State of Illinois
Department of Healthcare and Family Services
RFP 2018-24-001
CY 2018 Medicaid Capitation Rate Range Development

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Actuary

April 4, 2017
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

<table>
<thead>
<tr>
<th>MCO Experience Data</th>
<th>FFS Experience Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing managed care programs with CY 2015 experience data</td>
<td>New populations, expansion counties</td>
</tr>
<tr>
<td>FFS experience data excluded for counties / programs with CY 2015 MCO experience data</td>
<td>MLTSS (new in July 2016)</td>
</tr>
</tbody>
</table>

- 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
## Covered populations and services

### Covered populations

<table>
<thead>
<tr>
<th>Existing Population</th>
<th>New Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Health Plan (FHP)</td>
<td>Non-Disabled Children and Adults (NDCA)</td>
</tr>
<tr>
<td>New managed care population</td>
<td>Disabled Children (DC)</td>
</tr>
<tr>
<td>Integrated Care Program (ICP)</td>
<td>Disabled Adults (DA)</td>
</tr>
<tr>
<td>Affordable Care Act Adults (ACA)</td>
<td>Affordable Care Act Expansion Adults (ACA)</td>
</tr>
<tr>
<td>Managed Long-Term Services and Supports (MLTSS)</td>
<td>Managed Long-Term Services and Supports (MLTSS)</td>
</tr>
<tr>
<td>New managed care population</td>
<td>DCFS Youth (DCFS)</td>
</tr>
</tbody>
</table>
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**
- EUM data
- MCO survey
- Non-EUM data request
- Subcapitation template

**Base data and program adjustments**
- Aggregation of data sources
- Retrospective program adjustments
- Other data adjustments

**Prospective adjustments**
- 2016 & 2017 program adjustments
- Trend
- Managed care adjustments (low and high)

**Non benefit expense development**
- Administrative costs collected from MCO survey
- Adjustments for enrollment gains
- MCO procurement

**Capitation rate range**
- Does not reflect new services
- Range will be reviewed relative to CY 2016 experience
**Rate range methodology**

*Process overview: FFS experience*

<table>
<thead>
<tr>
<th>CY 2015 data collection</th>
<th>Base data and program adjustments</th>
<th>Prospective adjustments</th>
<th>Non benefit expense development</th>
<th>Capitation rate range</th>
</tr>
</thead>
</table>
| – 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

- **CY15 EUM quarterly summaries:** Regionally allocated via CY15 encounter data & MCO survey responses
- **CY15 non-EUM summaries:** Summarized from non-EUM data and CY15 MCO survey responses

Aggregate regionally allocated PMPM summaries

- Claims completion
- Policy and program adjustments
- Other base data adjustments (TPL, non-covered services)
- Acuity adjustments

**CY 2015 adjusted MCO experience**
Rate range methodology
Retrospective rating models: FFS experience

- CY 2015 FFS experience
- Claims completion
- Large claims smoothing
- Policy and program adjustments
- CY 2015 adjusted FFS experience
Rate range methodology
Prospective rating models

- CY 2015 adjusted experience
  - Trend adjustments to rating period midpoint
  - Policy and program adjustments
    - Managed care adjustments (low)
      - CY 2018 adjusted experience (low)
    - Managed care adjustments (high)
      - CY 2018 adjusted experience (high)
Rate range methodology
Non benefit expenses

CY 2018 adjusted experience

Administrative cost allowance

Care management allowance

Risk margin

CY 2018 MCO effective rate
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

<table>
<thead>
<tr>
<th>Adjustment Type</th>
<th>MCO Experience</th>
<th>FFS Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims completion</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Large claims smoothing</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Non-state plan services</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Pharmacy rebates</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>TPL &amp; fraud, waste, and abuse</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Acuity</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>ACA eligibility reassignment</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>FFS payments for MCO enrollees</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Policy and program changes</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Retrospective rating models
Policy and program changes

- **Dec 2015** Transportation fee schedule
- **Jan-Jun 2015** Outpatient dialysis reimbursement
- **May-Jun 2015** Public act 99-0002
- **Apr 2015** Government-owned nursing homes
- **Jul 2015** Government-owned hospital fee schedule*

* 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

- **Jul 2016**: Vaccines for Children (VFC) program
- **Jan 2017**: Methadone medication assistance
- **Oct 2016**: Hepatitis C coverage policy
- **Jul 2016**: Gov’t-owned hospital fee schedule and APR-DRG conversion
- **Jan 2017**: Average commercial rate (ACR)*

* 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 (ICF-DD) 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

<table>
<thead>
<tr>
<th>Region</th>
<th>MCO Base Experience</th>
<th>FFS Base Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Waiver</td>
<td>Low RB</td>
</tr>
<tr>
<td>Region 1 - Northwestern Illinois</td>
<td>76.6%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Region 2 - Central Illinois</td>
<td>74.9%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Region 3 - Southern Illinois</td>
<td>81.2%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Region 4 - Cook County</td>
<td>72.4%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Region 5 - Collar Counties</td>
<td>77.8%</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

#### MLTSS

<table>
<thead>
<tr>
<th>Region</th>
<th>MLTSS 21-64 FFS Base Experience</th>
<th>MLTSS 65+ FFS Base Experience</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% Waiver</td>
<td>Low RB</td>
</tr>
<tr>
<td>Region 1 - Northwestern Illinois</td>
<td>61.4%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Region 2 - Central Illinois</td>
<td>70.9%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Region 3 - Southern Illinois</td>
<td>73.5%</td>
<td>1.5%</td>
</tr>
<tr>
<td>Region 4 - Cook County</td>
<td>60.1%</td>
<td>2.0%</td>
</tr>
<tr>
<td>Region 5 - Collar Counties</td>
<td>56.3%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>

* 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.

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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.
Thank you