Milliman

State of Illinois

Department of Healthcare and Family Services

RFP 2018-24-001

CY 2018 Medicaid Capitation Rate Range Development

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Agenda

- Disclaimers
- Covered populations and services
- Rate range methodology
- Retrospective rating models
- Prospective rating models
- Non benefit expenses
- Blending and rebalancing
- Form VI: financial proposal
- Final CY 2018 offered rates
- Non-direct revenue payments

Disclaimers

Disclaimers

Limitations

This presentation is intended to enhance Offerors' understanding of information provided in RFP Appendix VII (data book) and RFP Form VI (financial proposal template). The presentation should not be relied upon as a stand-alone document.

Recipients of this presentation should also have access to the full data book and financial proposal template.

All questions concerning the data book and financial proposal template should be submitted in writing no later than April 10, 2017, 12:00pm CT.

Disclaimers

Final rates

Rate ranges presented herein reflect the rate ranges developed for the State of Illinois managed care RFP (2018-24-001).

The rate ranges reflect the currently covered services.

Final rates will incorporate required covered services during the rating period and will take into consideration emerging experience from calendar year (CY) 2016.

Covered populations and services

Covered populations and services

CY 2018 RFP rate range overview

- Existing managed care counties and populations
- New counties for existing populations
- New populations, statewide managed care (all counties)
- No remaining FFS or voluntary managed care counties
- Rate range developed by population
  - Low end rate range reflects greater managed care efficiencies achieved
  - High end rate range reflects limited managed care efficiencies achieved
  - Range developed separately for MCO and FFS experience
  - Range included in Form VI (financial proposal template) as composite of MCO and FFS rate ranges
- RFP excludes Medicare-Medicaid Alignment Initiative (MMAI)
  - Separate, three-way contract amongst CMS, HFS, and MCOs

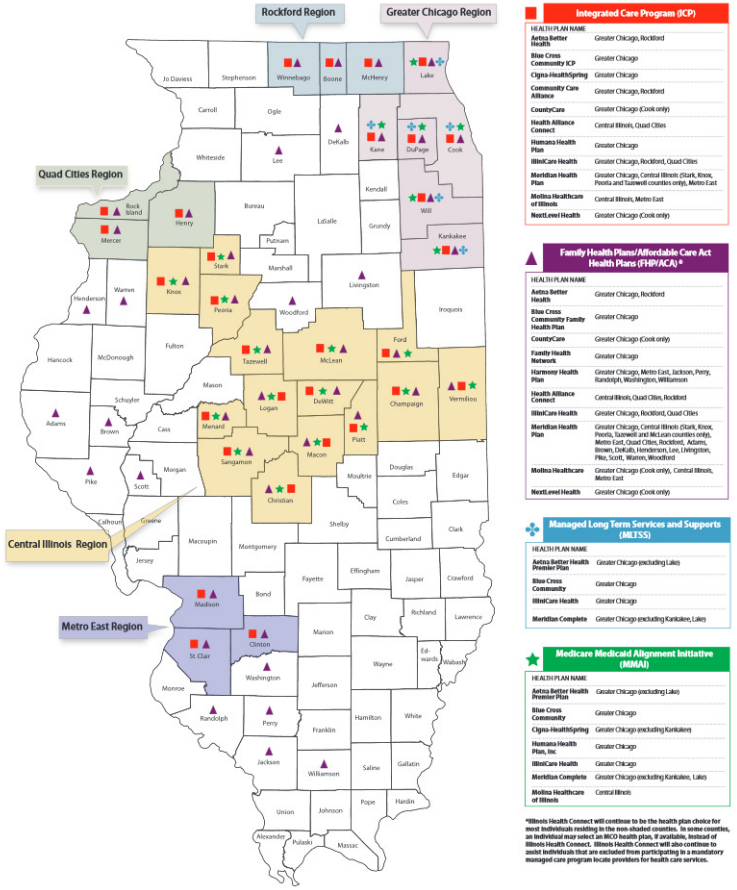
Covered populations and services

Base experience

MCO Experience Data	FFS Experience Data
Existing managed care programs with CY 2015 experience data	New populations, expansion counties
FFS experience data excluded for counties / programs with CY 2015 MCO experience data	MLTSS (new in July 2016)

- New populations: FFS-based rates
- Existing population with managed care expansion: FFS/MCO-based blended rates by region
- Cook County existing populations: MCO-based rates

Existing Managed Care Counties



Covered populations and services

Covered populations

Existing Population	New Population
Family Health Plan (FHP)	Non-Disabled Children and Adults (NDCA)
New managed care population	Disabled Children (DC)
Integrated Care Program (ICP)	Disabled Adults (DA)
Affordable Care Act Adults (ACA)	Affordable Care Act Expansion Adults (ACA)
Managed Long-Term Services and Supports (MLTSS)	Managed Long-Term Services and Supports (MLTSS)
New managed care population	DCFS Youth (DCFS)

