THE OKLAHOMA HEALTH CARE AUTHORITY

SOONERHEALTH+

DRAFT/MODELED CAPITATION RATE DEVELOPMENT & DATA BOOK

ACTUARIAL BIDDERS' CONFERENCE

FEBRUARY 1, 2017

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ABOUT THE OKLAHOMA HEALTH CARE AUTHORITY (OHCA)

The OHCA is the primary entity in the State of Oklahoma charged with controlling costs of state-purchased health care. The agency must balance this fiscal responsibility with two equally important goals:

1. Assuring that state-purchased health care meets acceptable standards of care.
2. Ensuring that citizens of Oklahoma who rely on state-purchased health care are served in a progressive and positive system.

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THE OHCA VISION

Our vision is for Oklahomans to be healthy and to have access to quality health care services regardless of their ability to pay.

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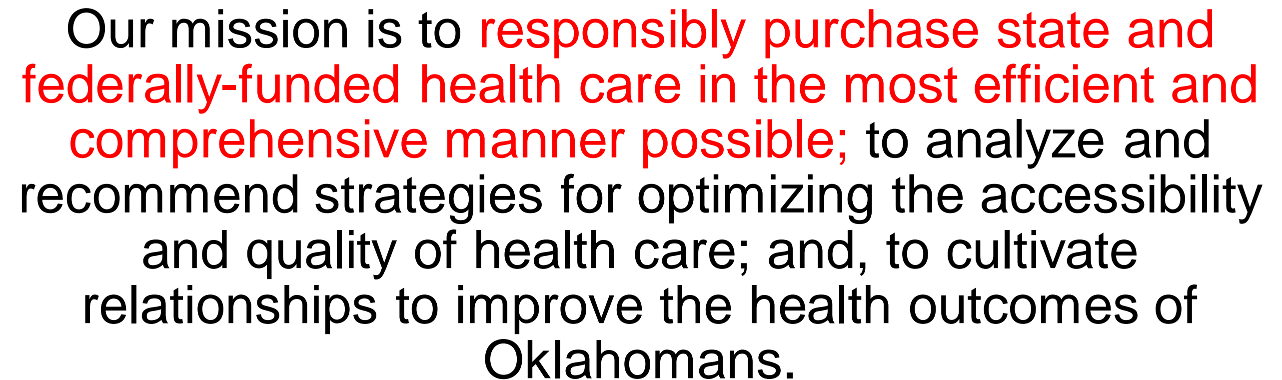
THE OHCA MISSION STATEMENT AND GOALS



Goal #1 – Financing and Reimbursement:
To responsibly purchase cost-effective health care for members by maintaining appropriate rates and to continue to strengthen health care infrastructure.

AND THE OHCA HAS DONE A SUPERB JOB!

Through various programs, initiatives and investments over multiple years, the OHCA has managed Aged, Blind and Disabled (ABD) claim costs and ABD claim cost trends extremely well.

	Annual $ Per Enrollee*	Annualized Trend	5 Year Annualized Trend
SFY 11	$13,387.42		
SFY 13	$13,866.56	1.8%	
SFY 15	$14,069.86	0.7%	
SFY 16	$13,818.38	-1.8%	0.6%

*Paid basis

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COSTS OHCA DOES NOT CURRENTLY HAVE - BUT WOULD UNDER FULL RISK MEDICAID MANAGED CARE

Non-Claim Rate Components	
MCO Administration (w/Care Coordination)	• 1st year for a population: x = 9.0%, 5.5%, 5.0%, 4.5%, 4.0% • 2nd year for a population: x–0.25% • 3rd year for a population: x–0.50% • No lower than 4.0% for any population
MCO Underwriting Gain	• 2.0%, 1.75%, 1.5%
Health Insurance Providers Fee (HIPF)	• Given all-around uncertainty, HIPF has not been estimated. If applicable, will be addressed at a later date.

