFINAL_20170808.pdf)

<sup>2</sup> Rate cells are payment categories for unique population cohorts that define how the State will make payments to the PHPs.

**Figure 1: Rate-Setting Methodology**



The key takeaways related to the proposed rate-setting process are below:

1. Historical claims data will be summarized for the covered populations and services included in the managed care program (detail in Section 2.3)
2. The base capitation rates for each rate cell will be separately calculated and the rate cell structure will be established in a way that differentiates expected service costs by eligibility group, age group and geography (detail in Section 2.3.3).
3. The overall base rate will consist of the projected service costs built from the base data using trend, program changes and managed care adjustments (Section 2.4.2-2.4.4). Capitation rates will also include consideration for the administrative and other non-medical expenses the PHPs are expected to incur operating under the contractual obligations of the program as well as consideration for the PHP's cost of capital and additional risk margin (Section 2.4.5).
4. The base capitation rates are expected to be consistent across PHPs within a region (Section 2.4.6).
5. A risk adjustment methodology based on the nationally-recognized Chronic Illness Disability Payment System plus Pharmacy (CDPS+Rx) model will be used to differentiate the final payment rates to the PHPs (Sections 2.4.6 and Section 3).
6. Alongside the rate-setting and risk adjustment methods, the managed care financial considerations will include required risk mitigation mechanisms to moderate any large gains or losses by the PHPs (Section 4) as well as incentives and withholds for the managed care program:

- A. DHHS will require PHPs to purchase commercial reinsurance to mitigate the potential financial impact of high-cost claims (Section 4.1.1).
  - B. DHHS intends to put in place a MLR arrangement with the PHPs (Section 4.1.2).
  - C. DHHS intends to adopt a phased incentive/withhold approach that will be tied to various PHP performance measures (Section 4.2).
7. The focus of this document is on the methodology to develop the initial capitation rates for managed care implementation for the various populations. The State will establish draft capitation rates for issuance with the request for proposal (RFP) by the spring of 2018. The final base capitation rates will be established closer to implementation and are anticipated to be provided between 90 and 120 days in advance of each contract year (Section 7). Section 8 provides information on considerations for rate-setting in future years of managed care.

The remainder of this document provides greater detail on the rate-setting and risk adjustment methodology and associated considerations.

## 2.2 Managed Care Program Design

The rate-setting methodology must take into account the coverage responsibilities of the PHPs to ensure the capitation rates are established to best match payments to expected costs under managed care. As outlined in the Medicaid Managed Care Proposed Program Design published in August 2017, DHHS has defined the population of Medicaid and NC Health Choice beneficiaries that will be enrolled managed care. In total, approximately 92% of current beneficiaries will ultimately be required to enroll in managed care for the majority of their Medicaid benefits.

### Covered Populations

The following populations are proposed to be covered after full implementation of the managed care program.

1. AFDC and related MAGI populations
2. Aged, Blind, and Disabled populations
3. NC Health Choice and Medicaid-Expansion Children's Health Insurance Program (MCHIP)
4. Legal Aliens
5. Long-term services and supports populations
6. Foster Children, Adoption Children, and Former Foster children
7. Dual eligibles (excluding partial duals and pending legislative change)

### Managed Care Phase-in

Most populations will enroll in standard plans upon the launch of the managed care program. DHHS has proposed allowing certain targeted populations with complex and unique health care needs to phase into the program between one and four years after managed care launch. The proposed phase in requires a legislative change.

DHHS is considering a phased in roll out of managed care beginning with standard PHPs or standard plans rollout in select regions. Rollout of certain other populations is proposed to occur no later than four years following managed care implementation. Under the proposal which requires a legislative change, beneficiaries with serious behavioral health (BH) and intellectual and developmental disabilities (I/DD) needs would not generally enroll in standard plans. Instead these beneficiaries would be covered by BH I/DD Tailored Plans (TPs) — separate integrated managed care products targeted towards this population. Please refer to the August 2017 Medicaid Managed Care Proposed Program Design for more information regarding the proposed managed care phase-in for special populations.

The following populations will be excluded from the initial managed care program and will continue to receive health benefits on a FFS basis or through their existing delivery systems.

1. PACE beneficiaries
2. Medically needy beneficiaries
3. Beneficiaries only eligible for emergency services
4. Presumptively eligible beneficiaries, during the period of presumptive eligibility
5. Beneficiaries eligible for Medicare, but not full Medicaid benefits
6. Health Insurance Premium Payment (HIPP) beneficiaries

In addition, DHHS has proposed that North Carolina's managed care statute be amended to exclude two additional populations<sup>3</sup>:

1. Family planning enrollees
2. Inmates of prisons

Along with the excluded populations listed above, members of Federally Recognized Tribes will be exempt from the program. DHHS is in active discussions with the EBCI Tribe on pathways to becoming the first Native American managed care entity in the country and is exploring options for Tribal members who elect to participate in PHPs. The rate-setting methodology will be adapted to align with the final design if there is a specific tribal PHP.

### **Managed Care Service Array**

At the outset of the managed care program, standard plans are proposed to be integrated managed care products covering physical health, BH, pharmacy services, and long-term services and supports (LTSS). Through the proposed BH I/DD TPs, beneficiaries with intensive BH and I/DD needs will receive physical health services, pharmacy services, LTSS, and BH and I/DD benefits plus additional waiver services. Only BH I/DD TPs will cover Innovations, Traumatic Brain Injury (TBI) and current 1915(b)(3) waiver services; these services will not be covered by standard plans. Table 1 summarizes benefits to be carved out of all PHPs.

## **2.3 Base Data Development**

Based on the covered populations and services for the managed care program, the State must identify necessary data, including historical cost, utilization and eligibility information, to inform the rate-setting methodology. DHHS has outlined a process below to identify, validate and summarize the necessary data to support the development of the capitation rates as well as summarize historical costs of the Medicaid program for stakeholders and potential PHPs.

The process described below is for the initial years of rate-setting prior to utilization of PHP encounter data.

### **2.3.1 Data Sources**

The historical data that will be used to develop the capitation rates comprises the service utilization, cost and eligibility of the population from a given historical time period. The base data for the initial capitation rates for each covered population will be FFS data for acute care services, pharmacy services, and long-term services and supports. The FFS data represents the payments made by the State to providers for individual medical services that were rendered. For behavioral health services, encounter data from the Local Management Entity/ Managed Care Organizations (LME/MCOs) will serve as the source of utilization and cost for any Medicaid populations

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<sup>3</sup> Note legislative change is required to exclude the family planning enrollees and inmates from managed care. These populations receive limited benefits through Medicaid, thus DHHS has proposed excluding these populations to avoid incurring unnecessary administrative costs with limited opportunities for offsetting savings.



covered by the LME/MCOs.<sup>4</sup> In subsequent years there will be a shift to relying on encounter data from the PHPs as the primary source of base data. Encounter data is critical for the purposes of future rate-setting and program monitoring as it captures data on the actual utilization of services under the managed care program.

The following data sources will be utilized for the initial capitation rate development process. It is anticipated that SFY 2017 data will be utilized to establish the draft capitation rates as part of the information shared for the RFP process. SFY 2018 data will be utilized to develop the final SFY 2020 capitation rates.

1. FFS data collected from the State's Medicaid Management Information System (MMIS)
  - A. FFS data is the source of utilization and cost for physical health, pharmacy, and LTSS benefits.
  - B. FFS data is also the source of BH service utilization and cost for NC Health Choice and legal alien populations.
2. Encounter data collected directly from the LME/MCOs
  - A. The data will be used to evaluate utilization of BH services that will be the responsibility of the standard plans upon implementation
  - B. The encounter data will also be utilized to support identification of populations that will be eligible for the BH I/DD TP along with rate-setting for the BH I/DD TP
3. Eligibility data collected from the State's eligibility system
  - A. The eligibility data will be used to assign members to rate cells based on eligibility code and demographic information
  - B. The eligibility data will be used to calculate member months, which represent the months of Medicaid eligibility for a beneficiary in a particular time period
  - C. Eligibility data will also be evaluated to understand the implications of carving out retroactive Medicaid eligibility as well as any other periods for which the beneficiary may be covered through the FFS program (for example, the time period from application to PHP effective date)
4. Supplemental data will be collected from the State to support adjustments necessary for the rate development process. The details are discussed further in Section 2.3.4.

### **2.3.2 Data Validation**

Actuarially sound capitation rates are dependent on complete, accurate and reliable data. Before using data for rate-setting and related analyses, the claims, encounter and eligibility data must go through a comprehensive data validation process. This process must adhere to the Actuarial Standard of Practice 23 (Data Quality) in order to deem the data sufficient to support rate-setting. Similar processes will be used for both FFS and encounter data. Details regarding the data intake/load process and data validation can be found in Exhibit A.

Upon completing the data validation steps for each applicable data source, the results will be reviewed to determine if there are any data problems or issues that need to be discussed. Any appropriate data corrections or adjustments will be made based on this process and conversations. A summary of the data validation results will be prepared to document the review of the data and any identified issues.

As indicated by the thoroughness of the data validation process, it is imperative to ensure the data received is of the best quality for the initial and future rate-setting work required in transition to managed care payments. Sharing validation results will foster continuous improvement in the data and increase its usability. Finally, the data collection and validation processes must comply with all Health Insurance Portability and Accountability Act (HIPAA) and data security standards.

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<sup>4</sup> BH data for NC Health Choice and Legal Alien population will be FFS as these populations are not covered by the LME/MCOs.  
Appendix A, Managed Care Program Actuarial, RFI #30-DHB-110217-18-A2

### 2.3.3 Data Summarization Process

Once the data is validated, the base data will be summarized to align with the coverage responsibilities of the PHPs and adjusted to make it suitable to use for the rate-setting process. Since this data is from the State’s entire Medicaid program, this data will need to be limited to what will ultimately be covered by the managed care program including the covered populations, services and geographical area. Then the data must be summarized by service categories for the population cohorts and geographies before applying any data adjustments to arrive at the summaries to be included in a Data Book.

#### Populations

Claims and beneficiary information will be assigned into the various population cohorts outlined in Section 2.2 for the covered populations using the program aid code assigned in the Department’s eligibility file for both the FFS claims and LME/MCO encounters. This eligibility information will also be leveraged to establish member month data. This step ensures the populations excluded from managed care noted in Section 2.2 are excluded from rate-setting analysis. See Exhibit B for more information on the covered populations. The data will be summarized for each covered population and the rate-setting methodology will be established in accordance with the phase-in to managed care.

#### Services

The Data Book will be summarized for the services that will be covered under the managed care program. The data will be summarized into the following service categories for rate development.