Covered populations and services

Existing populations

- Non-Disabled Children and Adults
  - Formerly Family Health Plan (FHP)
  - Children, pregnant women, and non-pregnant adults as a parent or caretaker relative; no change in eligibility criteria
  - Limited number of disabled and SSI children historically enrolled in FHP
  - All disabled and SSI children will be enrolled in the Disabled Children population effective in CY 2018
- Disabled Adults
  - Formerly Integrated Care Program (ICP)
  - Non-dual eligible disabled, aged, and blind adults; no change in eligibility criteria
  - Separate capitation rate development for service package I & II
  - Risk adjustment performed separately for service package I & II
- Affordable Care Act Expansion Adults
  - Formerly Affordable Care Adults (ACA)
  - Adults eligible for Medicaid through ACA expansion, up to 138% of FPL; no change in eligibility criteria

Covered populations and services

New populations

- Disabled Children
  - SSI eligible children
  - Disabled children
  - Limited number of beneficiaries previously enrolled in FHP will be enrolled in the Disabled Children population
- Managed Long-Term Services and Supports
  - Dual eligible beneficiaries not enrolled in the Medicare-Medicaid Alignment Initiative (MMAI) demonstration
  - Limited managed care roll out in July 2016
  - For purposes of RFP illustration, this is categorized as a “new” managed care population
- DCFS Youth
  - Children in the care of the Department of Children and Family Services (DCFS)
  - Includes beneficiaries formerly in care who have been adopted or entered a guardianship
  - Children who have been adopted or entered a guardianship may opt out upon enrollment in a statewide plan

Covered populations and services

Services for populations other than MLTSS

- Service package I (SP I)
  - All standard Medicaid medical services such as physician and specialist care, emergency care, laboratory and X-rays, pharmacy, mental health, and substance abuse services
- Service package II (SP II)
  - Nursing facility services and the care provided through home and community-based service (HCBS) waivers
- Coverage exclusions
  - Service package III (SP III): developmentally disabled waiver services
  - Early intervention services
  - PCCM payments
  - Certain services provided by an ICFDD or state operated facility provider type for NDCA and ACA populations
  - Services provided by a local education agency, state operated school, or developmentally disabled waiver service provider type
- See RFP Appendix VII, Attachment 4, for additional information

Covered populations and services

Services for the MLTSS population

- Behavioral health services
- Non-emergency transportation
- Long term care
- Waiver services
- See RFP Appendix VII, Attachment 5, for additional information

Rate range methodology

Rate range methodology

Process overview: MCO experience

CY 2015 data collection	Base data and program adjustments	Prospective adjustments	Non benefit expense development	Capitation rate range
– EUM data – MCO survey – Non-EUM data request – Subcapitation template	– Aggregation of data sources – Retrospective program adjustments – Other data adjustments	– 2016 & 2017 program adjustments – Trend – Managed care adjustments (low and high)	– Administrative costs collected from MCO survey – Adjustments for enrollment gains – MCO procurement	– Does not reflect new services – Range will be reviewed relative to CY 2016 experience

Rate range methodology

Process overview: FFS experience

CY 2015 data collection	Base data and program adjustments	Prospective adjustments	Non benefit expense development	Capitation rate range
– FFS claims experience received from HFS, run-out through January 2017	– Completion – Retrospective program adjustments – Large claims adjustment	– 2016 & 2017 program adjustments – Trend – Managed care adjustments (low and high)	– Developed from existing managed care populations – Adjustment for enrollment gains – MCO procurement	– Does not reflect new services – Range will be reviewed relative to CY 2016 experience

Rate range methodology

Primary data sources

- CY 2015 encounter utilization monitoring (EUM) quarterly spend summaries
- CY 2015 encounter data
- CY 2015 MCO survey responses
- CY 2015 non-EUM claims summaries
  - Division of Alcoholism and Substance Abuse (DASA)
  - Long term care facility services
  - Waiver services
- CY 2015 statutory financial statements
- CY 2015 fee-for-service (FFS) claims data

Rate range methodology

Encounter utilization monitoring (EUM)

- MCOs submit spend to HFS on a quarterly basis for evaluation
- Historical EUM information includes Medicaid benefit expense as follows:
  - By incurred quarter
  - By capitation rate cell
  - By service category
- Historical reported service categories exclude Division of Alcoholism and Substance Abuse (DASA), long term care, and waiver services
- Reported enrollment, units, and total expenditures
- Reported on a statewide basis (not regionally stratified)