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MCO ADMINISTRATION, UNDERWRITING GAIN, HIPF

"Statewide" Averages	Administration	UW Gain	HIPF
• Year 1	• 5.71%	• 2.0%	• 0%–?%
• Year 2	• 5.18%	• 1.8%	• 0%–?%
• Year 3	• 4.77%	• 1.7%	• 0%–?%

MCOs need to overcome these additional incurred costs to OHCA; otherwise, SoonerHealth+ does not work.

Fortunately, ***Labor Omnia Vincit***.

WHY ARE THE CAPITATION RATES DRAFT/MODELED AND NOT CERTIFIED?

CY 2015 base data is too “old” given Year 1, Year 2 and Year 3 population start dates of April 1, 2018, April 1, 2019 and April 1, 2020. Under the Medicaid Managed Care Final Rule, CMS targets utilization/consideration of base data only two years removed from the rate effective period.

Issues around exclusion/inclusion/reconfiguration of several “Supplemental Payments” (to be discussed later) need to be resolved.

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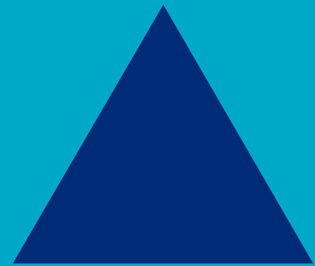
RATES TO BE REBASED/UPDATED BUT…

While the draft/modeled capitation rates will need to be rebased or updated prior to the Year 1, Year 2 and Year 3 rate effective dates, where OHCA paid claims are the Base Data, it is **highly unlikely** that key actuarial assumptions around Managed Care Adjustments, Nursing Facility/HCBS Rebalancing, MCO Administration and MCO Underwriting Gain will change materially, if at all.

- If you like them — Great!
- If you don't like them — Consider Not Passing Go and Not Collecting $200.

Absent State or federal mandated program changes, for this full-risk contract, **there will not be** off-cycle capitation rate increases.

SOONERHEALTH+
RATE DEVELOPMENT
OVERVIEW



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RATE DEVELOPMENT OVERVIEW
MANDATORY ENROLLMENT POPULATIONS

By Year 3 of the SoonerHealth+ program, the following mandatory enrollment populations, both duals and non-duals, will be eligible:

- Full benefit ABD members
- ABD members enrolled in one of the following HCBS waivers:
  - ADvantage
  - Medically Fragile
  - Community
  - In-Home Supports (Children and Adults)
- Children under the Tax Equity and Fiscal Responsibility Act (TEFRA)
- ABD Individuals with intellectual disabilities (non-HCBS waiver, State Plan only)
- ABD Custody children
- ABD members residing in institutions, including:
  - Nursing facility
  - Intermediate care facility for individuals with intellectual disabilities (ICF-ID)

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RATE DEVELOPMENT OVERVIEW
VOLUNTARY AND EXCLUDED POPULATIONS

Native American ABD members, who otherwise meet program eligibility criteria, will have the option to enroll in the SoonerHealth+ program during the annual open enrollment period, and may disenroll in any subsequent open enrollment period.

The following populations are *excluded* from the SoonerHealth+ program:

- Non-ABD members, except for TEFRA children
- ABD members enrolled in one of the following HCBS waivers:
  - Homeward Bound
  - Living Choice/Money Follows the Person
- Members enrolled in a Behavioral Health Home
- Members enrolled in the Program of All-Inclusive Care for the Elderly
- Duals with limited Medicaid benefits (for example, QDWI and SLMB)

RATE DEVELOPMENT OVERVIEW
MANDATORY ENROLLMENT PHASE-IN

Eligible populations will be phased in based on the following schedule

- **Year 1: April 1, 2018 to March 31, 2019**
  - Full benefit ABD members
  - ABD members enrolled in the ADvantage or Medically Fragile HCBS waivers
  - TEFRA children
  - ABD individuals with intellectual disabilities (non-HCBS waiver, State Plan only)
- **Year 2: April 1, 2019 to March 31, 2020**
  - ABD members enrolled in the Community or In-Home Supports HCBS waivers
- **Year 3: April 1, 2020 to March 31, 2021**
  - ABD Custody children
  - ABD members residing in institutions