- |                                                      |                                                                       |                                              |
|------------------------------------------------------|-----------------------------------------------------------------------|----------------------------------------------|
| 1. Advanced Medical Home (AMH) Payments              | 9. Other Behavioral Health Services                                   | 17. Personal Care Services                   |
| 2. Therapies                                         | 10. Physician — Primary Care                                          | 18. Home and Community Based Services (HCBS) |
| 3. Inpatient                                         | 11. Physician — Specialty                                             | 19. Hospice                                  |
| 4. Emergency Room                                    | 12. Federally Qualified Health Centers/Rural Health Clinic (FQHC/RHC) | 20. Prescribed Drugs                         |
| 5. Outpatient Hospital                               | 13. Other Clinic and Practitioner                                     | 21. Durable Medical Equipment                |
| 6. Innovations Services (BH IDD TP only)             | 14. Case Management                                                   | 22. Optical (limited)                        |
| 7. Intermediate Care Facility (ICF)                  | 15. Nursing Home                                                      | 23. Lab and X-ray                            |
| 8. Psychiatric Residential Treatment Facility (PRTF) | 16. Home Health                                                       | 24. Family Planning Services                 |
|                                                      |                                                                       | 25. Transportation                           |
|                                                      |                                                                       | 26. Dental (limited)                         |

Since the historical data contains a more comprehensive set of Medicaid claims than will be included in the managed care program, certain records will need to be excluded or flagged as part of the data summarization process. Table 1 outlines the services for which data adjustments are required.

**Table 1: Service Considerations**

Consideration	Description
Nursing Facility coverage	Long-term nursing facility stays are proposed to be phased-in to managed care after implementation. Individuals that have stays longer than 90 days will be flagged as a long-term user and segmented for purposes of rate-setting analysis.
Lab and Radiology Data	The historical claims data includes capitation paid to Medicaid’s capitated provider for lab and radiology services. The data captures both encounter claims as well as capitation payments. The capitation payments will be excluded from the data, while the actual services rendered will be included in rate-setting as the source of historical utilization and cost data.

Other Excluded Claims costs

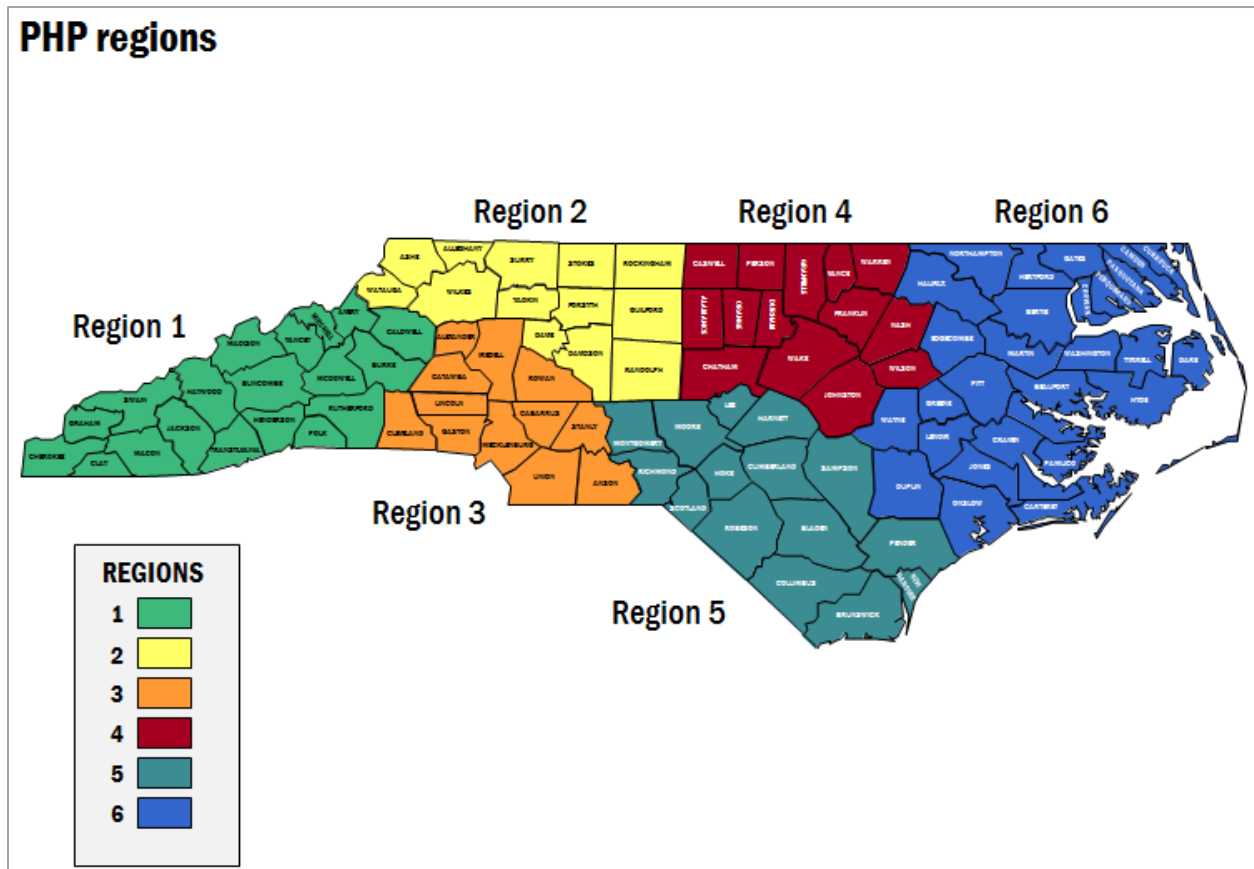
The following providers or claim records will be identified and excluded from the data summarization:

1. Children’s Development Service Agencies
2. Program for the All-inclusive Care for the Elderly capitation
3. LME/MCO capitation payments
4. Dental services (except dental varnish applied by non-dental practitioners)
5. Local Education Agency (LEA) services (note that LEA services can be identified as historical claims designated with claim type 0)
6. Eyeglasses fabrications and fittings, consistent with proposed program design (pending legislative change to exclude fittings)

**Geographical Area**

Information from the State’s eligibility system will be used to assign each Medicaid beneficiary to a county, which is based on an individual’s county of residence. This county-level information will be used to summarize the data into the managed care regions which are shown in the map below.

**Figure 2**



**Rate Cell Methodology**

Once the historical data has been summarized into population cohorts and geographies for the covered services, a rate cell analysis will be conducted to evaluate the recommended payment structure for managed care. The rate cell structure will be established in a way that differentiates expected medical costs by population as the ultimate goal of actuarial rate-setting is to match capitation payments to expected risk. As the managed care population will have a choice of PHPs, the rate cell structure is intended to differentiate payments to PHPs where disproportionate enrollment of certain populations can occur.

The rate cell analysis will be based on historical utilization and PMPM data from the North Carolina program. The rate cell analysis starts with a broader evaluation of PMPMs by various age, sex and eligibility code cohorts. Rate cells will be created to summarize the costs and enrollment for population cohorts with similar PMPM costs keeping in mind the risk adjustment and calibration will address cost differentials by age and sex as well. The rate cell analysis will evaluate the PMPM cost differentials for the population groups noted in Section 2.2 and consider the implications of the managed care phase-in for various populations. The rate cell structure will be evaluated across the following variables:

1. Population/Aid group codes
2. Child versus adult for certain populations
3. Eligibility for Tailored Plans
4. LTSS populations
5. Dual Eligibles
6. Geography

In addition to monthly capitation payments made for each rate cell, separate payments will be made for maternity events. These payments (sometimes called kick payments) are intended to cover the higher inpatient delivery-related costs and align payments to PHPs that may have a disproportionate number of delivery events compared to other PHPs. These kick payments are a form of risk adjustment and also serve to simplify the remaining rate cell structure. DHHS is in the process of determining how best to structure these kick payments.

For prospective capitation payment, the methodology must also consider how beneficiaries will be identified to be in a respective rate cell. For most populations, this identification will be based on their eligibility code, age, and geography captured on eligibility records. For populations requiring a qualifying diagnosis or level of care assessment, historical data may be reviewed to initially identify the qualifying population, but an approach must be determined to address how “new entrants” will be evaluated throughout the year. Beneficiaries that will be identified for initial enrollment to the proposed BH I/DD TP or are part of the LTSS populations will be excluded from the other eligibility code driven rate cells and will be summarized into specific rate cells according to the phase-in plan for managed care. In addition, separate rate cells will be created for dual eligibles for Medicaid services.

Eligibility and enrollment policies must be reflected in the rate cells. The rate-setting and risk adjustment methodologies will need to account for any populations that may be able to transition from a standard plan (SP) to a TP or vice versa. Prior to the proposed launch of TPs, certain populations may be allowed to remain in FFS for certain services and the LME/MCOs for other services. As the TP-eligible populations tend to have higher than average cost, actuarial analysis will need to be conducted to evaluate the implications of higher-cost populations moving across or out of the managed care program.

#### **2.3.4 Data Adjustments**

After obtaining, validating the reasonableness, and limiting the base data to the covered populations, services and geographical area, adjustments will be calculated and applied to make the data appropriate for analysis. These base data adjustments may be positive or negative depending on the source of the base data and the nature of the adjustment.

Adjustments are necessary to account for costs or design elements not currently reflected in the raw claims data. A brief description of the exclusions and adjustments that will be considered when summarizing the base experience is included below. These adjustments are specific to summarizing the base experience and do not

reflect any program/policy change considerations, medical trend, managed care adjustments, and non-medical considerations.

**Basic Data Adjustments**

Certain adjustments are common for most rate-setting processes and are evaluated to address CMS requirements or Actuarial Standards of Practice. These adjustments include certain cost settlements or provider payments made under the FFS system that may not be directly made to providers under managed care. Graduate Medical Expense (GME) and Disproportionate Share Hospital (DSH) payments are expected to be made by the State directly to providers for services covered under managed care. As such, the data adjustments ensure these costs are not captured in the base data for rate-setting. Table 2 summarizes these basic data adjustments.

**Table 2: Basic Data Adjustments**

Adjustment	Impacted Data Source	Description
Completion	FFS and Encounter	Adjustment to estimate incurred but not paid or reported claims (i.e., those claims not yet paid or reported as of the last date of payment in the data extract).
GME	FFS	GME factors are included directly in the calculation of FFS payment rates for the hospitals eligible for GME. It is DHHS’s intention to continue to make GME payments directly to the hospitals and exclude consideration for GME from the capitation rates. The GME payments will be identified and removed from the FFS data using an adjustment specific to the hospital claims data for GME hospitals.
DSH	FFS	CMS requires that all DSH payments be made directly by the State to the DSH facilities. No adjustment is required for the FFS claims data as the data does not reflect DSH payments.
Copayments, coinsurance and deductibles	FFS	The FFS claims are net of any cost sharing, and any cost sharing amounts. Because PHPs will be permitted to apply similar cost-sharing requirements, no adjustment will be made to the data.
Third-party liability (TPL) recoveries	FFS and Encounter	The claims data are net of TPL when submitted on the provider claim. An adjustment will be applied to reflect any non-claims TPL recoveries.
Beneficiary spend-down expenses	FFS and Encounter	The FFS claims data is net of any beneficiary payment responsibilities. Most spend-down individuals are in the Medically Needy population group excluded from managed care. This issue will be evaluated, but is expected to be minimal for the population in managed care.
Monthly payments made by Medicaid beneficiaries (e. g., net available monthly income)	FFS and Encounter	Certain beneficiaries receiving services in Nursing Facilities and ICF-IID facilities may have patient liability responsibilities through post-eligibility treatment of income to contribute to the reimbursement of their services. The FFS claims data is net of any beneficiary payment responsibilities. The specific requirements related to patient liability will be reviewed in the context of rate-setting for long-term services and supports.

