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RATE-SETTING OVERVIEW

Government Human Services Consulting

Minneapolis

MARSH & McLENNAN COMPANIES

Agenda

- Today's Goals
- Timelines
- Process
- Data Sources
- Supplemental Services
- Reinvestment
- Alternative Payment Arrangements (APAs)
- Rate Issues
- Trend & Managed Care Assumptions
- Administrative Load Development
- Program Changes
- Questions

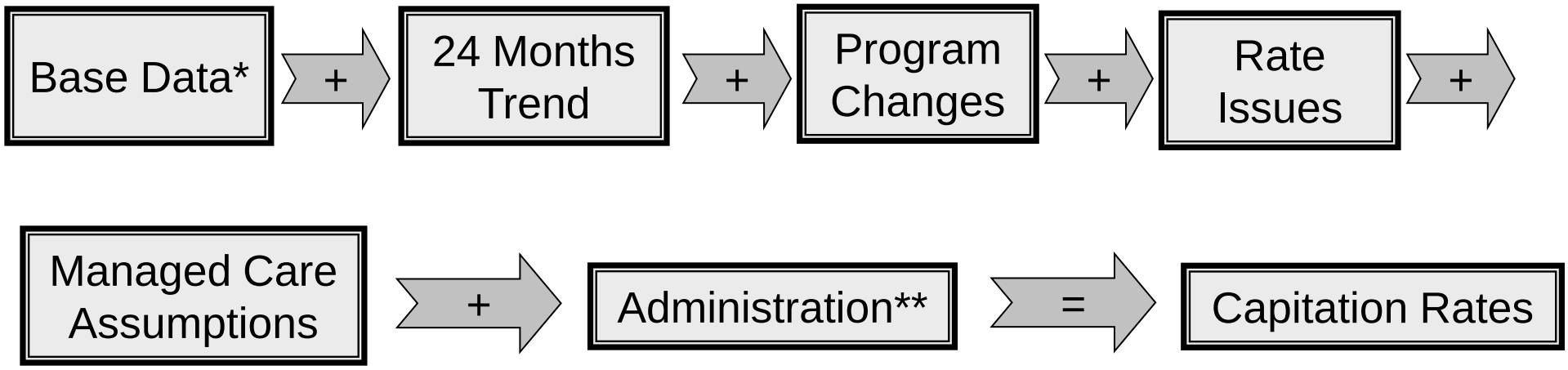
Rate-setting Overview
Today's Goals

- Provide overview of rate-setting process and timelines
- Highlight areas of rate-setting process assisted by Field Office information and input
- Discuss roles of Field Office staff and rate setting staff in rate-setting process
- Answer questions on rate-setting processes and rate issues

Rate-setting Overview
Timelines

- Process takes approximately 6-7 months
- High-level timelines for Southeast and Southwest Zones
  - May/June: Rate Issues Review/Discussions/Follow-ups
  - June/July: Program Change Discussions
  - June/July: Rate Development Process
  - July/August: Rate Approval Process
  - August/September: Rate Packages to Counties and Negotiations
  - October/November: CMS Certification

Rate-setting Overview
High-level Process



* The completeness of this data source will be reviewed and completion factors may be applied.

** Administration includes consideration for any assessments/taxes, as well as funding for JPT in applicable counties.

Rate-setting Overview
Data Sources

- Person-Level Encounter (PLE) Data
  - Primary/Preferred data source for rate setting
  - 2 year lag from base period to contract period; 2 years of experience is collected from the BH-MCOs (i.e. SFY 2009-2010 and SFY 2010-2011 data used for developing SFY 2012-2013 rates)
  - Support detailed analysis/ad hoc projects
- BH-MCO Reported Financial Data
  - Secondary data source for rate setting; provides very preliminary look at financial experience in the current contract year
  - Types of reports reviewed for rate setting
    - Report 7: Lag summary showing costs for each service by the month the service was provided and the month for which it was paid
    - Report 9: Revenue and Expense report for each county
    - Report 12: Actual reinvestment expenditures

Rate-setting Overview
Supplemental Services — HealthChoices BH Service Categories

- State Plan Services
- Non-Hospital D&A Services
- Reinvestment Services
- Supplemental “Other” Services
  - Not offered in FFS or mandated for HC
  - Included in PLE (if not Reinvestment)
  - Cost-effective (In-Lieu of In-Plan Services) are included in rates (e.g. Psychiatric Rehabilitation, ACT)
  - Services that are still being assessed by counties regarding cost-effectiveness or have been determined to not be cost-effective are not included in rates (In-Addition to In-Plan Services)