RATE DEVELOPMENT OVERVIEW
RATING REGIONS

West Region

East Region

Cimarron
Texas
Beaver
Harper
Woods
Alfalfa
Grant
Kay
Osage
Washington
Nowata
Craig
Ottawa
Woodward
Major
Garfield
Noble
Pawnee
Rogers
Mayes
Delaware
Ellis
Dewey
Blaine
Kingfisher
Logan
Payne
Creek
Tulsa
Wagoner
Cherokee
Adair
Roger Mills
Custer
Canadian
Oklahoma
Lincoln
Okmulgee
Muskogee
Okfuskee
McIntosh
Sequoyah
Beckham
Washita
Caddo
Cleveland
Pottawatomie
Seminole
Haskell
Greer
Kiowa
Grady
McClain
Hughes
Pittsburg
Latimer
LeFlore
Harmon
Jackson
Comanche
Garvin
Pontotoc
Coal
Stephens
Murray
Tillman
Cotton
Johnston
Atoka
Pushmataha
Carter
Jefferson
Marshall
Love
Bryan
Choctaw
McCurtain

RATE DEVELOPMENT OVERVIEW
RATE CELLS

SoonerHealth+ capitation rates are set based on the following population groups. Unless otherwise noted, a separate rate will be paid for the East and West regions.

- Year 1:
  - ABD <21 Non-Dual
  - ABD 21+ Non-Dual
  - ABD Dual
  - ADvantage Waiver, Non-Dual
  - ADvantage Waiver, Dual
  - Medically Fragile Waiver, Non-Dual (Statewide rate)
  - Medically Fragile Waiver, Dual (Statewide)
  - TEFRA (Statewide)
  - I/ID State Plan Only (Statewide)
- Year 2 (in addition to Year 1 rate cells):
  - Community, Non-Dual
  - Community, Dual
  - In-Home Supports, Non-Dual
  - In-Home Supports, Dual

RATE DEVELOPMENT OVERVIEW
RATE CELLS

In Year 3, SoonerHealth+ capitation rates will be set based on the following groupings:

- ABD <21 Non-Dual
- ABD 21+ Non-Dual
- ABD Dual
- TEFRA (Statewide)
- I/ID State Plan Only (Statewide)
- Custody Kids (Statewide)
- Nursing Facility Level of Care (NFLOC), which includes the following populations:
  - Institutional ABD members
  - ADvantage Waiver
  - Medically Fragile Waiver
  - Community Waiver
  - In-Home Supports Waiver

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RATE DEVELOPMENT OVERVIEW
COVERED BENEFITS INCLUDES/EXCLUDES

SoonerHealth+ will include most services currently covered under SoonerCare.

Draft/modeled capitation rates reflect the following:

- OU/OSU state-employed physician supplemental payments
- Nursing Home Quality of Care (QOC) supplemental payments

The following services were *excluded* from the capitation rates:

- Non-emergent medical transportation (non-HCBS waiver)
- Services furnished at Indian Health Services/Tribal/Urban Indian Clinic Settings

Draft/modeled capitation rates do *not* reflect the following supplemental payments:

- Supplemental Hospital Offset Payment Program (SHOPP)
- OU inpatient and outpatient facilities
- Enhanced Tier Payment System (ETPS)
- Nursing Home Non-State Government Owned (NHNSGO)

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RATE DEVELOPMENT OVERVIEW
BASE DATA SOURCES

As part of developing SoonerHealth+ draft/modeled capitation rates, the following base data sources were used and/or reviewed:

- OHCA Medicaid Management Information Systems (MMIS) eligibility and claims data:
  - Claims runout includes claims submitted through August 2016
  - Draft/modeled capitation rates used a base time period of CY 2015
  - The SoonerHealth+ Data Book includes claims with dates of service between January 1, 2013 through December 31, 2015
- OHCA Data and Statistics (http://www.okhca.org/research.aspx?id=87)
  - OHCA Annual Reports
  - Fast Facts
  - Studies and evaluations

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RATE DEVELOPMENT OVERVIEW
RETROACTIVE ELIGIBILITY

Managed care organizations (MCOs) will not be responsible for claims incurred prior to a member's enrollment

This includes the following situations:

- A member is eligible for Medicaid, but will not enroll with an MCO until a subsequent month
- A member is eligible for Medicaid, but is waiting to be deemed ABD

To account for this lag, a retroactive eligibility adjustment was made to the base data. The following retroactive periods were removed from the base data, which includes removal of eligibility and claims experience:

- Aged and Blind: 90 days
- Disabled: 180 days

The overall impact of removing the initial 90- or 180-day period from a member's experience *reduced* the overall base period PMPM by 0.8%

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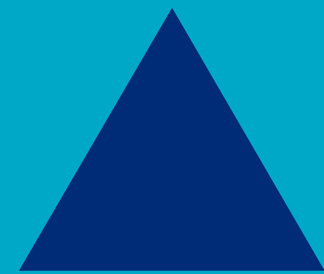
SOONERHEALTH+ RATE DEVELOPMENT
METHODOLOGY



RATE DEVELOPMENT METHODOLOGY
BASE DATA ADJUSTMENTS — DATA BOOK

The following adjustments were made to the data shown in the SoonerHealth+ Data Book, released on January 18, 2017:

- *Unknown County* — Some members did not have a specific county displayed in the eligibility data
  - Since the enrollment county was unknown, enrollment and dollars were evenly allocated to each region
- *ICF-MR Claims* — As part of the validation process, SFY 2015 ICF-MR claims for all populations were materially less than dollars displayed in the SFY 2015 OHCA Annual Report
  - ICF-MR claims were increased by $20.6M in the base data
- *Capitated payments* — Capitated payments made by OHCA for care coordination were not included in the claims data
  - CY 2015 Physician/Professional claims for non-dual, Year 1 populations were increased by $7.4M
- *Retroactive Eligibility* — Removes claims and enrollment from the first 90 days for aged or blind members and the first 180 days for disabled members

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BASE DATA ADJUSTMENTS — POST DATA BOOK

The following adjustments were made to the capitation rates; however, they were not applied in the SoonerHealth+ Data Book:

- *Incurred, But Not Paid claims (IBNP)* — Base claims data were adjusted to account for claims incurred during the base period, but have not been paid by the end of August 2016, increasing the overall base by 0.1%
- *Data Smoothing* — To account for particular variability of small cell sizes, data smoothing adjustments were applied to the Medically Fragile Non-Duals and I/ID State Plan Only Duals, increasing the overall base by $750K
- *Voluntary Take-Up* — Native Americans are eligible, but are not required to enroll in SoonerHealth+. For dollars & member months, Mercer applied the following factors:
  - Non-Waiver, Non-Institutional = 33.33%
  - HCBS Waiver and Institutional = 20.0%
- *Mental Health Parity* — Based on OHCA's review, no adjustment was necessary to account for the Mental Health Parity and Addiction Equity Act

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PROSPECTIVE ADJUSTMENTS – PROGRAM CHANGES

Program and fee schedule changes *during* the CY 2015 base data period were assumed to be budget neutral or incorporated within claim cost trend (with the exception of the July 1, 2015 Medicare crossover claims change)

Program changes that occurred *after* the base data period were considered as part of the rate development

- Many prospective program changes were deemed budget neutral and did not impact the rates

The following program changes impacted the SoonerHealth+ capitation rates, *reducing* the rates in aggregate by 1.1%:

- Eyeglass materials decrease
- Long-term care facility QOC fee increase
- Across-the-board 3% fee decrease (many exclusions)
- Medicare crossover claims decreases

- The Revised Statewide Transition Plan (SWTP) for HCBS change has not been incorporated in the SoonerHealth+ capitation rates

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RATE DEVELOPMENT METHODOLOGY
PROSPECTIVE ADJUSTMENTS — TREND

Trend projects the change in medical expense from the base period to the rate effective year(s), which includes change in utilization, unit cost, mix of services, etc.