**State-Specific Data Adjustments**

In addition to the common data adjustments, additional considerations must be made for issues specific to the State’s Medicaid program. Evaluating these adjustments requires additional data sources and relies on approaches designed to address each specific issue. Table 3 outlines these expected adjustments.

**Table 3: State-Specific Data Adjustments**

<b>Adjustment</b>	<b>Description</b>
Non-Emergency Medical Transportation (NEMT)	Prior to SFY 2017, NEMT services are not captured in the claims. Historical NEMT dollars will be obtained from the State to incorporate consideration for the cost of NEMT trips in the base data. NEMT services began to be submitted as claims beginning in SFY 2017. This data may be used to refine the allocation of the NEMT costs for years prior to SFY 2017.
Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF/IID)	ICF/IID cost settlements for children (ages 0–3) are not included in the claims data. An adjustment will be applied to the FFS data for the cost settlements associated with this population.
Cost Settlements	The following settlements are currently paid to providers in FFS: Ambulance, Acute Care Hospitals, Local Health Departments (LHDs), Rural Health Clinics, State-owned or operated Skilled Nursing facilities (SNFs), and FQHCs. Settlement amounts will be obtained by using National Provider Identifier (NPI) and analyzed to adjust the base data. Under the proposed program design, the State is seeking a waiver to continue to pay public ambulance, stated owned or operated SNFs and LHD settlements under managed care (payments to FQHCs can continue without a waiver). Other historical settlements will be accounted for in the capitation rates as appropriate to capture the full Medicaid payment for these services.
Pharmacy Rebates	The State is expected to continue to receive federal and supplemental rebates for prescriptions administered to individuals covered through PHPs. Thus, no adjustment for FFS rebates will be made to the base data.
Retroactive eligibility considerations	In order to ensure the data summarization reflects only cost/utilization that will be the responsibility of the PHPs, an adjustment or exclusion may be needed to account for the implications of retroactive eligibility on the average PMPMs. See below for more information.

There may be some limitations inherent in the available data that may impact the base data or the adjustments applied to the data. In these cases alternative methodologies will need to be examined to determine the most appropriate method to use to ensure the base data represents the design of the program. The following known data limitations are described below:

1. NEMT — The historical NEMT data that will be used for the period prior to fiscal year 2017 has a limitation in that it is only available in aggregate and does not associate the costs to individuals. More recent data will be used to inform the allocation of the aggregate costs, but this allocation will be based on assumptions rather than actual historical data.
2. Retroactive Eligibility — The FFS data may not clearly identify which individuals were enrolled in the Medicaid program retroactively. DHHS is exploring data from NC FAST that may be used to identify the specific periods of retroactivity and in combination with the claims data can be used to exclude periods of retroactivity from the rate-setting. In the event actual periods of retroactivity are not able to be identified, the Actuary will need to calculate an adjustment based on a review of the durational PMPM costs in the NC data and experience with other Medicaid programs.
3. Cost Settlements — The current cost settlement process typically involves review of audited provider cost reports for a historical period. This creates a time lag in the availability of the final cost settlement data in conjunction with the most recent claims data available. Where cost settlement data is not readily available for recent claims data, the Actuary will complete an analysis of historical cost settlements for prior years to develop an assumption.

### **2.3.5 Data Book**

The historical utilization and costs of covered services will be summarized into a Data Book. The Data Book is a report that will include a description of the data sources used, description of covered populations including rate cells, methodology for the applicable adjustments and criterion definitions, possible limitations, and data exhibits. The Data Book will be provided to potential PHPs as part of the RFP and future rate-setting processes. The following exhibits will be included in the Data Book:

1. Population: Profiles by geography and rate cell summarizing the utilization and claims data by major category of service into the following statistics:
  - A. Utilization: Utilization for each service line item. This represents the number of visits, days or services for each category.
  - B. Member months: Total member months over an annual period for each rate cell.
  - C. Users: Unique user count for that service.
  - D. Unit Cost: Average cost of each service line item; paid claims divided by the utilization of services delivered.
  - E. PMPM: Paid claims divided by total member months.

A snapshot of historical claims experience will allow the State and potential PHPs to appropriately understand the cost exposure and make programmatic and rate-setting decisions.

## **2.4 Capitation Rate-Setting**

Based on the defined population for the managed care program and validated data, DHHS will set capitation rates for the PHPs based on an actuarially sound methodology, accounting for projected medical and pharmacy trends, the programmatic design of the State's managed care program, assumed savings from shifting the State's Medicaid program from FFS to managed care, and consideration for non-medical expenses.

### **2.4.1 Base Data**

For rate-setting purposes, the historical data summarized in the Data Book will serve as the base data for rate-setting. The Actuary will consider two years of data, and potentially blend together, to arrive at base data that is suitable for setting rates. Blending multiple years of data will smooth fluctuations in the data between years which helps increase consistency in the final rates. Generally, more weight is placed on the later year of data to reflect the more recent claims experience.

### **2.4.2 Trend**

Medical trend is the projection of utilization and unit cost changes over time. A trend factor is necessary to estimate the expenses of providing health care services in a future period. Per §438.5(b)(2) of the Final Rule, in setting actuarially sound rates, the State must "develop and apply trend factors, including cost and utilization, to base data that are developed from actual experience of the Medicaid population or a similar population in accordance with generally accepted actuarial practices and principles." CMS requires that trends are based on the analysis of actual historical experience, which would be FFS claims and BH encounter data for the initial rate-setting process.

### **Trend Analysis**

For the trend development process for Medicaid transformation, trend factors will be developed for each of the major service categories. While any differences by rate cell will be evaluated as part of the trend analysis, the trends typically only vary by category of service within a region. Since different rate cells are likely to have different distributions of services, the overall trend factor for each rate cell is likely to be different. Trends are comprised of changes in unit cost, as well as changes in utilization, which leads to an ultimate change in the PMPM trend.

Initially, these prospective trend factors will be developed by analyzing historical FFS and BH encounter data, including all data adjustments outlined previously in this document.

Quantitative methods such as rolling average analysis and/or regression analysis are used. Additionally, qualitative information such as additional provider capacity or new technologies may also be considered. Trends from other Medicaid programs and knowledge of health care trends will also be used to check reasonability, but not used as a primary data source as many of these comparison points are from established managed care programs.

Once the final unit cost and utilization trend factors are determined, they will be applied for the appropriate number of months from the midpoint of the base data period to the midpoint of the rating period. For example, if the base data period is SFY 2018 and rates are being set for SFY 2020, 24 months of trend will be applied representing the number of months between January 1, 2018 (midpoint of SFY 2018) and January 1, 2020 (midpoint of SFY 2020).

### **Pharmacy Trends**

Pharmacy trends usually require special consideration in rate-setting. Recently, pharmacy trends have been higher than trends for other services covered under Medicaid programs driven by large trends in specialty medications. The overall pharmacy trend analysis will review projections for specialty and traditional pharmacy trends. Some of the underlying reasons for the higher specialty trends include: expanded indications; direct to consumer advertising; and new drugs entering the market faster due to breakthrough therapy approvals granted by the Food and Drug Administration (FDA).

Pipeline drugs, which are drugs that are still under development or discovery, may not be reflected in the historical claims data, but are known to impact utilization and cost beyond the base data period. These types of drugs will be evaluated and accounted for in the pharmacy trend development. There may also be significant growth in other drug classes such as diabetes (traditional), asthma (traditional), rheumatoid arthritis (specialty), oncology (specialty), HIV (specialty) and other new and emerging therapeutic drugs. Some recent examples of emerging drugs that have impacted expected pharmacy costs are treatments for hypercholesterolemia, cystic fibrosis and hepatitis C. Pharmacy-specific trend models utilize this information along with historical utilization data to develop pharmacy trends.

#### **2.4.3 Programmatic Considerations**

Programmatic considerations include adjustments intended to capture any changes in program design or structure that is not fully reflected in the base data. These considerations are in addition to the base data adjustments discussed in the data summarization section. This would include any changes that would have a material impact on the cost, utilization or demographic structure of the program. The Actuary and DHHS will review any programmatic changes that should be considered as part of this process.

The following tables outline the known programmatic changes that will be evaluated as part of the initial rate-setting process. Once calculated, the impact will be applied to the appropriate rate cells and category of service(s). The first table captures provider reimbursement related considerations from the program design.



**Table 4: Reimbursement Considerations**

Consideration	Description
Local Health Departments, State SNFs and Public Ambulance Providers	The State currently cost settles local public health departments, State-owned or operated SNFs and public ambulance providers. The State is requesting waiver authority to establish a wraparound payment process for these providers similar to the process for FQHCs and RHCs, so no adjustment to the historical claims costs is expected.
Advanced Medical Homes (AMHs)	The State currently makes primary care medical home payments directly to providers under the fee-for-service program. As such, the historical claims data captures these transactions to providers. The rate-setting analysis will consider payment requirements related to AMH and include consideration for any payments required to be made to providers by PHPs.
FQHC/RHC Reimbursement Requirements	Federal law requires FQHCs and RHCs to be reimbursed for the full cost of care. The PHP contract will require that FQHC and RHC providers be reimbursed by the PHPs using similar reimbursement levels as other providers. In addition, the State will provide a wrap-around payment to cover any difference between the FQHC's PPS rates and the PHP's negotiated rates. An adjustment in rate-setting will be evaluated comparing the current cost per visit for FQHCs and RHCs in the base data to the payment requirements of the PHPs.
Rate Floors	The State will establish rate floors for statutorily required provider types (i.e., in-network primary care and specialist physicians) and will expand rate floor protections to include physician extenders. The rate floor for these provider types will be 100 percent of the Medicaid FFS rate. Initially the current FFS levels will be assumed as the payment level for these providers for the rate-setting process.
Hospital Reimbursement	Per federal requirements, the State will no longer be permitted to make the supplemental payments to hospitals for utilization covered under managed care without a waiver. Consideration will need to be made in the rate-setting process to ensure there is funding in the capitation payments consistent with the final reimbursement design and waiver approval.
Preferred Drug List (PDL)	Consistent with State law, DHHS intends to develop a single formulary that will incorporate all drugs on the FFS PDL and all covered outpatient drugs for which the manufacturer has a rebate agreement. PHPs will be required to reimburse pharmacies based on a dispensing fee floor in perpetuity and at established FFS levels for ingredient costs for at least the first year of managed care, to support a smooth transition to managed care. The capitation rates will be developed to align with the requirements for dispensing fees and ingredient costs. This includes consideration for any changes in the required PDL or reimbursement levels.

