Minnesota Department of Human Services (DHS)

Financial Review Checklist for

At-Risk Capitated Contracts Rate Setting

**Minnesota Senior Care Plus** and

**Minnesota Senior Health Options**

Contract Period: January 1, 2015 - December 31, 2015

December 30, 2014

**List of Attachments**

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| Attachment A | Actuarial memo: “Rate Development of CY 2015 Basic Care, EW, and NF Add-on for MSHO and MSC+” November 10, 2014.  Filename: 2015\_MSHO\_MSC+\_Rate\_Memo\_2014-11-10.pdf |
| Attachment B | Actuarial Certification for Minnesota Senior Health Options / Minnesota Senior Care Plus, December 17, 2014.  Filename: MSHO-MSC+\_Act\_Cert\_2015\_Rates\_2014-12-17.pdf |
| Attachment C | Comparison of Monthly MSHO and MSC+ Expenditures Using 2015 Rates.  Filename: 2014-15\_Seniors\_Rates\_Compare\_2014-12-19.pdf |
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| **State:** | Minnesota |
| **Type of Program:** | Minnesota Senior Care Plus (MSC+): 1915(b) and 1915(c) waiver authority  Minnesota Senior Health Options (MSHO): 1915(a)/1915(c) waiver authority |
| **Type of Entity:** | MCO |
| **Type of Review:** | Renewal |
| **Contract Period:** | January 1, 2015 - December 31, 2015 |
| **Contractors:** | Blue Plus, HealthPartners, Itasca Medical Care, Medica Health Plans, PrimeWest Health, South Country Health Alliance, UCare Minnesota |

**Reviewer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Background:**

1. Minnesota Senior Care Plus (MSC+)

Most Minnesota Medicaid seniors age 65 and over, including dual eligible persons, are required to enroll in managed care. Minnesota converted enrollment in Minnesota’s Medicaid managed care program (known as the Prepaid Medical Assistance Program) to a 1915(b) waiver approved April 1, 2005 and implemented effective June 1, 2005. Enrollment is mandatory in all 87 counties. The State has contracted with seven MCOs to provide MSC+ in 2015.

2. Minnesota Senior Health Options (MSHO)

MSHO began in 1997 as a Medicare demonstration for dually eligible seniors age 65 and older. It was transitioned to Medicare Advantage Special Needs Plan (SNP) contracts in 2005 and 2006. MSHO operates under 1915(a) and (c) authority for Medicaid.

For 2015, MSHO continues to integrate Medicare and Medicaid service delivery and funding for dual eligible persons under a Memorandum of Understanding (MOU) with CMS titled “Federal-State Partnership to Align Administrative Functions for Improvements in Medicare-Medicaid Beneficiary Experience.” The MOU does not affect ratesetting. Under MSHO, the State contracts with eight MCOs to provide integrated Medicare and Medicaid services; all seven MCOs also participate in MSC+. All MCOs participating in MSHO have also been approved by CMS as Medicare Advantage Special Needs Plans (SNPs) for dual eligible persons, with an approved subset for seniors age 65 and over. CMS has entered into a separate SNP contract for Medicare services with each MSHO plan for the upcoming year. MSHO is operated as an integrated program in which Medicare and Medicaid enrollment, member materials and most other administrative features are integrated, and has provided a unique opportunity to offer a fully integrated Medicaid and Medicare program, including Part D and Long Term Care benefits, to most seniors enrolled in Medicaid in Minnesota.

Enrollment in MSHO is voluntary, so that enrollees can choose MSHO as an alternative to mandatory enrollment in MSC+. Most seniors required to enroll in MSC+ have chosen to enroll in MSHO. Enrollees who disenroll from MSHO are returned to the mandatory MSC+ program.

Total enrollment for seniors in all managed care options is currently 48,297 out of approximately 56,000 Medicaid-eligible seniors (December 2014).