Rate-setting Overview
Supplemental Services — CMS Regulations for Rate Setting

- All payments must be actuarially sound
- FFP available only for State Plan Services and Non-State Plan Services approved under 1915(b)(3) waiver
- Non-State Plan Services
  - CMS recognizes potential dilemma for states and asks that they propose their methodology incorporating In-Lieu of Services for CMS approval
  - Entities (BH-MCOs) can continue to provide additional services out of savings, but adjustments must be made in rate-setting to ensure that additional services not previously eligible for FFP are not included

Rate-setting Overview
Supplemental Services — What is Included/Excluded in Rate Setting

- Cost-effective Alternative Services are included in the base data for rate-setting
- Counties perform cost-benefit analysis for Other/Supplemental Services
  - Part of enrollment application or reinvestment plan
  - Provides supporting information regarding cost value or cost offset compared to currently existing services
- Mercer and OMHSAS role
  - Review county analysis, external studies and historical data, if any, to verify cost-effectiveness
  - Discuss services with program and clinical staff
  - Service needs to be approved by time rate issues are considered
- Services determined to be additional or not cost-effective are not included in the base data

Rate-setting Overview
Supplemental Services — How are the Services Included in Rate Setting

- Cost-effective Other/Supplemental Services costs in encounter data are reallocated to the State Plan Service they offset
- Time period for approved Other/Supplemental Services costs included in rate setting
  - Only historical costs from the base data period are considered
  - No adjustment is made for costs in a future contract period since it will offset costs already in the rate base period experience

Rate-setting Overview
Reinvestment — Generating and Using Funds

- Definition — Capitation revenues from DPW and investment income which are not expended during an Agreement year by the Primary Contractor for purchase of services for members, administrative costs, risk and contingency funds, and equity requirements but may be used in a subsequent Agreement year to purchase start-up costs for in-plan services, development or purchase of supplemental services or non-medical services, contingent upon DPW prior approval of the Primary Contractor's reinvestment plan
- How generated — Through efficient program operation and highly effective management of care at the individual and program levels
- How used — Financially assist in the development and delivery of new or expanded services or programs

Rate-setting Overview
Reinvestment — Types of Reinvestment Plans

- Supplemental Services – In-Lieu Of
- Supplemental Services – In-Addition To
- Non-Medical Services
- Start-up (In-plan and Supplemental Services)
- Bricks and Mortar

Rate-setting Overview
Reinvestment — Incorporation into Rate Process

- OMHSAS financial staff maintains approved reinvestment plan charts
  - Effective date
  - Program type and service offset, if any
  - Budget amount
- Some cost-effective Supplemental Services plans (Supplemental – In-Lieu Of) are considered in the rate development process
- Financial reporting — Report #12
  - Outlines funds actually spent
  - Detail at the rating group level for each reinvestment plan
- Costs are allocated to the State Plan Service which was offset by the Reinvestment Service
  - Costs are added to both the encounter and financial data

Rate-setting Overview
Reinvestment — Example of Timing for Rate Adjustment

	Year 1	Year 2
Base Data (PLE)		
Partial Hospital	$ 100,000	$ -
PRS	$ -	$ -
All Other Services	$ 900,000	$ 900,000
Reinvestment		
Start Up	$ 50,000	$ -
Service Costs (for MA eligibles)	$ -	$ 100,000
Total Base Data	$ 1,000,000	$ 1,000,000

	Year 3	Year 4	Year 5
Base Data (PLE)			
Partial Hospital	$ -	$ -	$ -
PRS	$ 100,000	$ 100,000	$ 100,000
All Other Services	$ 900,000	$ 900,000	$ 900,000
Reinvestment			
Start Up	$ -	$ -	$ -
Service Costs (for MA eligibles)	$ -	$ -	$ -
Total Base Data	$ 1,000,000	$ 1,000,000	$ 1,000,000

Rate-setting Overview
APAs — Incorporation into Rate Development

- Alternative Payment Arrangement (APA) Types
  - Case Rate – Professional
  - Case Rate – Institutional
  - Per Diem – Institutional
  - Per Diem – Professional
  - Subcapitation
  - Retainer Payment to Providers
- Approved APAs are incorporated into base data in rate development

Rate-setting Overview
APAs — Incorporation into Rate Development

- APA data should be submitted with current rate setting submission of PLE data
  - Claims data allows OMHSAS and Mercer to review PLE data in comparison to approved APAs
  - Claims payment amounts that cannot be reported at the encounter level are submitted via a separate monthly file from the BH-MCO to DPW
  - APA Annual Update form contains summary statistics showing total cost and utilization along with cost-effectiveness certification
- Counties/Contractors must annually certify the payment arrangement as cost effective
- OMHSAS/Mercer are in the process of reviewing APAs for cost effectiveness