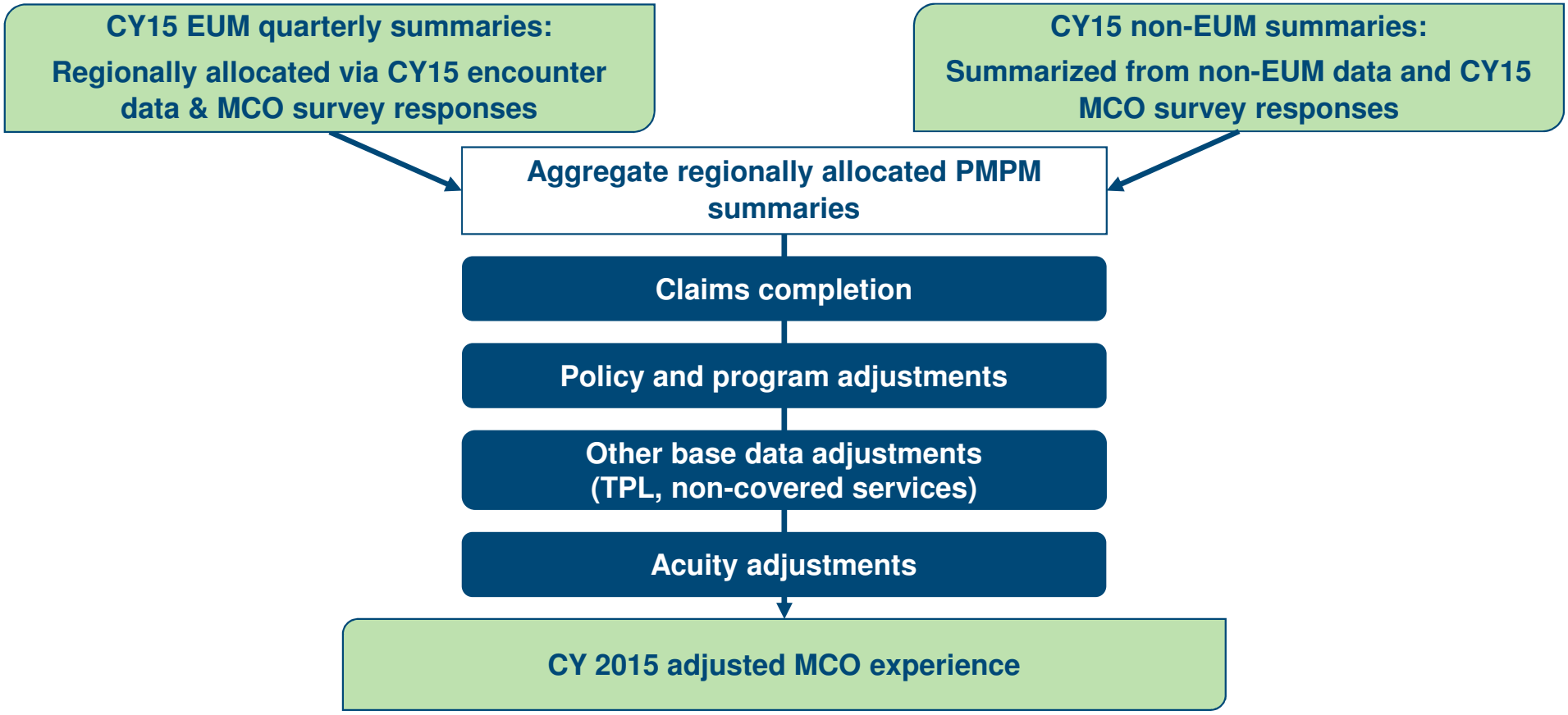
Rate range methodology

MCO survey

- Regional expenditures by population and high level service category
- Subcapitated arrangements
- Provider contracting arrangements
- Government-owned provider utilization and expenditures
- Pharmacy rebates and contracting information
- Non EUM expenditures (DASA, long term care, and waiver services)
- Other missing claims
- Administrative and care management expenses