Data/information used to develop trend factors included, but was not limited to

- OHCA MMIS eligibility and claims data, as well as SoonerCare reports
- Department of Labor Consumer Price Index (regional and national)
- Federal and industry reports and projections, such as the National Health Expenditures and the annual Actuarial Report for Medicaid

The projection period is the midpoint of the base period (July 1, 2015) to the midpoint of the rate year

- Year 1: October 1, 2018 (39 months projection period)
- Year 2: October 1, 2019 (51 months)
- Year 3: October 1, 2020 (63 months)

The overall annualized PMPM trend adjustment for Year 1 is 4.1% and reduces to 3.5% in Year 3 with the introduction of additional NFLOC populations

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RATE DEVELOPMENT METHODOLOGY
PROSPECTIVE ADJUSTMENTS — TREND

- The following table displays average *annual* utilization, unit cost and PMPM trend factors by service category:

Service Category	Utilization per 1,000	Unit Cost	PMPM
Inpatient Hospital	-2.0%	4.4%	2.4%
Outpatient Hospital — Non-ER	0.5%	3.5%	4.0%
Outpatient Hospital — ER	1.0%	3.7%	4.8%
Behavioral Health	0.5%	2.5%	3.0%
Physician/Professional and Clinics (w/ FQHC/RHC)	0.3%	3.5%	3.8%
Physical/Occupational Therapy	0.3%	2.3%	2.5%
Pharmacy	1.0%	7.0%	8.1%
Laboratory/Radiology/Pathology	0.2%	3.0%	3.3%
Nursing Facility and ICF/MR	0.0%	2.5%	2.5%
HCBS/Home Health/Hospice	0.0%	2.5%	2.5%
DME and Supplies	0.3%	1.0%	1.3%
Dental	0.5%	2.8%	3.3%
All Other	0.3%	3.0%	3.3%

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RATE DEVELOPMENT METHODOLOGY
MANAGED CARE ASSUMPTIONS

Projected medical expenses were adjusted to account for care management under a full-risk Medicaid managed care model.

- Certain services were adjusted to account for anticipated changes in utilization patterns and unit cost levels under full-risk managed care.
- For example, inpatient and emergency room utilization is expected to decrease materially for lower acuity cases. However, because this will increase remaining inpatient and emergency case-mix levels, an increase in average unit cost was assumed.

Managed care assumptions for the pharmacy service category include the impact of pharmacy MCO supplemental rebates, resulting in a 3.0% downward adjustment to pharmacy unit cost

In Year 3, the managed care assumption for the NFLOC rate cell was an adjustment to the blend of HCBS waiver and institutional projected enrollment.

- HCBS waivers make up 58% of the member months in CY 2015
- The Year 3 blend was rebalanced so HCBS waivers made up 63% of the member months, resulting in an effective 2.9% reduction to the NFLOC rate

The overall impact of managed care assumptions for Year 1 is -8.9%, and reduces in magnitude to -5.9% in Year 3 (exclusive of the NFLOC blend change).