Rate-setting Overview
APAs — AOP Cost-Effectiveness

- Components of Adult Outpatient Services in Alternative Settings (AOP) Adjustment
  - AOP APAs collected and previously reviewed by Field Offices
  - Service utilization data reported in the Quarterly Reports
    - Collected from each provider for each county they are serving
      - Providers serving multiple counties (Irene Stacy) submit multiple reports
    - Reports identify individuals served in AOP during a quarter
      - Document number of days in AOP
      - Document units of service received in the quarter
      - Include unit cost information incorporated by county/MCO
  - Encounters and payments reported in the PLE data (PT/PS: 11/110 and procedure code H0037)
  - Counties with AOP: Allegheny, Armstrong/Indiana, Beaver, Butler, Greene, Lawrence, Chester, Philadelphia, Crawford/Mercer/Venango

Rate-setting Overview
APAs — AOP Cost-Effectiveness

- Validate APA per diem in PLE using the average service utilization per diem in the quarterly reports.
  - The unit costs included in the reports are compared to HealthChoices average unit cost for discrete services to ensure reasonable
  - If the APA per diem exceeds the average service utilization per diem, an adjustment is calculated to remove costs from the base data.
  - If APA per diem is lower, no additional adjustment except normal trend is necessary
- Recent Counties who received downward adjustment
  - Philadelphia – quarterly reports documented much lower utilization of services than other AOP providers.
  - Allegheny – AOP per diems are highest in HealthChoices, yet the service utilization is below average. County included very high unit costs for service ($46 for 15-minute of group psychotherapy) in their AOP report. Documented service utilization will need to increase to support the high AOP per diems.

Rate-setting Overview
Rate Issues — Use in Rate Development

- Rate issues collection and discussion is one of the most important components of the rate development process
  - Opportunity for OMHSAS rate setting staff and Mercer to get information on new programs, access needs in the counties, and initiatives to manage costs better
  - Rate issues have become an important discussion topic in rate presentations with the Deputy Secretary and Secretary to explain rate changes, since some rate changes are significant because of approved rate issues
- Information from Field Office staff is vital to the use of rate issues in rate development
  - OMHSAS rate setting staff and Mercer need to know whether the program or initiative is being supported by the Department and whether expansion addresses an existing service access waiver
  - Field Office staff provide valuable insight regarding the program readiness, capacity, and expected utilization

Rate-setting Overview
Rate Issues — Use in Rate Development

- Field office staff will perform an initial review of the rate issue letters from counties before they are sent to OMHSAS rate setting staff/Mercer
  - Ensures all appropriate information is included with rate issues including:
    - Anticipated dollar Impact
    - Populations impacted
    - Anticipated start date of each rate issue
    - Any start-up costs associated with each rate issue
  - Issues that are not necessary to include in the letter (issues with no anticipated impact, provider rate increases) can be removed from the draft
  - A more concise draft will reduce follow-ups with counties during rate development and meetings with field office staff, rate setting staff, and Mercer may be shorter

Rate-setting Overview
Rate Issues — Use in Rate Development

- Remaining issues forwarded by Field Office Staff are reviewed by Mercer
  - Mercer reviews the impact of the rate issues on overall rates
- Discussion with Field Office and rate setting staff provides insight into particular rate issues to be included for rate setting based on:
  - Expectations of utilization, cost and offsets associated program expansion
  - Feasibility of implementation by target start date
  - Prioritization of rate issues based on budgetary or other limitations
- Mercer includes any costs associated with acceptable rate issues based on guidance and feedback from Field Office Staff
- Current and emerging rate issues should be monitored throughout the year by Field Office Staff
  - Tracking of new emerging issues will improve the rate issues process for the following year and will provide an indicator for upcoming issues

Rate-setting Overview
Trend Development

- Necessary to estimate the expense of providing healthcare services in future period, i.e. project costs from base period to contract period
- Reviewed for each county/MCE by category of service (COS)
- Statistics reviewed in the PLE data; County Financial/Program Monitoring reports contain many of these statistics
  - PMPM
  - Average cost per user
  - Unit cost
  - Utilization per 1,000
- Input from field office staff provides insight on reasons for emerging trends (i.e. new initiatives, access issues, provider issues, population changes)
- Trend factors are not shared with counties

Rate-setting Overview
Trend Development

- General Questions/Issues
  - What percent is included for unit cost trend?
  - How is emerging financial experience factored into trend development?
  - Are rate issues included in the trend?
- Ongoing Monitoring
  - Identify drivers (new users, high cost populations, etc.) of significant increases or decreases from one year to another
  - Discuss what the counties are doing to manage these increases or impact of decreases
  - Track issues raised during quarterly meetings with counties and discuss with rate setting and financial staff