In addition to provider reimbursement changes, programmatic changes must also address any modifications to the service array. The following table addresses the general approach to any service changes.

**Table 5: Service Changes**

Consideration	Description
Service Array	Base data must be adjusted to reflect changes such as requirements for services provided in institutions of mental disease (IMD).
In-lieu of Services	DHHS will encourage PHPs to use "in-lieu-of services" (ILS), services or settings that are not covered under the State Plan but are a medically appropriate, cost-effective alternative to a service that is covered. Initially there will be no rate-setting considerations necessary as these services by definition are cost-effective services compared to the State Plan services. Once the base data reflects utilization of any in-lieu of services, analysis will need to be performed to determine their cost effectiveness compared to the State Plan alternative. If the services are cost-effective, the base data will consider the costs of the ILS in the future.

Finally, programmatic considerations must also evaluate implications that beneficiary choice or transitions may have on the managed care rates. The following table identifies choice considerations that must be evaluated in rate-setting.

**Table 6: Beneficiary Choice Considerations**

Consideration	Description
Populations eligible for the Tailored Plans	While initial analysis will be performed to identify the historical population who meet the TP eligibility criteria, additional analysis and potential adjustments may be needed to account for the implications of new beneficiaries that may meet the TP criteria as well as the implications of any TP-eligible beneficiaries that may choose to enroll in the standard plans rather than the tailored plans.
Beneficiary Choice period	Any beneficiary choice period prior to PHP enrollment will need to be evaluated to determine the effects of choice on the average PMPM capitation payment. As beneficiaries may utilize services at an increased rate during the initial months of enrollment, an actuarial analysis of the expected costs during any period of FFS coverage compared to the costs for later months of enrollment will need to be conducted.
Tribal Members Choice	Members of federally-recognized tribes will be exempt from mandatory enrollment in managed care and will have the choice between Medicaid FFS and enrolling in a PHP. Tribal member choice will need to be analyzed to determine any impact on the capitation rates. Available data will need to be explored to identify this segment of the current Medicaid population and whether any adjustments are needed in the capitation rate development.

As the program design continues to evolve, the rate-setting methodology will be adjusted. For example, the State will be exploring value-based payment approaches under Medicaid Transformation. These approaches may intersect with capitation rate-setting and require special consideration. As these items evolve, the rate-setting methodology will adapt with the initiatives with consideration of applicable federal rules to ensure the rates remain actuarially sound.

#### 2.4.4 Managed Care

Managed care adjustments are intended to capture future changes in the utilization of certain services as a result of care management initiatives by the PHPs. Data-driven approaches are preferred to determine efficiency adjustments that can help serve as a standard to measure successful program management such that overall health care costs are reduced with an improvement in patients’ health and quality of medical care. The following factors will be considered in development of the managed care adjustment:

1. Comparison of North Carolina FFS statistics to other state managed care experience
2. Research regarding other state program initial managed care expectations and experience operating under managed care
3. Pharmacy considerations under managed care
4. Low Acuity Non-Emergent (LANE) analysis related to avoidable visits to the Emergency Room (ER) in NC Medicaid data
5. Potentially Preventable Admissions (PPA) analysis in NC Medicaid data for Inpatient Hospital visits
6. Analysis of Inpatient Hospital readmissions

More detail on each analysis is included in Exhibit C.

The interaction of the results from each of these analyses will be considered as part of the managed care analysis. It is important to consider that comparisons to other state programs may indicate utilization differences that may be partially based on maturity of a managed care program, and it may take time to impact behavior and alter utilization of services. This means that the full potential of managed care savings will not be realized in the first year after implementation; the ultimate savings may not be realized for a number of years.

Generally, managed care can reduce service costs through management of utilization of high-intensity services and redirection of care to other settings. Rate setting will reflect assumptions about the degree of expected savings which will be informed by observations from North Carolina data analysis and existing programs. The service cost savings are partially offset by the additional non-medical cost considerations associated with the managed care program as described in the next section.

#### **2.4.5 Non-Medical Expenses**

Capitation rates will include consideration for the administrative and other non-medical expenses the PHPs are expected to incur operating under the contractual obligations of the program as well as consideration for the PHP's cost of capital and additional risk margin. Administrative costs are generally calculated as a PMPM, while underwriting gain (also called risk margin) and premium taxes are applied as percentages of the total capitation rate. The non-medical expense consideration will also address CMS regulations. CMS requires that actuarially sound capitation rates be developed so the expected MLR is at least 85% for the rate year. The final pricing assumptions will be developed to ensure the MLR requirements are addressed. Further detail on MLR is included in Section 4.1.2.

#### **Administrative Expenses**

The overall capitation rates will include consideration for administrative expenses. The following types of expenses are generally considered part of costs to administer a managed care program:

1. Claims processing and information systems
2. Care coordination and utilization management
3. Member services
4. Provider services
5. General corporate overhead
6. Other material non-benefit costs

It is worth noting that there may be an interaction between general care management requirements for the PHPs and any care management for AMHs. Care management will be a shared responsibility between the PHPs and AMHs. There are patient-centered medical home PCMH payments in the historical FFS data, and it will be evaluated what portion of these payments should remain under the service costs for the managed care program specific to AMHs versus considered in PHP administration. As addressed in Section 2.4.3, payments to providers will be addressed in the programmatic considerations of the service cost development.

The PHP administration load for the program will be developed as a PMPM cost that is added on to the medical portion of the capitation rates. Initially, the aggregate administrative costs will be developed using experience from other states and a modeled approach. Special requirements for certain populations including foster care children and the individuals identified for the Transition to Community Living (TCLI) will be evaluated as part of the administration PMPM development. Financial information provided by the PHPs may be used as the primary source for developing the aggregate administrative amounts for future rate-setting cycles once reliable financial data becomes available.

Once the overall targeted administrative amount is determined, the application of the administrative load by rate cell and region in the rate development process will incorporate a two-step process to recognize that certain administrative expenses occur for the maintenance of membership regardless of the amount of medical services, while other administrative expenses are proportionate to the amount of medical services rendered.

The first step will allocate a flat PMPM dollar amount that is applied uniformly to each individual rate cell. This will reflect approximately half of the total projected administrative expenditures. The second step will allocate the remaining total administrative dollars proportionally by rate cell based on medical expenditures. This yields a

varied calculated percentage of administrative expenditures by rate cell but will result in a total combined administrative load of the targeted premium in total. The final PMPM for administrative allowances will not vary based on whether or not current supplemental payments are included in the capitation rates.

### **Underwriting Gain**

An underwriting gain component will be applied to the rates, across all PHPs, regions and rate cells (including any kick payments). This adjustment will be applied as a percent of premium. Underwriting gain implicitly and broadly considers the cost of capital for the PHPs. Typically underwriting gain of approximately 1%–2% of premium is sufficient to cover the cost of capital needs for a typical PHP.

### **Premium Taxes**

The costs associated with any State-specific taxes will be included in the capitation rates as these taxes reflect legitimate costs of business in North Carolina.

### **Health Insurance Provider's Fee**

The Health Insurer Provider Fee (HIPF) applies to certain health insurers. In the context of rate-setting, the HIPF is considered a cost of doing business that is appropriate to recognize in the capitation rates.

The Consolidated Appropriations Act of 2016, Title II, § 201, Moratorium on Annual Fee on Health Insurance Providers, suspended the collection of the health insurance provider fee during 2017. Thus, there is currently not a required fee payable for 2017. However, the fee is anticipated to apply in 2018 and beyond. DHHS intends to reimburse PHPs for these fees and will determine the appropriate approach as part of final rate-setting prior to managed care launch. If the HIPF implications vary by PHP, DHHS will make PHP-specific considerations when finalizing the methodology to address the HIPF.

#### **2.4.6 Base Rate Considerations**

The overall base rate will consist of the projected service costs built from the base data using trend, program changes, and managed care adjustments as well as the non-medical expense considerations noted above. The base rates will be consistent across PHPs within a region unless differentiation for tax considerations is required. With a common base rate, DHHS has decided to implement risk adjustment to differentiate the final payment rates to the PHPs.

The Actuary will develop actuarially sound rate ranges for each rate cell for DHHS to make the final base rate contracting decision. The rate ranges will be developed by varying assumptions in the rate-setting methodology such as trend and managed care adjustments that may inherently have some variability. Through discussions with the Actuary, DHHS will make the final selection of base capitation rates for contracting with the PHPs. The final selected rates will be submitted to CMS for review and approval.

## **3 RISK ADJUSTMENT APPROACH**

### **3.1 Overview**

DHHS will implement a prospective risk adjustment process as required by the managed care legislation (Section 5.5(a) of Session Law 2015-245). Health-based risk adjustment has been documented in multiple Society of Actuaries (SOA) studies and other publications as a significantly better predictor of health care costs than traditional age/sex rating. A risk adjusted payment process differentiates capitation payments to PHPs based on measured risk differences in their enrolled populations. Appropriately paying PHPs for their enrolled population enables the overall managed care program to operate effectively and efficiently and discourages PHPs to avoid enrolling higher risk individuals. Since risk adjustment is reliant on detailed claims or encounter information, the

PHPs have a strong incentive to submit complete and accurate encounters. Finally, risk adjustment can simplify the rate structure by reducing the number of rate cells needed from a systems and payment perspective.

### 3.2 Risk Adjustment Model

While many models exist, DHHS is proposing to use the Chronic Illness Disability Payment System plus Pharmacy (CDPS+Rx) model to adjust the capitation payments beginning July 1, 2019 to reflect the underlying health risk of the members enrolled in each PHP. The CDPS+Rx model is a disease classification system developed by researchers from the University of California, San Diego (UCSD). The model uses medical and pharmacy data to assign risk markers that correlate to predictive, high cost disease conditions. Along with being built on a Medicaid-specific framework, the CDPS+Rx model is the most prevalent model used within Medicaid, approved by CMS, has limited licensing fees, and maintains a high level of transparency regarding its model logic and assumptions. Many commercially available models that were developed using commercial health care populations and services are not as transparent and are generally more costly to implement. While the CDPS+Rx model inherently addresses some unique aspects of Medicaid members, additional information may be incorporated into the model where appropriate. For example, stable housing and other social determinants of health information could be incorporated in the future depending on the availability, predictive nature and quality of data.