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RATE DEVELOPMENT METHODOLOGY
MANAGED CARE ASSUMPTIONS — EXAMPLE

- The following displays the varying Year 1 impact of managed care on two populations:

Service Category	ABD 21+ Non-Dual (East Region) Utilization Per 1,000	ABD 21+ Non-Dual (East Region) Unit Cost	ABD 21+ Non-Dual (East Region) PMPM	Advantage 21+ Dual (East Region) Utilization Per 1,000	Advantage 21+ Dual (East Region) Unit Cost	Advantage 21+ Dual (East Region) PMPM
Inpatient Hospital	-45.0%	7.5%	-40.9%	-5.0%	1.0%	-4.1%
Outpatient Hospital - Non-ER	-22.5%	7.5%	-16.7%	-2.5%	0.0%	-2.5%
Outpatient Hospital - ER	-45.0%	7.5%	-40.9%	-5.0%	1.0%	-4.1%
Behavioral Health	-20.0%	5.0%	-16.0%	-2.0%	0.0%	-2.0%
Physician/Professional	15.0%	-10.0%	3.5%	1.0%	0.0%	1.0%
Clinics (w/FQHC/RHC)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical/Occupational Therapy	-5.0%	1.0%	-4.1%	-1.0%	0.0%	-1.0%
Pharmacy	5.0%	-5.5%	-0.8%	0.5%	-3.3%	-2.8%
Laboratory/Radiology/Pathology	2.5%	-1.0%	1.5%	0.0%	0.0%	0.0%
Nursing Facility	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
ICF/MR Services	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
HCBS/Home Health/Hospice	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
DME and Supplies	-15.0%	5.0%	-10.8%	-1.0%	0.0%	-1.0%
Dental	25.0%	-15.0%	6.3%	2.0%	0.0%	2.0%
All Other	-10.0%	2.0%	-8.2%	-2.0%	0.0%	-2.0%
Total Medical Claims			**-12.6%**			**-0.9%**

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RATE DEVELOPMENT METHODOLOGY
NON-MEDICAL LOAD

Administrative Expense	• Includes administrative expenses and care coordination • Determined as a percentage of pre-tax premium, ranging from 4.0% to 9.0% • Reduces by 0.25% in Years 2 and 3 after the population's eligibility date • The lowest administrative expense percentage in any year is 4.0%
Underwriting Gain	• Includes cost of capital and risk • Determined as a percentage of pre-tax premium, set at 2.0% in Year 1 • Reduces by 0.25% in Years 2 and 3 after the population's eligibility date
Premium Tax	• Determined as 2.25% of the total rate (all years)
Health Insurance Providers Fee	• Not included in the rates at this time

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RATE DEVELOPMENT METHODOLOGY
INCENTIVES, WITHHOLDS AND RISK MITIGATION

Performance Incentives and Withholds

- No capitation rate performance incentive opportunities, nor withholds, are applied
- Penalties are described in the contract, and are handled outside the capitation rate development process

Risk Mitigation

- No State-sponsored risk mitigation provisions are provided in the contract, such as reinsurance, risk pools or other risk sharing
- Risk adjustment between MCOs is not included in the contract

RATE DEVELOPMENT METHODOLOGY
MISCELLANEOUS TOPICS

- *Enrollment Projections* — Member months are projected to increase 4.5% annually for TEFRA children and 0.5% annually for all remaining SoonerHealth+ populations
- *Medical Loss Ratio (MLR)* — With an average priced-for MLR of over 92% in Year 1 and approximately 93.5% in Year 3, the 85% minimum MLR in Section 2.21.2 of the SoonerHealth+ RFP affords considerable financial opportunity

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RATE DEVELOPMENT METHODOLOGY
DATA BOOK

The SoonerHealth+ Data Book provides three calendar years of historical eligibility and claims experience, including the base period used to develop draft/modeled rates

Data are provided in a flat file format for easier analysis

The following adjustments are applied to the data:

- Unknown county
- ICF-MR claims
- Capitated payments
- Retroactive eligibility

Voluntary populations' experience separated from mandatory populations

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NEXT STEPS – RE: CAPITATION RATES AND DATA BOOK

DEADLINE FOR WRITTEN QUESTIONS IS FEBRUARY 10, 2017

RESPONSES TO QUESTIONS ISSUED FEBRUARY 17, 2017

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QUESTIONS?

MAKE
TOMORROW,
TODAY