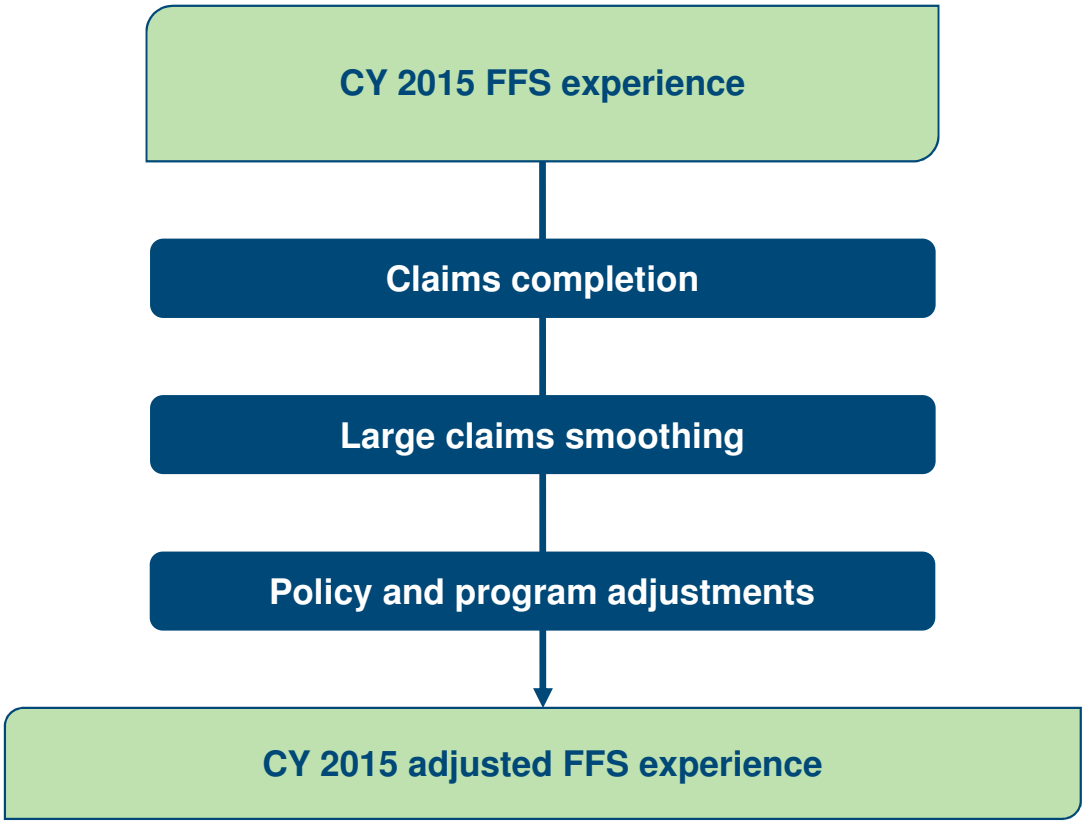
Rate range methodology

Retrospective rating models: MCO experience



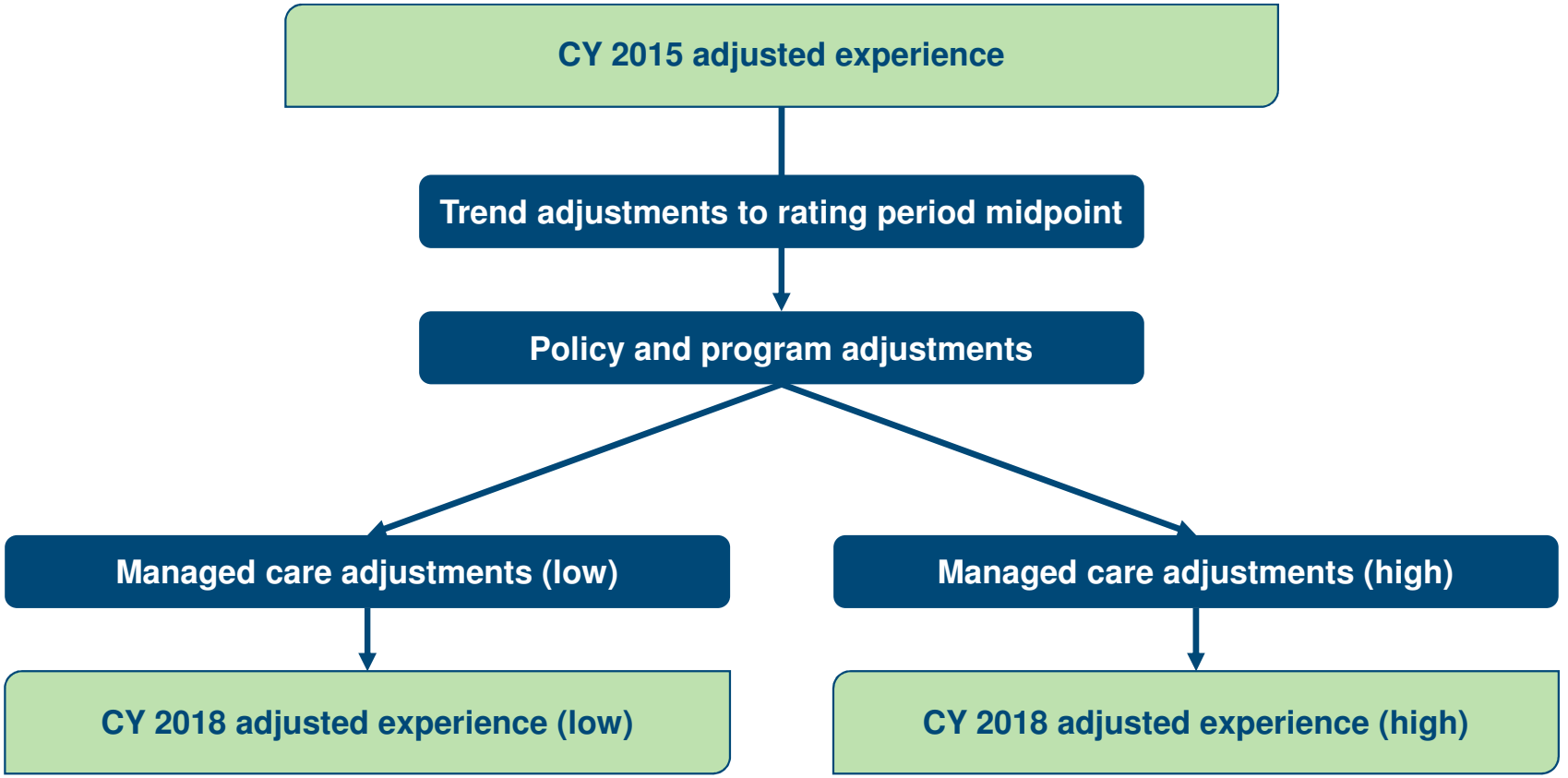
Rate range methodology

Retrospective rating models: FFS experience



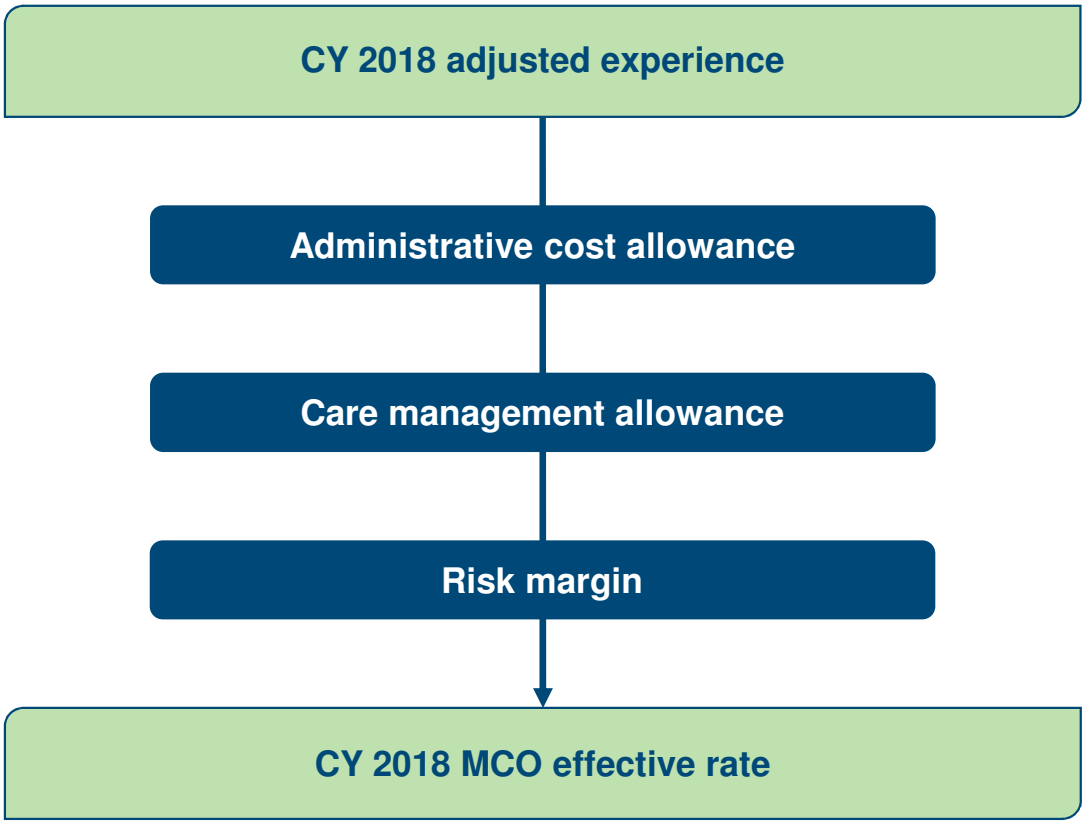
Rate range methodology

Prospective rating models



Rate range methodology

Non benefit expenses



Rate range methodology

Changes from CY 2017: MCO experience

- Methodology and base experience data consistent with CY 2017
- Acuity adjustment to Non-Disabled Children for historically enrolled SSI children
- Additional 12 months of trend
- Targeted reimbursement adjustment for office visits
- Behavioral health bonus payment sunset
- Maternity case rate carve in
- Capitation rate range vs. capitation rate
- IMD State Funded
  - Enrollees residing in an institution for mental disease (IMD) for greater than 15 days
  - Excluded from federal-matched capitation rates (consistent with CY 2017)
  - No rate range to be bid

Rate range methodology

MLTSS rate development

- MLTSS new managed care population effective July 2016
- MLTSS historically in Cook county and certain Collar counties
- No historical MCO experience for MLTSS in CY 2015
- MLTSS illustrated for all counties statewide using FFS experience
- Dual eligible beneficiaries enrolled in the Medicare-Medicaid Alignment Initiative (MMAI) demonstration are excluded from this RFP and all illustrations