Medicaid Rx will also be run in conjunction with CDPS+Rx as a means to evaluate the impact of encounter data submitted by the PHPs. Medicaid Rx was also developed by UCSD and is based on a similar framework and common principles as CDPS+Rx. Since pharmacy claims/encounters are typically more straightforward to collect, Medicaid Rx results can be used as a benchmark against the CDPS+Rx results where full medical claims/encounters are being utilized. Medicaid Rx uses only pharmacy information within the risk assessment process and has been used by states where full diagnostic encounters were not reliable. Both model results will be actively evaluated and available in the event the results need to be adjusted based on the adequacy and validity of PHP-reported encounters.

Both models will be calibrated using State-specific FFS data upon implementation. While the model developers often utilize an external (“national”) data set for producing relative cost categories, the use of state-specific data best reflects North Carolina’s populations, provider practice patterns, and covered benefits. FFS data are readily available and of sufficient quality to use for the calibration process. Since the risk adjustment will be applied prospectively to capitation payments, the model weights will be calibrated on a prospective basis. The risk adjustment cost weights may be updated periodically if material changes are made to covered benefits, more relevant data becomes available, or at the discretion of DHHS.

Risk adjustment considerations will be specifically evaluated for the Tailored Plans as well as the LTSS populations to assess whether the current models selected for implementation of the standard plans are suitable for risk adjustment of those populations. Alternatively, other models or calibration will be considered for these specialized populations.

### 3.3 Data Collection

The risk adjustment process utilizes beneficiary eligibility, demographic, diagnosis, and pharmacy claims data. Risk adjustment will be implemented at the start of the program and will initially utilize the State’s FFS data. PHP-reported encounter data will also be collected and validated as it becomes available. After the data elements have been collected, they must be validated for completeness and accuracy. Risk adjustment data will be evaluated for consistency of reporting in terms of volume and completeness of critical fields (i.e. diagnosis codes). During the initial months after implementation, DHHS will review encounter data as often as monthly to identify and address issues with the completeness of the data. This validation is crucial for general program monitoring as well as rate-setting and risk adjustment.

For risk adjustment analysis, data will be extracted and analyzed on a semi-annual basis for development of beneficiary risk scores. The data extraction dates will be clearly communicated to the PHPs to ensure they have a chance to submit/re-submit any encounters to be considered in the risk adjustment process. While the PHPs are expected to constantly be submitting encounters to the State in a timely manner, clearly communicating cut-off dates when the data are utilized for risk adjustment analysis will allow the PHPs to plan resubmissions, adjustments and other transactions to ensure they are included in the risk adjustment process.

The presence of a single diagnosis, regardless of position on the claim, or a single national drug code is sufficient to support a classification into a CDPS+Rx diagnostic category. Consistent with general risk adjustment practices, laboratory and diagnostic radiology claims will be excluded from the disease classification process. These services often do not indicate the presence of a disease condition and may produce “false positives” within the results. While only managed care covered benefits will be included in the cost weight development, FFS claims will be used for disease condition flagging where available and appropriate.

## **3.4 Calculation of Risk Scores**

### **3.4.1 Beneficiary Risk Score Development**

Using the models and data described above, a risk assessment will be performed for each scored beneficiary. Scored beneficiaries are defined as any individual with at least six months of eligibility (non-continuous) during the 12-month study period. The six month scoring criteria provides sufficient time to accumulate beneficiary’s applicable health diagnosis and pharmacy usage.

The risk assessment is performed by assigning any applicable disease condition categories to each scored beneficiary. Once the disease condition flagging is complete, each beneficiary’s acuity level (i.e., beneficiary risk score) will be determined by adding the relative cost of all their flagged conditions and demographic category. This process of calculating individual beneficiary risk scores is anticipated to occur every six months.

Beneficiaries that do not meet the six month scoring criteria or are new to the program since the end of the study period are considered “unscored”. Unscored beneficiaries will receive the average (all PHPs combined) risk score for beneficiaries within their respective demographic grouping, by rate cell. As the program matures, the unscored assumption may be revisited.

### **3.4.2 PHP Enrollment**

Once the scored and unscored beneficiaries are given a risk score, actual PHP enrollment is collected to evaluate the average risk scores for each PHP. Since the goal of risk adjustment is to project payments during the contract period, an enrollment snapshot that represents PHP membership will be applied as close to the contract period start date as possible. For example, for July risk adjustment, an enrollment snapshot as of June based on beneficiary selection and assignment is expected to be utilized.

The enrollment snapshot is cross-referenced to the individual beneficiary risk score file to develop a raw average risk score for each PHP. DHHS is considering updating the enrollment snapshot each month for the first six months of program implementation in each region to account for the higher member movement that may occur. At that point it will be evaluated if moving to quarterly updates is appropriate and eventually moving to semi-annual updates when deemed appropriate. Similarly, as populations are phased into managed care, the PHP enrollment snapshots may be updated monthly for the first six months of managed care.

### **3.4.3 Budget Neutral Risk Scores**

The average risk scores will be calculated for each rate cell for all beneficiaries who are enrolled in each PHP. Since the data used to produce the risk adjustment cost weights and the 12-month application are from different time periods, distortions in the model results occur due to changes in practice patterns and coding specificity.

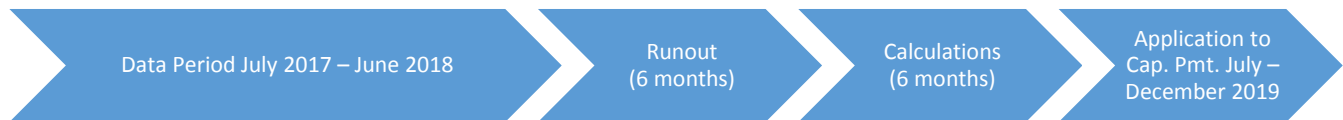
Therefore, the initial results are considered to be “raw” risk scores. The distortions described previously may cause the raw risk scores to be inappropriately inflated or deflated, depending on the populations and models being applied. To address this issue, a budget neutrality adjustment is required.

CMS requires that risk adjustment be applied in a budget neutral manner. This calculation is done by dividing each PHP’s raw risk score by the total PHP raw risk score for each rate cell. This adjustment will result in the weighted average of the budget neutral risk scores within a rate cell equaling 1.0. The final payments made to the PHP are determined by multiplying a base capitation rate by each PHP’s budget-neutral (BN) risk score and by its enrollment for each rate cell.

### 3.5 Frequency of Updates

The risk adjustment study period (used to set risk scores by beneficiary) will be updated every six months corresponding with the first and second half of each contract year. For each six-month update cycle, a full year of encounter or claims data will be pulled for a time period beginning two years before the beginning of the cycle. This timing allows for six months of runout and six months of calculation time. This semi-annual process will also allow for 6 months of overlapping data with each update. The illustration below shows a sample timeline.

**Figure 4: Risk Adjustment Analysis**



### 3.6 Final Capitation Rates

The final budget neutral risk scores for each PHP will be applied to the base capitation rates for the Medicaid and NC Health Choice populations, thus producing the risk adjusted rates for each rate cell. The resulting capitation rates will reflect the relative risk between PHPs and rate cells. Risk adjustment is anticipated to be applied to all managed care populations, but will not be applied to the maternity kick payments and newborn rate cells. Maternity kick payments are not typically risk adjusted because the delivery payment is already a form of risk adjustment. Newborns are also typically excluded from risk adjustment because it is challenging due to the lack of historical data at the beneficiary level. DHHS plans to create a separate rate cell for newborns to account for their higher than average costs.

The resulting risk adjustment scores are projections of relative risk, and actual relative risk will likely differ from that which was projected. The PHPs are encouraged to review the results with their own data. DHHS will use the risk adjustment scores to adjust actuarially sound base capitation rates as a means of matching PHP payments to their relative risks. Use of the risk adjustment results for any purpose beyond that stated may not be appropriate. The risk adjustment model produces precise adjustment factors that are applied to the capitation rates. However, acceptable variation exists within the calculated results due to the specific risk adjustment model chosen, the various assumptions applied and the availability and accuracy of the source data utilized. Although health-based risk adjustment is not a perfect system that predicts all variation in beneficiary and PHP costs, published results have shown that using health status as a predictor of costs is a significant improvement over age/gender rating.

When developing a risk adjustment payment approach, there are many decision points and assumptions that need to be determined. The methodology described in this section is based on program goals and objectives, multiple discussions between DHHS and its actuaries, and best/common practice of risk adjustment use in other state Medicaid programs. Further, DHHS made decisions based on the specific implementation schedule and approach

to managed care within North Carolina's Medicaid program. For example, the selection of both a diagnosis and pharmacy-based models provides DHHS with flexibility and options in light of encounter data uncertainty at the onset of the program. As the program matures, certain assumptions may be re-evaluated to enable the risk adjustment methodology to best achieve DHHS's objectives.

## 4 OTHER FINANCIAL CONSIDERATIONS

When two or more PHPs participate in a managed care program, the financial risk likely will not be evenly distributed between PHPs. While risk adjustment accounts for some of the risk differential, it is not a perfect solution. Each PHP will inevitably get more or less of the high cost/risk members creating the potential need for additional risk mitigation techniques. Generally, risk mitigation, also called risk sharing, strategies either pool risk between the PHPs or transfer some risk away from the PHPs with the purpose to mitigate large gains or losses by the PHPs. There are different mechanisms available to accomplish this. DHHS evaluated different options with the goal of paying PHPs at-risk capitation rates with budget predictability and effectively managing state administrative resources needed to support the program. The Medicaid managed care program design will initially have two risk mitigation provisions including a requirement for stop-loss coverage and a minimum MLR.

### 4.1 Risk Mitigation

#### 4.1.1 Stop-Loss

DHHS will require that PHPs purchase stop-loss coverage which will provide protection to PHPs for covered services that exceed a specific dollar threshold incurred by a beneficiary within a contract year. This risk mitigation technique helps shield the PHPs against large losses, as well as helps protect providers and consumers by helping to protect the solvency of the plans. These policies should be purchased on the commercial marketplace from a carrier that is willing to offer the specified coverage.

Covered services and specific attachment point(s) under these required policies are yet to be determined by DHHS. The anticipated costs of purchasing required stop-loss coverage will be considered in the capitation rates.

#### 4.1.2 Minimum Medical Loss Ratio (MLR)

DHHS intends to put in place a MLR arrangement with the PHPs which provides incentive for the PHPs to appropriately manage expenses. The risk mitigation arrangement will incentivize the PHPs to operate efficiently and generate net income, and will require the return of any excessive profit to the State and federal government. The MLR must conform to the standards established 42 CFR 438.8, which is 85%, but DHHS may establish a higher MLR threshold. The minimum MLR will be set to reflect the treatment of supplemental payments. Assuming supplemental payments currently made to certain providers are included as part of the capitation payments to PHPs, the minimum MLR will be higher than if the State were to make those payments directly. If the actual expenses result in a loss ratio of less than the minimum MLR, it will result in a reconciliation process with the affected PHP making a rebate (i.e., payback to the State). DHHS intends to establish the minimum MLR and include it in the PHP RFP.