Rate-setting Overview
Managed Care Assumptions

- Target rates reflect expected costs of a moderately efficient BH-MCO using enhanced care management practices
- Comparison of utilization and cost metrics across counties, zones and population type
- Considerations
  - SMI readmission rates
  - Overlap of services, such as RTF, Family-Based and BHRS
  - Penetration, Cost/User, Unit Cost, PMPMs across services
- The final adjustment factors, reasons and category of service impacted are identified on the PCCs
- Input from the field office staff on care management initiatives

Rate-setting Overview
Programmatic Changes

- Why do we apply programmatic changes?
- Program Changes considered
  - State Hospital Bed Closures (Allentown, Norristown)
  - Act 62
  - Expedited D&A Enrollment

Rate-setting Overview
Programmatic Changes — State Hospital and Bed Closures

- Program change reflects the additional costs that will be incurred in HealthChoices when individuals live and receive services in the community as opposed to a State Hospital
- Adjustments have been made for the closure of Harrisburg State Hospital, Mayview State Hospital, as well as the ongoing closures of the Allentown State Hospital and bed closures at Norristown State Hospital
- Adjustment reflects impact of discharge and diversionary costs
  - Discharge costs are the additional HealthChoices costs once the recipients currently in the State Hospital are discharged into community settings
  - Diversionary costs are the additional HealthChoices costs that will be incurred as a result of not having access to the closed bed (e.g. additional costs for ACT to prevent hospital admission)
- Historical discharge and pre-admission costs are reviewed to develop the assumptions for monthly costs per bed

Rate-setting Overview
Programmatic Changes — Act 62

- Act 62 became effective on July 1, 2009
- Due to primary insurer participation, HealthChoices costs are expected to be reduced for individuals considered to be Act 62 eligible
- Program change adjustment is applied based on additional anticipated cost avoidance
  - Analysis of standard benefit plans and Act 62 eligible kids provides an estimate of total anticipated cost avoidance
  - Observed cost avoidance levels are significantly lower than original expectations due to lower than anticipated Act 62 eligibles; BH-MCOs also cite provider struggles with interpretation of Act 62 procedures.

Rate-setting Overview
Administrative Load Development — Primary Data Sources

- Emerging Financial Experience
  - Review administration expenses from previous and current years compared to administration load to assess sufficiency
- Discussions with Commonwealth
  - Due to budget constraints and admin profits, recent discussions have focused on admin experience for each contract
  - Administration discussions with counties
  - New initiatives or costs that need to be factored into administrative loads
  - Possible changes to administration structures

Rate-setting Overview
Administrative Load Development — Secondary Data Sources

- Mercer Administration Model
  - Was used as a primary data source for implementation in Expansion Zones, but would also be used for any significant changes in contracts (i.e. decision by counties to combine into a multi-county entity)
  - Estimates administration requirements for moderately efficient managed care organizations based on estimates of staffing, salaries, and overhead by region
- County Contracts
  - Includes consideration for reasonable oversight and administrative structures approved by the Commonwealth
  - Provides insight into where the medical risk and administration functions reside (County, MCO or Other Risk-Bearing Entity)
- CMS Guidelines
- Experience in Other Zones

Rate-setting Overview
Administrative Load Development — JPT

- Joint Planning Team (JPT) expenditures
  - Mercer reviews JPT expenditures in financial reports, which varies depending on whether the program is funded out of reinvestment or capitation funds
  - Expenditures may be incorporated into capitation admin if program is considered cost-effective within county/MCE
- Current counties with JPT programs: Allegheny, Bucks, Chester, Delaware, Erie, Fayette, Lehigh, Montgomery, Northumberland

Rate-setting Overview
Administrative Load Development — JPT

- Cost Effectiveness determination
  - Mercer reviews the quarterly reports for county expenditures and analyzes claims for JPT participants before and during JPT
  - The program is considered cost-effective if the total medical and JPT costs are lower during JPT than prior to JPT
  - If program is not cost-effective expenditures may be included in capitation admin on a pro-rated basis
  - Mercer and OMHSAS continue to review the impact of JPT on medical expenses as JPT programs mature

Rate-setting Overview
Administrative Load Development — Development of Administration Percentages

- Preliminary Administration Percentages
  - By using the various data sources, Mercer calculates a PMPM administration cost for each contract
  - Near completion of the rate range development, the administration PMPM is compared to the targeted medical rate to calculate the percentage load appropriate to include the administration PMPM
  - Example: $10.00 administration PMPM; $90.00 medical PMPM = 10.0% administration load percentage
- Final Administration Percentages
  - Allowance for JPT expenditures may be added to the initial administrative load percentage
  - Based on final review of financial experience and approved rate placement of offer rates, administration percentage may be modified by the Commonwealth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