Retrospective rating models

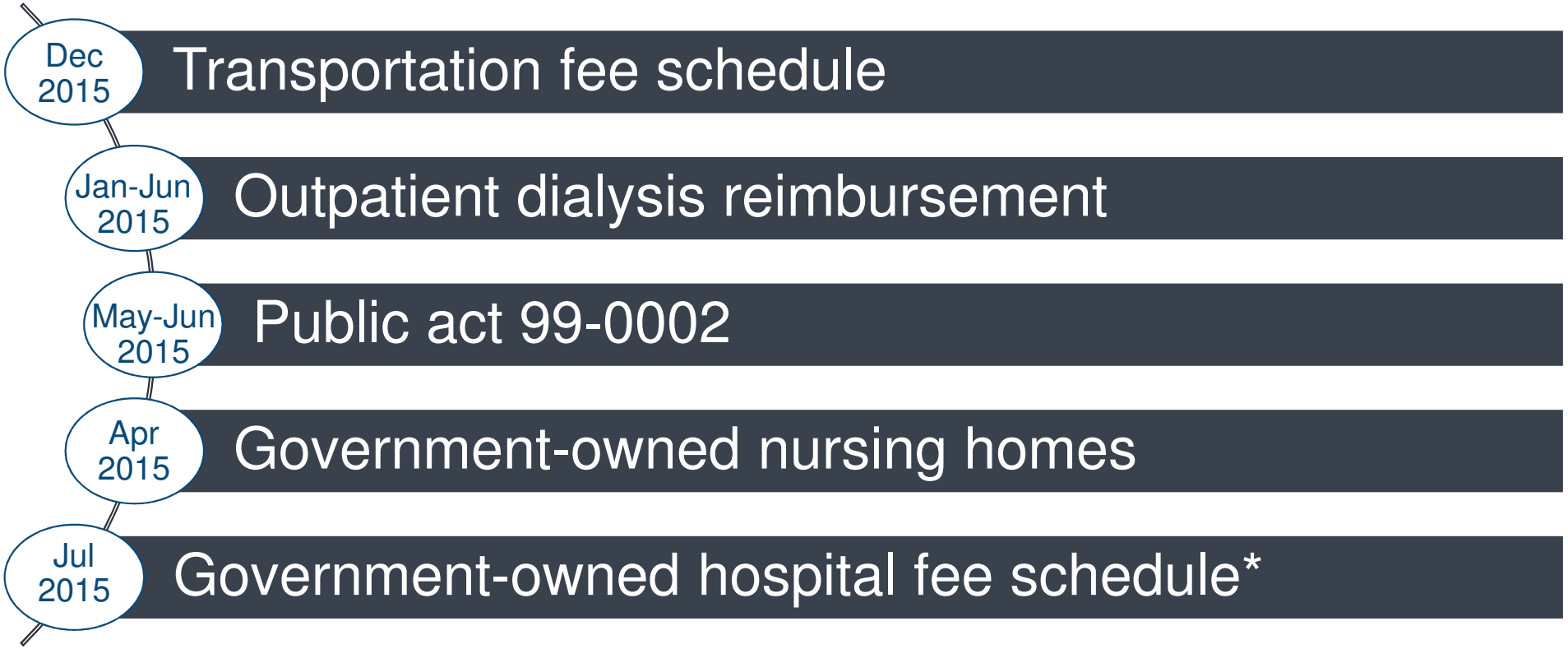
Retrospective rating models

Data adjustments by data book

Adjustment Type	MCO Experience	FFS Experience
Claims completion	X	X
Large claims smoothing		X
Non-state plan services	X	
Pharmacy rebates	X	
TPL & fraud, waste, and abuse	X	
Acuity	X	
ACA eligibility reassignment	X	X
FFS payments for MCO enrollees	X	
Policy and program changes	X	X