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| AA.1.0. The contract must specify the payment rates and any risk-sharing mechanisms and the actuarial basis for computation of those rates and mechanisms. Includes: the rates and time period; the risk-sharing; the actuarial basis. Specify new or updated rates.  AA.1.0. CONTINUED The contract must specify the payment rates and any risk-sharing mechanisms and the actuarial basis for computation of those rates and mechanisms. Includes: the rates and time period; the risk-sharing; the actuarial basis. Specify new or updated rates.  AA.1.0. CONTINUED The contract must specify the payment rates and any risk-sharing mechanisms and the actuarial basis for computation of those rates and mechanisms. Includes: the rates and time period; the risk-sharing; the actuarial basis. Specify new or updated rates. | **Overview of Senior Products rate setting methodology (MSC+ and MSHO, or “Seniors” Contract)**  This checklist submission addresses only the Medicaid payments made under MSHO and MSC+. Medicaid contract requirements for MSC+ and MSHO are combined under one contract (“Seniors”) with each SNP/MCO. The rate methodology and rate base for Medicaid services are the same for MSHO and MSC+.  The rates for Seniors products consist of three main components, each of which is developed independently.  (1) Basic Care Component:  This component pays for the State Plan services included in MCO contracts, excluding nursing facility (NF) and Elderly Waiver services. The methodology for MSHO and MSC+ is the same. The basic care component is paid for both institutional and community members. Adjustments are made for institutional and non-institutional status, Medicare status, age and geographic region. For the upcoming year, new rates were developed for the basic care component as described in Attachment A, Section II.  (2) Elderly Waiver (EW) Add-On:  The EW Add-On methodology is the same for both MSC+ and MSHO. It is paid only for enrollees who have been enrolled in EW under 1915(c) waiver authority. The EW Add-On was updated for the upcoming year as described in Attachment A, Section III.  (3) Nursing Facility (NF) Add-On:  This component is a 180-day NF benefit for both MSC+ and MSHO. The methodology is the same for both products. The NF Add-On is paid only for non-institutionalized enrollees and is designed to cover risk for the expected utilization of NF services for these enrollees, who reside in the community upon enrollment. The NF Add-On continues to be paid while the enrollee remains in the community. An enrollee who remains in the community with intermittent nursing facility stays might never exhaust this benefit, while others who are institutionalized on a long term basis will exhaust the benefit within 180 days.  Once the 180-day benefit is exhausted, institutionalized enrollees remain enrolled in the MCO, but nursing facility costs are paid under the FFS program. The MCO receives the basic care payment component of the rate for enrollees who are in the nursing facility upon enrollment, but other NF costs for those enrollees are paid under FFS. The NF Add-On was updated for the upcoming year as described in Attachment A, Section IV.  Basic Care Rates  The State has developed new rates for the upcoming year contract period January 1, 2015 to December 31, 2015. The base utilization and cost data used to determine the rate levels is actual MCO experience for Medicaid-covered services for 2015. The methodology is included in Attachment A, Section II. The actuarial certification is found in Attachment B.  Attachment A, pages 5-7, outline the actuary’s methodology for basic care trend, benefit and surplus adjustments. For the upcoming year the actuary’s analysis incorporated MCOs’ medical cost and utilization experience as well as expected price changes in Medicare and Medicaid FFS used as a benchmark. The annual trends for the various benefits and subpopulations were applied to the 2013 actual PM/PM medical cost to calculate the projected 2015 annual PM/PM claim cost for the year. Two regions are needed to capture differences due to geographic area (see page 16 of Attachment A).  Elderly Waiver (EW) Add-On Rates  EW rates are paid under a separate rate cell covering only those community members who have been assessed to need a NF level of care but who may remain in the community with Elderly Waiver services.  The EW Add-On rates were developed using 2013 MCO experience for both EW and care coordination / case management (CC/CM) services. The EW rates are adjusted for subsequent benefit and trend changes. The rates include a risk adjustment component to allocate revenue for the EW population based on difference between activities of daily living (ADL), age, and metro/non-metro status (see Attachment A, section III on pages 18-22).  Nursing Facility (NF) Add-On Rates  The MSC+ and MSHO rates include a component covering a Medicaid NF 180-day benefit, which is applied only to non-institutional rate cells. Once the 180-day benefit is exhausted, enrollees remain enrolled but may access NF services through FFS payment.  The rates were based on recent managed care experience with adjustments to reflect changes in utilization and trend. This component is not MCO-specific: costs and utilization across all plans and FFS are used to develop standard factors that are applied to all MCOs with adjustments as noted in Attachment A, section IV, on pages 23-26. Costs were trended to CY 2015 using State forecast projections for utilization, benefit changes and charges. |