#### 4.1.3 Other Risk Mitigation Techniques

Other risk mitigation tools and techniques were evaluated by DHHS but ultimately are not planned to be used for the program upon implementation of currently covered populations. DHHS explored whether specific risk mitigation was needed for high-cost specialty drugs that may be introduced to the market. While this presents financial implications, analysis will be conducted in the development of trends for pharmacy services to include considerations for high-cost drug utilization rather than create a separate risk mitigation mechanism.

Ultimately other risk mitigation techniques either didn't support the balance between risk accepted by PHPs and budget predictability or are too much of an administrative burden. Risk adjustment, stop-loss coverage and MLR



requirements should meet DHHS’s objectives for supporting the managed care program without adding a significant amount of additional state administrative requirements. Risk mitigation techniques will be evaluated as the managed care program evolves and matures.

Other risk mitigation approaches that were considered are included in Exhibit D of this document.

## 4.2 Performance Incentives and Withholds

DHHS may adopt a PHP contract incentive and/or capitation withhold program which could be tied to various compliance measures during the first and subsequent years of the managed care program. The measures will be used to ensure that the PHPs comply with key administrative or clinical contract provisions or DHHS priorities such as timely and accurate submission of encounter data (i.e., PHP claim data), PHP financial reports, or meeting particular quality measures (e.g., 90% EPSDT screening rate). The long-term goal of the incentives would be to ensure that PHPs deliver value around the various State priorities and ultimately improve quality of care provided to the Medicaid population in North Carolina. Consistent with federal rules, DHHS will link any payments made through incentive arrangements or withholds to managed care quality strategy and may explore rewarding higher performing plans. Future rate-setting processes will consider how incentives and withholds may impact expected claims and administrative costs.

DHHS and its actuaries will ensure the payment implications of incentives and withholds are designed to comply with federal regulations. Incentives are limited to 105% of the approved capitation rates in federal regulations. Similarly, there are rules around the use of withholds applied to the capitation rates. For example, any withhold must be reviewed by the Actuary to determine that the withhold should be “reasonably achievable” and the capitation rate, including the withhold must be certified as actuarially sound. The methodology to perform the actuarial soundness assessment will be further refined as the actual withhold percentages are defined and the metrics finalized.

## 4.3 Carolina Cares

The General Assembly is currently considering the proposed Carolina Cares program, which would make childless adults and parents with low incomes who meet certain work requirements eligible for Medicaid. This new population may have specific considerations and this section explains risk mitigation and rate setting approaches should the General Assembly implement Carolina Cares.

### 4.3.1 Rate-Setting Methodology

Historical base data will need to be assessed with respect to populations that are not currently part of the State’s Medicaid program. Data from “like populations”, typically Temporary Assistance for Needy Families (TANF) or Aged, Blind and Disabled (ABD) populations can be used as a proxy for the new populations. Alternative data sources will also be explored to determine if available data exists from commercial sources.

This data from “like populations” or a population that most resembles the expansion population would be used as a starting point for analysis adjusted to account for the risk of the population, including:

1. Demographics
2. Differences in acuity or health status — Acuity is a morbidity adjustment meant to account for the expected difference in health between the base and populations.
3. Pent-up demand — Pent-up demand will be developed to capture the effect of people putting off medical services, because they had no or limited access to health care or the access was prohibited by costs.
4. Adverse selection — Accounts for the fact that the beneficiaries in most need of care will have an increased awareness and motivation of obtaining coverage early where choice is involved.

### **4.3.2 Risk Adjustment and Other Risk Mitigation**

The rates for this new population likely cannot be risk adjusted as historical data needed to score individuals are generally not available initially. This may require more detailed rate cells to best match payments to expected costs.

DHHS will likely want to explore other risk mitigation techniques for any new populations as these populations may have a greater degree of uncertainty due to having minimal or no historical data to be used in the rate-setting process.

## **5 INFORMATION SHARING AND TRANSPARENCY**

DHHS is committed to a transparent process with consideration for stakeholder input. The following outlines key milestones for communicating capitation rate-setting information to PHPs and other stakeholders through the procurement process.

### **5.1 Request for Information (RFI)**

This document is being released along with an RFI soliciting feedback on specific components of the proposed program, including the proposed rate setting methodology outlined in this document.

### **5.2 Request for Proposals (RFP)**

A proposal process will be used to determine which PHPs will be awarded contracts for the Medicaid Transformation program. DHHS intends to procure bids from potential PHPs with clinical, access and operational components to be scored based on technical merit. DHHS anticipates releasing the RFP in the Spring of 2018 assuming a launch date of July 2019.

Draft rates will be calculated by DHHS's Actuary and shared in the RFP process. The draft rates would be included in the RFP along with a data book and thorough rate documentation including the assumptions and approach to setting the rates.

### **5.3 Rate Contracting**

Given the gap between issuance of procurement and contract effective date of July 2019, the rates will be re-evaluated based on emerging utilization and cost. It is anticipated that final rates will be published 90-120 days in advance of the contract effective date.

During the contract implementation, the final rates would be calculated using the methodology outlined in Section 2.3 of this document and the most recent available data. All PHPs will be paid the same base capitation rates by rate cell, unless there is variation in taxes or fees. The base rates will be risk adjusted for each PHP as outlined in Section 3 of this document, resulting in the final capitation rates being different by PHP.

### **5.4 Risk Adjustment**

Upon completion of the risk adjustment analysis, DHHS will provide PHPs with their final budget-neutral risk scores as well as a prevalence report outlining the observed conditions of their members compared to other PHPs.

## **6 TIMELINE FOR RATE-SETTING AND RISK ADJUSTMENT**

The following table outlines the anticipated timelines for PHP procurement, rate-setting processes and program implementation assuming a July 1, 2019 launch date. For the standard plans, it is intended that the data collection and rate-setting processes for any regions implemented at any point during the first year of the program will occur

as part of the initial managed care capitation rate-setting process. For example, the rates for any regions that launch on after July 1, 2019 will be set at the same time as the region(s) implemented on July 1, 2019. Any populations that are implemented during any State Fiscal Year (SFY) will be included in the rate-setting process for that year.

**Table 1: Proposed PHP Capitation Rate Setting Timeline for the Initial Year of Managed Care**

RFI to include proposed rate-setting methodology	Fall 2017
Development of draft capitation rates (based on SFY 2017 data)	Fall 2017–Spring 2018
RFP including draft capitation rates and associated documentation	Spring 2018
Development of Final Year 1 capitation rates (based on SFY 2018 data)	Fall 2018–March 2019
Rate discussions with selected PHPs	First Quarter 2019
Rate certification sent to CMS	March 2019
Program implementation in first region	July 2019

As noted in Section 3, risk adjustment will be utilized to differentiate the base capitation rates across the PHPs. To best align the risk scores with each PHP’s enrolled population, risk scores are calculated closer to the rate effective period. Risk scores are also updated at least twice a year to account for changes in the Medicaid enrolled population for each PHP. The following table outlines the timelines specific to the risk adjustment process for the year one capitation rates. As noted in Section 3.4, DHHS is considering updating the enrollment snapshot each month for the first six months of program implementation in each region to account for the higher member movement that may occur.

**Table 2: Proposed PHP Risk Adjustment Timeline for the Initial Year of Managed Care**

Initial Risk adjustment model calibration	July–December 2018
Collect SFY 2018 data needed for risk adjustment process	January 2019
Calculate PHP risk scores for July 2019–December 2019 rate period	January–June 2019
Collect CY 2018 data needed for risk adjustment process	July 2019
Calculate PHP risk scores for January 2020–June 2020 rate period	July–December 2019

The rate-setting timeline for future years will generally begin in the late fall of each year with base capitation rates shared with PHPs in the first quarter of each year. Risk adjustment will continue to be analyzed twice a year consistent with the timelines in Table 9.

## 7 CONSIDERATIONS FOR FUTURE YEARS

This methodology document focuses primarily on the process that will be used for the initial implementation of the program. As the program evolves, it will be important to evaluate the steps of the rate-setting process and modify as necessary. The sections below outline likely considerations and modifications that may need to be made as part of future processes.

### 7.1 Data

Many of the future considerations are related to the collection of encounter data and its intended uses. DHHS’s expectation is that the PHPs will submit encounter data on a timely and accurate basis upon implementation of the program. The encounter data will be evaluated for completeness to ensure it is sufficient to be one of the primary data sources for rate-setting purposes. Many of the future considerations related to the future rate-setting processes are dependent on the encounter data being complete and accurate.

The first step in this process is to collect the encounters and validate against the historical FFS data. This process involves evaluating the volume of data to help determine completeness, the distribution of diagnoses by major diagnostic categories, and assessing the number of reported diagnoses included on each encounter. Another

validation check is to compare encounter totals to the financial reports provided by the PHPs. While the financials typically do not have as much detail as the encounter data, they can be used to assess the overall volume of claims.

As encounters are collected, they will likely be initially used in tandem with historical FFS data. Even if the initial encounters prove to be complete and reliable, there will not be enough data available to serve as the sole basis for the rate-setting and risk adjustment processes. Typically a blended approach is used during this time period, moving towards encounters being the primary data source, supported by other data sources such as financial data.

In addition to encounter data, the State will begin collecting financial reports from the PHPs. These submissions will be used for monitoring the profitability, solvency and efficiency of the PHPs, as well as comparing results against expected outcomes. The State will work to develop key measures and oversight based on the original goals of the program.

## 7.2 Rate-Setting

The following items will be considered in the rate-setting processes in future years of the program:

1. DHHS will consider reevaluating rate cells once the program has been established. Rate cells typically do not change, but it is good practice to ensure that the chosen rate cell structure is meeting the goals of the program.
2. The impact that managed care initiatives have on prospective trends.
3. Programmatic considerations should be evaluated throughout the year and discussed starting at the front end of the rate-setting process to determine if any additional data is needed to support any program changes. This includes, but is not limited to, changes in covered benefits, the preferred drug list, and provider reimbursement requirements.
4. Actual managed care savings should be compared with expectations included in the initial rate-setting process. Savings should continue to be monitored, as they often take multiple years to fully materialize. Eventually, the PHP encounter data should reflect most managed care savings. However, DHHS may want to continue performing certain analysis such as LANE and PPA.
5. DHHS will continue to evaluate efficiency adjustments such as LANE and PPA as well as consider the need for new efficiency adjustments related to fraud, waste, and abuse issues. These analyses are critical to ensure the base data reflects costs and utilization consistent with an efficiently managed program.
6. Funding for administrative costs will eventually be informed based on financial data submitted by the PHPs. This information should be evaluated as it becomes available.
7. Continue to monitor new and evolving rules and regulations related to Medicaid managed care rate-setting to ensure that the process is adhering to best practices.