Retrospective rating models

Policy and program changes

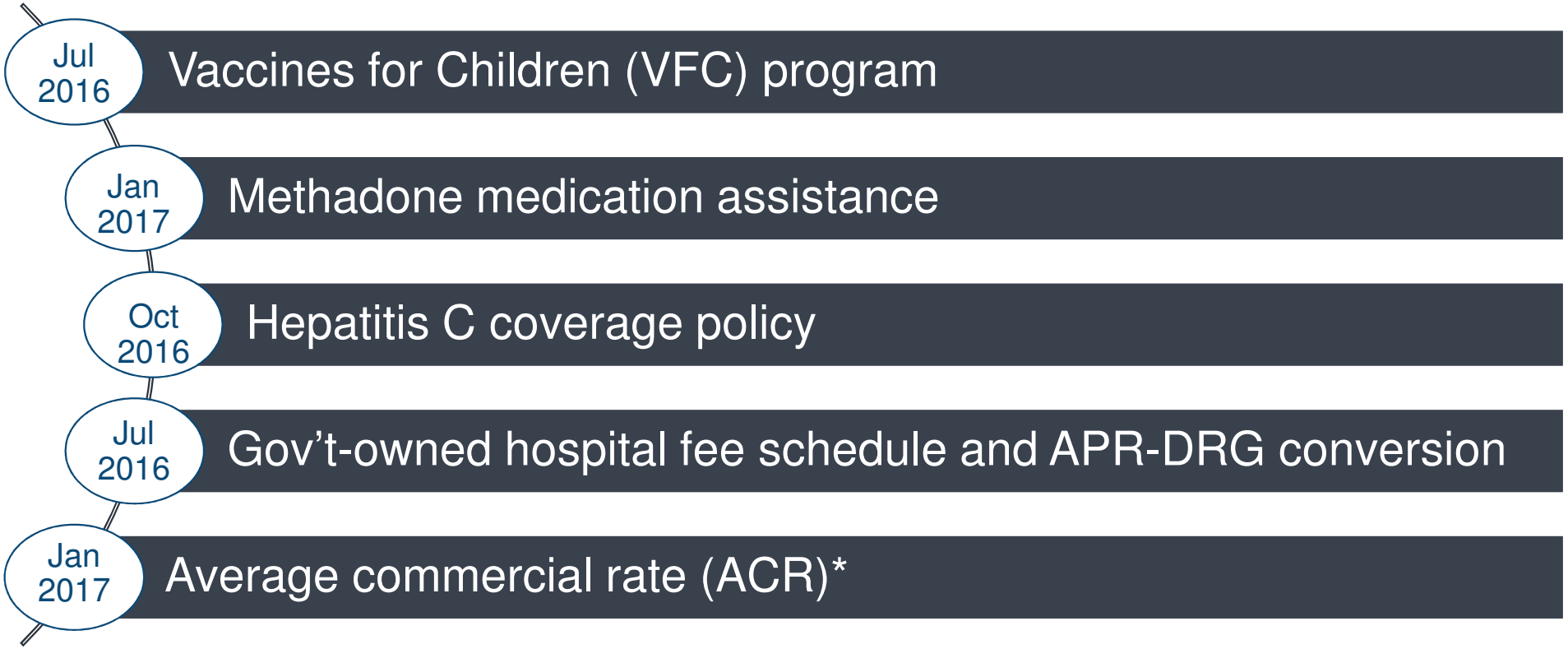


* Note: This change was not material for FFS and was illustrated on a combined basis with the prospective change effective July 2016.

Prospective rating models

Prospective rating models

Policy and program changes



* Note: This change only applied to MCO experience; historical FFS experience included reimbursement at the ACR.

Prospective rating models

Hyper rates

- Government-owned hospital provider reimbursement rates (“hyper rates”)
- Fee schedule specific to government-owned hospital providers
  - Cook County Health & Hospital Services (CCHHS)
  - University of Illinois Chicago (UIC)
- Significantly higher than other state-approved hospital reimbursement rates
- MCO experience during base period reflected limited utilization and lower reimbursement
- Rate development reflects specific adjustments for reimbursement (retrospective and prospective cost adjustments) and utilization (prospective utilization adjustments) to reflect current fee schedule and anticipated utilization of these providers in Cook and Collar counties

Non benefit expenses

Non benefit expenses

Development and assumptions

- Administrative and care management expenses collected from CY 2015 MCO survey responses
- Assumed contracted plans would achieve lower per member administrative expenses due to economies of scale and greater efficiencies relative to currently contracted MCOs in aggregate
- Assumed higher care management expenses for low end rate range
- Risk margin percentages for existing populations unchanged from CY 2017
  - 0.5% for Disabled Adults, service package II, and MLTSS
  - 1.0% for all other existing populations
- Risk margin for Disabled Children and DCFS Youth set at 1.5%

Blending and rebalancing

Blending and rebalancing

Disabled Adults, State Operated Facility

- Beneficiaries residing in an intermediate care facility for persons with developmental disabilities (ICFDD) operated by the State
- Fewer than 300 beneficiaries statewide
- Regional experience is not credible
- MCO effective rates developed on a regional basis
- Statewide rate based on regional rates, weighted on historical experience
- Statewide MCO effective revenue less than $1 million

Blending and rebalancing

LTSS-eligible population

- Beneficiaries residing in a nursing home or enrolled in a 1915(c) waiver (excluding developmentally disabled waiver)
- LTSS population paid on a blended basis
- Service package II (SP II) component of the capitation rate is blended for Disabled Adults' Nursing Facility and Other Waiver rate cells
  - SP II limited to nursing home facility and HCBS expenditures
- MLTSS capitation rates blended for Nursing Facility and Other Waiver rate cells, blended by age group (21-64 Years and 65+ Years)
- Rebalancing of LTSS-eligible population from institutional to home- and community-based settings