| AA.1.1 | **Actuarial certification**  Actuarial certification of the methods used and the final rates is found in Attachment B. |
| AA.1.2  The State must provide a projection of expenditures under the previous contract compared to those projected under the proposed contract. | **Projection of Costs**  Attachment C shows Milliman’s Projection of Costs for the Senior programs for the upcoming year. This projection compares the rates in effect in the last quarter of CY 2014 to the new rates effective January 1, 2015 using December 2014 enrollments. Total monthly expenditures using CY 2014 rates were $69,563,493. Projected monthly expenditures for 2015 will be $71,058,934 for an overall increase of 2.1%. |
| AA.1.3 All contracts must meet 45 CFR Part 74 regulatory requirements.  Two options:  1) State set rates are developed using federal regulations. These may be open cooperative or sole source.  2) Competitive bidding offered on a rate range and negotiated within the range. | **Procurement, Prior Approval and Rate Setting**  Option 1: State set rates.  Contracting was done on an open cooperative basis. Each MCO serves a different group of counties, with many overlapping service areas among them. The rate methodology was public information available to all MCOs. They had opportunity to review and respond to the methodology. Their comments were considered in making revisions to the final methodology. |
| AA.1.5  The MCO assumes risk and must accept the rates as payment in full. All payments are MA costs. | **Risk contracts**  MCOs bear full risk for their enrollees for the services covered by the contract. See section 4.8.1 of the Seniors Contract. All costs are for Medical Assistance Services covered under the State Plan. Additional expenditures that MCOs may have made for non-covered State Plan services are not included in rates. |
| AA.1.6  The State must ensure that no provider payment is made outside of the rates, except GME and other statutory exceptions. | **Limit on payment to other providers**  MCOs are responsible for all services covered by the contract. The monthly capitation is full payment for those services. Additional covered Medicaid services which are not part of the MCO’s contractual responsibility (for example, NF services beyond the first 180 days) may be paid by the State on a FFS basis. The State has Medicaid Management Information System (MMIS) edits in place to deny payment of FFS claims for a service covered under the contract. |
| AA.1.7 Modified rates include adjustments for program structure and medical trend. Trends are documented and justified. Previous changes must be backed out if applicable. Changes must be in a formal amendment. | **Rate Modifications**  See Attachment A, pages 4 through 14, for a discussion of all programmatic changes, factors and assumptions applied to rate development for the upcoming year. Rates are adjusted for enrollment, benefits, and trend changes since the previous rates. See Attachment A, pages 4-5 for a discussion of trends.  For any changes made during the contract year to eligibility, benefits or rates, the State will submit such amendments to the CMS Regional Office for approval. |
| AA.2.0  The State must assure that rates are based only on State Plan services (and directly related costs) and provided to eligible persons. Utilization and cost data must be derived from or adjusted to the Medicaid population. | **Base Year Utilization and Cost Data**  Basic Care Rates  The base year data used for developing basic care rates for senior products was CY 2013 actual experience for Medicaid covered services for the MSHO and MSC+ populations enrolled in managed care programs in Minnesota. As such, the underlying data are based only on services provided to eligible Medicaid individuals enrolled in managed care.  Non-covered services make up less than 1.25% of the total medical expenses for the MCOs, which was immaterial to the trend analysis. As noted above and on page 4 of Attachment A, these costs and administrative costs were excluded from the analysis. See AA.2.4 of this checklist for more discussion of non-covered services.  The State determines enrollees’ eligibility for managed care and issues the capitation payments. The State makes adjustments with the MCOs each month for persons no longer eligible, for example due to death, and reports them on the MCOs’ remittance advice. |