## 7.3 Risk Adjustment

The risk adjustment analysis will be heavily dependent on quality data in future years under managed care. Most of the steps for risk adjustment will be consistent with the steps outlined in Section 3, however, critical evaluation of the data is needed to ensure the process is accounting for risk differences and is not unduly impacted by data challenges.

1. The frequency of encounter data collection from the State by the actuarial vendor for the risk adjustment process should continue to be evaluated. More frequent updates may be beneficial during the initial year of the program, eventually moving to a semi-annual basis. PHPs would submit encounter data on a regular basis to the State and the State will extract data on a periodic basis to support risk adjustment analyses.

2. Update the beneficiary risk score development every six months using updated encounter data.
3. PHP risk scores should be evaluated on a more frequent basis, as often as monthly, for the initial year of the program using the beneficiary risk score file (updated every six months) and monthly PHP enrollment snapshots. After the first year DHHS should evaluate moving towards semi-annual updates of PHP risk scores depending on how much enrollment shifting between plans is occurring. This should also include consideration for program phase-in for new regions and populations.
4. The risk adjustment methodology will need to be evaluated as new populations enroll in managed care. This is especially critical for the tailored plan population to ensure the model is calibrated to capture the unique characteristics of the population and enrollment considerations related to TPs.
5. The models should be evaluated as the program matures, especially once encounter data becomes available.
6. Blending should be considered once encounter data becomes available to help with the transition and provide consistency for the PHPs. The blending may include blending results from different models, PHP risk scores, or FFS and encounter data.

## 7.4 Other Risk Mitigation Techniques

The initial program design includes required stop-loss coverage as well as a minimum MLR. As the managed care program matures and new issues arise, DHHS should continue to evaluate the current risk mitigation techniques and consider whether any additional techniques are needed in the future.

1. DHHS should monitor the MLR for each PHP on a regular basis.
2. DHHS should evaluate specific stop-loss requirements for BH I/DD TP s and monitor the BH I/DD TPs' ability to obtain coverage from the commercial market.
3. Any State mandated stop-loss requirements should be evaluated on an annual or semi-annual basis to confirm that the coverage is appropriate and meeting the intended goals. This may include evaluating any State mandated attachment points as medical inflation will likely increase the number of claims reaching the attachment point(s).

**EXHIBITS**

## EXHIBIT A — DATA PROCESSES

### Intake/Load Process:

1. Data Dictionary/File Layouts — File layouts and data dictionaries should be obtained to guarantee a thorough understanding of the data contents.
2. Control Total Verification — It is vital that all data is collected and properly transmitted. As part of all file loads, control totals must be required to be sent with the data to ensure all data has been successfully transmitted and loaded.
3. Field Check — All files will be checked to make sure that all fields requested are included in the files.

### Data Validation Process:

1. Referential Integrity — Processes will be performed to ensure that files are able to be joined for analysis. Common verifications are that header and detail records can be linked, claims match eligibility, and claims match provider files. Strong referential integrity is critical for all projects to ensure no data loss.
2. Lag Triangles — An analysis will be performed that evaluates the dollars paid by month of service and month of payment. This allows the identification of any possible missing data. A month with low payments could indicate a missing file or submission.
3. Frequency Report — Frequencies should be run on all text fields. This report is then reviewed to make sure that the fields contain values that would be expected.
4. Valid Values — National standard fields will be checked to make sure that they contain valid values. These fields include diagnosis codes, procedure codes (International Statistical Classification of Diseases (ICD), Healthcare Common Procedure Coding System (HCPCS) and the American Medical Association's Current Procedural Terminology (CPT) codes), revenue codes, and National Drug Codes (NDC). These fields are of particular importance when risk adjustment processes are to be performed using the data. Additionally, the identification of certain services requires these fields.
5. Missing Values — Records will be checked to identify unpopulated fields, as well as the corresponding percent of total records this represents. This should be done for each variable in the data. This provides an overview of the completeness of the data. Missing data in key fields can greatly affect the analysis.
6. Date Distributions — A complete overview of the date fields within the data, specifying the minimum, maximum, and median values, and the 5th and 95th percentiles will be performed. This report quickly identifies possible problems within the data such as dates in the far past (1/2/1867) or distant future (7/1/2024). It is important to identify and quantify the occurrences of dates out of range because those records would be excluded if a specific date range is selected for analysis.
7. Numerical Distributions — Descriptive statistics for financial variables will be run. This report aids in identifying extreme values that could affect analysis. Negative, zero, or very high amounts could be a concern for rate-setting if the fields are required.
8. Duplicates — Data are run through processes to identify possible duplicate payments/claims for the same service. In order to perform a projection that utilizes claims data, the information must be as accurate as possible. Having additional claims/services in the dataset that do not belong can introduce bias in downstream analyses.

Encounter to Cost Report Comparison — Comparison of provider payment amounts contained in encounter data with medical expenses reported on the PHP's financials. The comparison is preceded by adjustments to the encounter data to reflect sub capitation amounts, incurred-but-not-reported (IBNR) claims, settlements, risk

pools, risk sharing, reinsurance and any other items that are reflected in the PHP's financials but are not included in the encounter data line items.



## EXHIBIT B — POPULATION CRITERIA

**Table A: Detailed Population Information:**

Population Group	Sub-Population	Timing of Implementation (no later than)
Excluded	Medically Needy Partial Duals: MQB-Q, MQB-B, MQB-E Aliens (Emergency Services Only) Refugees Presumptively eligible individuals PACE beneficiaries Health Insurance Premium Program Inmates (pending legislative change) Family Planning (pending legislative change)	N/A
Legal Aliens (full Medicaid)	N/A	Initial implementation
LTSS — Nursing Facility Level of Care (NFLOC)	N/A	4 years after managed care implementation (pending legislative change)
LTSS — CAP/C	N/A	4 years after managed care implementation (pending legislative change)
LTSS — CAP/D	N/A	4 years after managed care implementation (pending legislative change)
LTSS — Innovations	N/A	2 years after managed care implementation (pending legislative change)
Temporary Assistance for Needy Families (TANF) and Other Related Children/Adults	Aid to Families with Dependent Children (AFDC), Other Children & Infants and Children Other Child Pregnant Women Infants and Children Breast and Cervical Cancer (BCC) Population	Initial implementation
Foster Children & Adopted Children (including former Foster Children)	N/A	1 year after managed care implementation (pending legislative change)
Aged, Blind, Disabled	Aged Blind Disabled	Initial implementation
NC Health Choice	Children’s Health Insurance Program (CHIP) CHIP — Extended Coverage	Initial implementation
M-CHIP	MCHIP	Initial implementation
Dual Eligibles	N/A	4 years after managed care implementation (pending legislative change)

**Table B: Other Specialty Populations are listed below:**

<b>Population Group</b>	<b>Sub-Population</b>	<b>Timing of Implementation (no later than)</b>
Maternity Events	Maternity events will be identified in the claims data to create a separate kick payment for these higher-cost events.	Initial implementation
BH I/DD	Beneficiary identified with an I/DD including Innovations, long-term ICF/IDD clients, TBI waiver, TCLI, history of use of state-funded BH services and users of 1915(b)(3) services  High Needs Seriously Mentally Ill /Seriously Emotionally Disturbed (SMI/SED) and Dependence-Level Substance Use Disorder (SUD) with history of enhanced behavioral health service utilization	2 years after managed care implementation (pending legislative change)

## EXHIBIT C — COMPONENTS OF MANAGED CARE ANALYSIS

### Other State Medicaid Managed Care Program Analysis

Information from other state's Medicaid programs will be collected to serve as a comparison to North Carolina data and provide context regarding potential savings under managed care. While doing so, it is important to note that the State currently utilizes Community Care of North Carolina/Carolina ACCESS (CCNC/CA), which is an enhanced Primary Care Case Management (ePCCM) model. Since the State already operates under a "managed" FFS model with CCNC/CA and capitated BH model, the State may observe lesser managed care savings opportunities compared to other states, given a degree of care management is already being achieved. The other State comparison analysis focuses on utilization comparisons for acute care and pharmacy services. Services such as dental or mental health generally have a wide variation of state-specific benefit coverage and thus, other state data does not serve as a good comparison point for this type of analysis.

The information from this process may serve as an indicator of potential State managed care opportunities. This process should involve analyzing North Carolina experience, along with a range of other state managed care per member per months (PMPMs) and utilization/1,000 metrics by population cohort.

The analysis should include the following considerations when analyzing results:

1. Have steps been taken to remove North Carolina and other state maternity costs for purposes of this comparison? Other states may have varying birth rates and maternity costs that may not serve as a good comparison for a managed care analysis.
2. For NC Medicaid FFS Inpatient Hospital — Physical Health (PH) and Outpatient Hospital — Do PH PMPMs include historical hospital supplemental payments? Other state Medicaid data used for comparison may include different reimbursement arrangements under managed care that consider prior supplemental payments, which may distort PMPM comparisons for these services.
3. Have the rebates the State receives for prescription drugs been factored into the comparison? Prescription drug costs represent the gross costs that would be included in a capitation rate.
4. Are the differences due to the utilization of services or variation in reimbursement methodologies? Managed care analysis will focus on differences in utilization due to potential differences in reimbursement methodologies across state programs.

### BH/PH Integration

An analysis will be conducted related to BH/PH Integration to support Medicaid transformation efforts. Initial research suggests 1%–2% savings opportunity based on management of acute care services through BH/PH integration for beneficiaries with a BH diagnosis.<sup>5</sup> BH/PH integration does not reduce services for members in need, but should result in reductions in avoidable visits to the ER and hospital and more services provided in other community settings. Integration is expected to result in increased preventive BH or PH services that lead to treating conditions prior to the onset of acute episodes, as well as beneficiaries receiving the care they need in the most efficient setting. Individuals with BH diagnoses and chronic medical conditions tend to incur costs over twice that of a beneficiary with the same chronic medical condition without a BH diagnosis.

BH/PH integrated programs have recently been implemented in other states such as Arizona, California, and Washington. These programs are in their infancy, but expected savings are related to management of hospital and ER services. Administrative efficiency is also expected in the area of care coordination for an integrated BH/PH program versus the current program that has care coordination at both LME/MCO and CCNC/CA.

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<sup>5</sup> Impact of Integrated Medical-Behavioral Healthcare: Implications for Psychiatry, April 2014, <https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care>  
Appendix A, Managed Care Program Actuarial, RFI #30-DHB-110217-18-A2

To evaluate managed care savings opportunities for the BH I/DD TP, State-specific data will be divided into the BH I/DD clinical condition categories and summarized: I/DD and high needs SMI/SED and SUD Dependence-Level Users. Analysis of utilization data for the BH I/DD population will be conducted to supplement the general managed care savings analysis described above. Beyond managed care savings, the cost and utilization differentials of any specialty populations must be evaluated for rate-setting and overall beneficiary choice implications.