Blending and rebalancing

LTSS rebalancing assumptions

- Disabled Adults

	MCO Base Experience			FFS Base Experience		
Region	**% Waiver**	**Low RB**	**High RB**	**% Waiver**	**Low RB**	**High RB**
Region 1 - Northwestern Illinois	76.6%	0.5%	0.0%	66.2%	3.0%	1.0%
Region 2 - Central Illinois	74.9%	0.5%	0.0%	74.4%	3.0%	1.0%
Region 3 - Southern Illinois	81.2%	0.5%	0.0%	79.0%	2.0%	0.0%
Region 4 - Cook County	72.4%	1.5%	0.0%	NA	0.0%	0.0%
Region 5 - Collar Counties	77.8%	1.5%	0.0%	87.2%	2.0%	0.0%

- MLTSS

	MLTSS 21-64 FFS Base Experience			MLTSS 65+ FFS Base Experience		
Region	**% Waiver**	**Low RB**	**High RB**	**% Waiver**	**Low RB**	**High RB**
Region 1 - Northwestern Illinois	61.4%	2.0%	0.0%	42.8%	4.0%	2.0%
Region 2 - Central Illinois	70.9%	1.5%	0.0%	40.8%	4.0%	2.0%
Region 3 - Southern Illinois	73.5%	1.5%	0.0%	53.7%	3.0%	1.0%
Region 4 - Cook County	60.1%	2.0%	0.0%	64.3%	2.5%	0.5%
Region 5 - Collar Counties	56.3%	2.0%	0.0%	50.4%	3.5%	1.5%

* Rebalancing is abbreviated as “RB” in the tables above

Form VI: financial proposal

Form VI: financial proposal

Overview

- Instructions
- Option A - Statewide
- Option B - Cook County
- Population-specific development

Form VI: financial proposal

Blended rates

- Weighting based on projected CY 2018 member months by rate cell.
- Assumed FFS enrollees enter managed care in April 2018.

Final CY 2018 offered rates

Final CY 2018 offered rates

Rate development methodology

- Data book split between MCO and FFS experience, similar to RFP
- Adjust for CY 2016 experience
- Reflect policy and program changes subsequent to the RFP
- Updated government provider risk pool
- Risk adjustment methodology documented

Final CY 2018 offered rates

Offeror-specific rates

- Offeror RFP submission determined as a percentile of RFP rate range
- Final rate range developed as described on previous slide
- Final Offeror rate determined as the percentile of the final rate range
- MCOs will be paid the same percentile across rate cells within a population

Final CY 2018 offered rates

New counties and populations phase-in

- Anticipate newly managed care counties and populations enroll in April 2018
- Offeror rates based on blend of existing and new counties and populations
- To the extent significant acceleration or delay occurs in the roll out of Medicaid managed care to new counties and populations, final or amended rates may be adjusted to reflect the updated timing

Non-direct revenue payments

Non-direct revenue payments

Overview

- Payments in addition to benefit and non-benefit expense
- Established on a regional basis as a per member per month (PMPM) rate
- Excluded from rate range development and illustration
- Will not vary by MCO- vs. FFS-based experience

Non-direct revenue payments

Pass-through payment

- Cook County Health & Hospital System (CCHHS)
- Paid directly to CCHHS to maintain access to CCHHS facilities for all MCO enrollees
- Historical amount has been $10 PMPM
- CY 2018 final rates will include fee for region 4 (Cook County) and region 5 (Collar Counties)
- Exclusions
  - Disabled Adults, State Operated Facility rate cell
  - Managed Long-Term Services and Supports

Non-direct revenue payments

Managed care access payments (MCAP)

- Add-on payments to reflect historical managed care access payments made under the FFS delivery system
- Developed for providers qualifying for enhanced payment under the state plan
  - Local government-owned hospitals providing services to Medicaid enrollees
  - Privately owned hospitals providing services to Medicaid enrollees
- Historical payment rates have varied by region and population
- Exclusions
  - Disabled Adults, State Operate Facility rate cell
  - Managed Long-Term Services and Supports

Non-direct revenue payments

DCFS non-Medicaid payments

- Care management fees associated with coordination of non-Medicaid services
- DCFS Youth population only
- Anticipate adding to DCFS revenue
- Amounts will be documented in final CY 2018 capitation rate certification

Limitations

The information contained in this report has been prepared for the State of Illinois, Department of Healthcare and Family Services (HFS) to provide documentation of the development of the calendar year 2018 RFP rate range for its Medicaid managed care programs. The data and information presented may not be appropriate for any other purpose.

The information contained in this letter, including the enclosures, has been prepared for HFS and their consultants and advisors. It is our understanding that the information contained in this letter will be shared with CMS and may be utilized in a public document. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for HFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

Milliman has relied upon certain data and information provided by HFS and the participating Medicaid MCOs in the development of the calendar year 2018 capitation rates. Milliman has relied upon HFS and the MCOs for the accuracy of the data and accept it without audit. To the extent that the data provided is not accurate, the capitation rate development would need to be modified to reflect revised information.

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Results will differ if actual experience is different from the assumptions contained in this report.

The services provided by Milliman to HFS were performed under the signed contract agreement between Milliman and HFS dated December 23, 2016.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analyses contained herein.

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Thank you