| AA.2.1  Rates must be appropriate to the populations covered under the contract (e.g., excluded populations have been removed from the base data, or adjustment was made). | **Medicaid Eligible Persons Under the Contract**  Managed care programs for seniors are currently operating in all of Minnesota’s 87 counties. Medical Assistance will continue to operate on a FFS basis in all counties for excluded populations and for covered services not included in the MCO contracts (e.g., certain NF services). Rates paid to MCOs for enrollees are based on data that reflect only the costs of the eligible populations and covered services. They do not include payments for populations or services that are exempt from managed care enrollment. The same basic care rates are paid for MSHO and MSC+ enrollees.  The population of seniors required to enroll in managed care is specifically defined in the MCO contract. All seniors who are required to enroll in managed care enroll in MSC+ or may choose MSHO as an alternative. New MSHO enrollments come primarily from the MSC+ population, and upon disenrollment from MSHO, recipients are generally re-enrolled into MSC+. Because MSC+ is the base population for MSHO, the MSC+ basic care capitation rates are appropriate for MSHO.  For similar reasons, the same base data are used in the development of the MSC+ and MSHO NF and EW Add-On rates. |
| AA.2.2  Rates must be adjusted for dual status. | **Dual Eligible Persons**  Dual Medicare/Medicaid eligible recipients are included as a mandatory group in Minnesota’s MSC+ program under the 1915(b) waiver authority. MSHO enrollment for these recipients is optional and provides another choice of product for them. However, those eligible for QMB and SLMB without also being eligible for full Medicaid are not eligible to enroll in managed care programs. Persons with only Part A or only Part B of Medicare are also not eligible to enroll.  The payments for full dual eligible enrollees reflect only the Medicaid costs of Medicaid services, and do not include any of the medical expenses paid by Medicare. The data used reflect only Medical Assistance costs. |
| AA.2.3  Rates must be adjusted for recipient liability.  AA.2.3 continued  Rates must be adjusted for recipient liability.  AA.2.3 continued  Rates must be adjusted for recipient liability. | **Spenddown**  Community Enrollees with Spenddowns  Community Medicaid recipients eligible for spenddown are one of the groups generally excluded from PMAP and MSC+, and the State’s expenditures for them are not part of the MCO cost experience.  In general MSC+ and MSHO do not enroll Medicaid clients with medical spenddowns who reside in the community. However, under MSHO, some continued enrollment is allowed for community-based enrollees who accrue monthly medical spenddowns after enrollment, when application of a spenddown would require a current enrollee to disenroll. This policy allows for continuity of access to Part D and long term care benefits for those members. Only clients who meet their entire medical spenddown amount on a monthly basis remain enrolled in MSHO. These clients are required to pay their entire medical spenddown to the State on a monthly basis and the spenddown collections made by DHS are used to reduce the overall Medicaid expenses for MSHO. The amount of federal financial participation (FFP) is reduced by the collection of the spenddown amounts.  Because clients with medical spenddowns are excluded from enrolling in MSC+ and because the basic care component of the MSHO rate was derived from recent MSC+ experience, spenddown payments are not included in the data used to calculate the basic care component of the MSHO rates. However, only a small number of these persons have ever been enrolled in MSHO; the experience of such a small number of enrollees with this status does not significantly affect the overall acute care experience of the enrolled population.  Institutional Enrollees with Spenddowns  Under MSC+ and MSHO, MCOs have responsibility for the first 180 days of nursing facility services for those who enroll from a community setting. (For those who enroll in MSHO from an institutional setting, Medicaid-covered NF services are paid on a FFS basis.) During periods when the MCO is responsible for NF services, individual institutional spenddown amounts are automatically deducted from Medicaid payments to nursing facilities for those enrollees. If the spenddown amount changes retroactively, the amount previously deducted is also adjusted. Through this automated process of adjusting payments to nursing facilities for individual institutional spenddown amounts, the State does not claim FFP on these enrollee participation amounts.  The NF Add-On component of the MSC+ and MSHO capitation rates includes both the Medicaid payment and the institutional spenddown amounts. However, as described above, adjustments are made to deduct individual spenddown amounts through the automated process so that FFP is not claimed on the recipient contribution amount.  Enrollees with Waiver Obligations  While both MSHO and MSC+ enroll people with waiver obligations, the EW rates do not include these amounts. Enrollees are responsible for paying their waiver obligation directly to a waiver service provider. |