### **Pharmacy**

Reimbursement and utilization management strategies play an important role in controlling pharmacy costs. Effective management of federal and supplemental rebates also contributes to decreasing the overall net drug costs to the Medicaid program. Along with other medical services, DHHS is planning to move the pharmacy benefit under managed care. However, DHHS intends to maintain a level of oversight and management of the program through current management strategies, such as the PDL and the actual acquisition cost (AAC) reimbursement model. While much of the pharmacy benefit will be prescribed, there is likely some additional observations regarding how other state Medicaid programs, and potentially North Carolina, could explore additional savings.

The review will be focused on the following:

1. Reimbursement requirements
2. Clinical Edits and Efficiency analyses
3. Pharmaceutical Rebates

### Reimbursement

In 2016, North Carolina implemented a new reimbursement methodology for pharmacy services based on AAC approach with a higher dispensing fee compared to historical reimbursement. The net impact of this change was a lower cost reimbursement methodology. The rate-setting methodology will need to evaluate the implications of the lower costs associated with the acquisition cost reimbursement model when setting the initial PHP capitation rates depending on the base year of data. Eventually, this change will be captured in the claims costs utilized for rate-setting.

### Clinical Edits and Efficiency Analysis

It is recommended that a clinical edits and a HCPCS (for physician-administered drugs) efficiency analysis be incorporated into the initial capitation rates to ensure the plans are being efficient at the initial transition to managed care. These analyses will identify inefficiencies for utilization in excess of FDA guidelines, as well as identify inefficiencies in reimbursement for top drugs covered in the physician administered drug program.

### Pharmaceutical Rebates

Under FFS, the State has developed a strong pharmacy benefit program, which includes a PDL that generates significant pharmacy rebates to the State on the prescription drugs administered to Medicaid beneficiaries. By requiring the PDL, the State should expect to receive similar federal and supplemental rebates on the drugs administered to PHP beneficiaries. In addition, it has been observed that PHPs are able to negotiate additional nominal rebates under managed care. For states with a mandated PDL, it is estimated that PHP rebates are approximately 1%–2%.

### **Potentially preventable admissions**

#### Methodology

The PPA analysis will follow a general methodology followed by most state Medicaid managed care programs incorporating this type of efficiency analysis.

Step 1: The initial step in the PPA analysis involves collection and validation of the claims data. The data set utilized for the PPA analysis should be the same data set validated and utilized for rate-setting. As part of the PPA analysis, an eligibility data source is needed to determine the number of months that a beneficiary is enrolled in Medicaid.

Step 2: Every inpatient stay will be reviewed to determine if it met the Pediatric Quality Indicators (PDI) or Prevention Quality Indicators (PQI) criteria. For the child cohorts, the diagnosis fields are compared against the diagnosis fields for five PDI indicators. Similarly, for the adult cohorts, the diagnosis fields are compared against the diagnosis fields for 13 PQI indicators. Admissions that are identified as meeting the criteria for one of the PDI or PQI indicators were flagged as a PPA admission.

Step 3: The underlying risk for each of the beneficiaries will be considered using a Clinical Global Exclusion (CGE) methodology. The CGE methodology was developed by clinicians with managed care experience as a mechanism to identify serious clinical conditions that could impact the general course of care and/or treatment over a period of time. An exclusionary flag should be applied at the beneficiary level for all inpatient claims associated with individuals that met the CGE criteria. Flagged individuals likely required a higher level of care and experienced admissions that were less likely to be avoided. The CGE methodology provides further clinical relevance by identifying global conditions that affect care for a longer period of time that may not be easily discernible in a claim by claim review.

Step 4: Each admission is reviewed to see if it had met the minimum threshold of months the beneficiary was Medicaid eligible prior to the admission. The minimum enrollment duration requirements should be developed by clinicians experienced with Medicaid managed care and reflects insight gained from external quality reviews, readiness assessments and operational efficiency reviews of Medicaid health plans. The duration requirements reflect best practices in care management and disease management and give consideration to whether conditions are acute or chronic in nature. For any admission for a beneficiary that does not meet the minimum eligibility threshold, the admission is not considered in the final assessment calculation.

Step 5: Some states also apply a targeted efficiency level to the PPA results. The targeted efficiency level is applied to recognize reasonable time expectations regarding a plan's ability to incorporate additional best practices to mitigate the incidence of preventable admissions. Additionally, the targeted efficiency level also recognizes replacement costs associated with alternative treatment. The typical treatment services related to managing the PQI and PDI conditions are physician, pharmacy, durable medical equipment and laboratory services and not outpatient hospital treatment. These replacement services are expected to be provided as key components to the long-term care management for individuals with the identified PPA disease conditions, avoiding inpatient admissions and ER visits and preventing the disease progression.

### Analysis

A PPA analysis will be performed to identify opportunities for managed care impact on inpatient admissions that could be achieved through PHP management of PPAs. The PPA analysis will identify inpatient admissions that could have been avoided through high quality outpatient care and/or reflects conditions that could be less severe and not warrant an inpatient level of care if treated early and appropriately. The PPA analysis can help identify potential reductions of health care inefficiencies in the inpatient hospital setting and support DHHS's desire for a more value focused purchasing strategy.

The criteria for identifying potentially preventable hospital admissions have been established by the Agency for Healthcare Research and Quality (AHRQ).<sup>6</sup> The PQIs applicable to the adult cohort and PDIs applicable to the child cohort will be used to analyze the FFS data and the LME/MCO managed care claims data to identify those admissions that could have potentially been avoided. The inpatient claims/encounters identified as potentially

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<sup>6</sup> Criteria available at: [www.qualityindicators.ahrq.gov](http://www.qualityindicators.ahrq.gov)

preventable were then analyzed individually and additional consideration was given based on an individual beneficiary's eligibility span within the study period.

### **Inpatient Readmission**

Like PQI and PDI admissions, hospital readmissions represent health care expenditures that could possibly be avoided through high-quality outpatient care and post-discharge transition planning. The readmission analysis will be focused on hospital admissions within 30 days of a previous discharge for the same beneficiary at any facility and for any diagnosis-related group.

Due to the inherent nature of these types of admissions (i.e., a readmission is seen as a potential breakdown in discharge planning or outpatient care subsequent to the original admission), enrollment duration is not seen as a factor and, therefore, is not considered.

It is worth noting that there will likely be a level of overlap between the PPA and Inpatient Readmission analysis; this will be evaluated. Additionally, similar to other data driven adjustments, oftentimes states will apply a Targeted Efficiency Level adjustment when considering an attainable level of savings from avoidable readmissions.

### **LANE**

#### Methodology

The following methodology is based on the actual LANE analysis performed for other state Medicaid managed care programs.

Step 1: The initial step in the LANE analysis involves data gathering and validation. The data set utilized for the LANE analysis should be the same data set validated and utilized for rate-setting analyses.

Step 2: All ER claims will be reviewed to determine whether they qualified as a LANE visit by examining the ICD-9 and ICD-10 fields of the data.

Step 3: For each of the LANE diagnoses, each visit was evaluated from low to high acuity based on the attending physician procedure code. Visits with a procedure code of 99284 or 99285 may be assumed to be more severe and unlikely to be preventable and may be excluded from the final count of LANE visits.

Step 4: Other state Medicaid managed care programs have taken steps to develop an assumption of the percentage of visits that are potentially avoidable for an efficient managed care organization by diagnosis. Over time as the managed care program becomes more mature, the potentially preventable percentages can be adjusted to reflect an expectation of a high level of avoidable visits. The State may want to further explore these options as the State continues to transition under managed care.

Step 5: The last step is to build in a replacement cost for each preventable LANE encounter. The replacement cost may reflect the average cost for a physician office visit; visits coded 99201–99215 can be used to model the replacement cost since they generally do not require ancillary services. The replacement costs built into the adjustment are considered sufficient to cover the necessary services to avoid the ER visits with appropriate care-management practices. Additionally, the number of ER visits that are replaced may be capped for each Medicaid beneficiary.

Step 6: Note that some states also apply a targeted efficiency level to the adjustment. The targeted efficiency level recognizes that some plans may need time to incorporate additional cost-containment strategies in the future as alternatives to ER services.

### Analysis

A LANE analysis will be performed as part of the managed care analysis to determine an appropriate expectation for PHP management of care. The LANE analysis identifies instances when Medicaid beneficiaries may not have needed to make a trip to the ER if they had received effective outreach, care coordination and/or access to preventive care. The management of the identified LANE visits is an effective cost-containment strategy that can help reduce health care inefficiencies in the ER setting and therefore supports DHHS's desire for a more value-focused purchasing strategy.

The LANE methodology has been developed by actuaries and clinicians with ER and managed care experience with input from various Medicaid program clinical staff, including Medicaid Medical Directors. Information was predicated upon Medicaid program experience, national guidelines and best practices and supported by a national literature review. Based on review of these various sources of information, the clinical panel developed a process to identify low to moderate acuity diagnosis codes. This process generated a list of primary diagnosis codes representing a high percentage of ER visits that could be avoided.

In many states, for identified LANE visits, managed care assumptions representing the percentage of LANE ER visits that could be prevented in an efficient, well-run managed care program are applied to calculate an initial estimate of reduced ER expenditures. Additionally, costs of services that would have been incurred in other medical settings, such as clinics, to avoid the unnecessary ER utilization may be subsequently built into the adjustment.

## EXHIBIT D — OTHER RISK MITIGATION TECHNIQUES

The other risk mitigation tools and techniques that were evaluated by DHHS but ultimately are not planned to be used for the program upon implementation are listed below. DHHS believes these programs are inconsistent with the objective for the transformation to increase the budget predictability of the program.

1. Risk sharing — May be in the form of reinsurance where the State shares in the risk of a certain service or population with the PHP. The PHPs would pay some form of premium, or have an amount withheld from their capitation payments. In return, the State would pay a portion of the costs for any beneficiaries with claims that meet specific criteria thus spreading the risk.
  - A. Example: The State pays 50% of the costs for any beneficiary with more than \$100,000 in claims.
2. Risk corridors — The State and PHPs share in some portion of both gains and losses within a pre-defined or set of corridors. Multiple corridors may be used, potentially for different populations and/or services.
  - A. Example: PHPs pay back 75% of profits above a set threshold, and the State covers 75% of losses above a threshold.
3. Risk pools — A form of reinsurance where instead of an open-ended payment the amount of payments is limited to the funds set aside in the pool to cover eligible expenses.
  - A. Example: If the State withholds \$500,000 from the PHPs, that amount is distributed to the PHPs based on predefined coverage terms, such as claim experience.
4. Benefit carve-outs — Where the risk of a certain service or consideration is removed from the at-risk capitation rates. These expenses may be subject to reconciliation or may revert to the Medicaid FFS program.