| AA.2.4  The State must assure that rates are based only on State Plan services (and directly related costs), and these costs must be specified in the contract. | **State Plan Services Only**  The managed care contracts specify which services are to be provided and paid for with the capitation. See Article 6 of the Contract for a listing of covered services. All State Plan services covered under the contract and provided to Medical-Assistance-eligible enrollees are included in the base year data for developing the rate trends. The State requested data from each MCO in order to identify the amount of non-State Plan services the MCOs provide and required that the data submitted be certified by the MCO. |
| AA.2.5 Non-State Plan services may be covered but must be excluded from the rates. | **Services That May Be Covered By A Capitated Entity Out of Contract Savings.**  No material effect. |
| AA.3.0 The rate base must be adjusted for known factors, must not be double-counted, and must be documented. (See examples.) | **Adjustments to the Base Year Data**  Basic Care  Attachment A, Section II provides the documentation of rate cell adjustments made for anticipated benefit and eligibility changes. There are no eligibility changes for the upcoming year that affect rates for seniors’ products.  Elderly Waiver (EW)  Attachment A, Section III provides the documentation of the adjustments made to the 2013 trended base costs. There are no eligibility changes for the upcoming year that affect the EW Add-on rates.  Nursing Facility (NF)  No benefit and eligibility changes were needed. See Attachment A, Section IV. |
| AA.3.1  Differences between the base year and the contract year must be adjusted and documented.  AA.3.1 continued  AA.3.1 continued  AA.3.1 continued | **Benefit Differences**  Basic Care  The State has made an adjustment to the capitation rates to account for several benefit and reimbursement changes implemented the most recent years and those scheduled to be implemented in CY 2015. Attachment A, Section II lists the basic care benefit and fee schedule changes that have been incorporated into the senior Medicaid rates for the upcoming year. The benefit changes, also detailed on pages 9-13 of Attachment A, section II, include adjustments for legislation through the 2014 session.   * Legislation reduced the 2009 rates for certain services by 1%, which continued to affect the 2013 experience used to develop the 2015 rates. The aggregate factors applied for the upcoming year to the community rates and the institutional rates for this adjustment are 1.0013 and 1.000 respectively, considering costs in personal care services, home health, and home care nursing (formerly private duty nursing) services. * Effective September 1, 2011, provider fee schedule reductions for various providers were implemented, that sunset on July 1, 2013, affecting the experience used to develop 2015 rates. The aggregate factors applied to the community rates and the institutional rates for this adjustment are 1.0147 and 1.0144, respectively. * Additional preventive dental services were added to the benefit set effective July 2013: up to four dental prophylaxis visits per year, oral or IV sedation, behavior management, and house or facility calls. The aggregate factors applied to the community rates and the institutional rates for the dental benefits are 1.0013 and 1.0035, respectively. * Based on Minnesota Statutes, § 256B.76, subdivision 2, payment rates for dental services were increased 5% effective January 1, 2014. The aggregate factors applied to the community rates and the institutional rates for this adjustment are 1.0008 and 1.0025, respectively. * Minnesota Session Law Ch. 108, Article 7, Section dion 47 and 60 Ch. 108, Articel explantion ied here. he MCO is paying for a service not otherwise covered in the contrac60 required reimbursement rates, grants, allocation, individual limits, and rate limits to be increased by 1% for the rate period beginning April 1, 2014. Adjustment factors were calculated for the 2015 rate development based on service category mix of the 2013 experience for each population. The aggregate factors applied to the community rates and the institutional rates for this adjustment are 1.0054 and 1.0002, respectively. * 2014 legislation required a 5% rate increase for continuing care providers, effective July 1, 2014. Factors of 1.0272 for community and 1.0010 for institutional populations were applied, based on the cost of the affected services. * Based on Minnesota Statutes 2012, section 256B.0911, effective January 1, 2015 (following a statutory one-year delay), the determination of the need for NF level of care will change such that a percentage of the community EW individuals will lose their EW eligibility. A concomitant increase in PCA for the population losing their EW eligibility is blended into the overall community rate, resulting in rates being increased by a factor of 1.0024. * HCBS providers will receive a quality add-on increase to their rates effective July 1, 2015. Based on the use of these services in the Seniors contract, aggregate factors applied to the community rates and the institutional rates for this adjustment are 1.0027 and 1.0001, respectively. * The Medicaid FFS inpatient hospital rates were reduced from September 1, 2011 through October 31, 2014, by 10%. The reduction was not applied to managed care rates, and the state does not believe the managed care organizations follow the FFS rates closely; no adjustment was made to managed care rates, though inpatient unit cost trend was included in the trend adjustment for 2015. * The Medicaid FFS inpatient hospital rates were rebased to APR-DRGs effective November 1, 2014, which would affect only the small non-dual part of the Seniors population. No adjustment was made for this change. * Section 1902 (a)(13) of the Affordable Care Act (ACA) requires Medicaid primary care providers (PCPs) to be paid at 100% of the Medicare fee schedule for specific evaluation and management (E&M) services. This provision was amended into the 2013 managed care contracts but paid as a lump sum after the 2013 financial information showing MCO 2013 experience had been submitted. Thus, the PCP payment did not affect the 2013 experience upon which the 2015 rates are based. * Changes in vaccine replacements, vaccine administration rates, and exclusions of certain vaccines became effective January 1, 2014, for adults other than dual eligibles. The effect of the change on this small part of the population did not require a rates adjustment. * No adjustments were made for the following legislative changes due to very low impact on the rates or delays in implementation: payments to Community Health Clinics for Family Planning; prohibition on prior authorization of certain dental services and on the first 24 chiropractic visits in a calendar year; Community First Service and Supports will replace PCA services (another delayed implementation); new mental health providers will soon be allowed to provide existing services, and some expansion of mental health crisis provider responsibilities; a small (0.33%) reduction for FFS DME rates was implemented in 2014, and the Legislature has extended a freeze on DME pricing; a change in the method of payment to FQHCs and RHCs affecting only the 4% of the Seniors population that is dually eligible.   Further details of the basic care changes can be found in Attachment A, Section II, pages 9-14.  Elderly Waiver  The EW add-on rates were developed using CY 2013 health plan experience. The experience was adjusted to account for legislative changes that affected the relevant year’s rates. For brevity, previous benefit changes are not listed again in this checklist.   * Legislation reduced the 2009 rates for certain services by 1.0% which continued to affect the 2013 experience used to develop the 2015 EW rates. The aggregate factors applied for the upcoming year are 1.0009 for EW services and 1.0025 for the care coordination services part of the EW rates. * Minnesota Session Law Ch. 108, Article 7, Section 60 required reimbursement rates, grants, allocation, individual limits, and rate limits to be increased by 1% for the rate period beginning April 1, 2014. An adjustment factor of 1.0100 was calculated based on service category mix of the 2013 experience. * 2014 legislation required a 5% rate increase for continuing care providers, effective July 1, 2014. A factor of 1.0500 was applied, based on the cost of the affected EW services. * HCBS providers will receive a quality add-on increase to their rates effective July 1, 2015. Based on the use of these services an adjustment of 1.0050 was applied for EW services.   Details can be found in Attachment A, Section III, pages 18-19.  Nursing Facility (NF)  There are no NF benefit changes for the upcoming year. |
| AA.3.2  An adjustment must be made and documented for allowable administrative costs. | **Administrative Cost Allowance Calculations**  In addition to claim costs, the State pays the MCOs an administrative margin that is included in the capitation. For the upcoming year, the trend development provided for a 1.5% per year increase in nursing facility relocation case management, mental health targeted case management, and administrative costs together (see page 6 of Attachment A). |
| AA.3.3 If the eligibility/utilization data are different from the base rate data, or if they change, an adjustment must be made. | **Special Populations Adjustments**  Since past MCO experience is used to determine the rates, any special population adjustments made historically would be reflected in that experience.  For any changes made during the contract year to eligibility rules affecting rates, an amendment to the rates will be developed and submitted to CMS for approval. |
| AA.3.4 If certain eligibility periods (e.g. newborn month) are in the base but not in the rates, or vice versa, an adjustment must be made. | **Eligibility Adjustments**  Since past MCO experience is used to determine the rates, eligibility adjustments made historically would be reflected in the MCO’s cost structure. The State does not anticipate any changes in the eligibility criteria for seniors required to enroll in MSC+ during the upcoming year contract period, but if changes that affect rates are legislated, a rate amendment will be developed and submitted to CMS for approval. |
| AA.3.5  DSH payments may not be made in the rates. The State must pay DSH directly to the DSH facility. | **DSH Payments**  The State does not make DSH payment to hospitals through the capitation rates. Capitation payments are determined by actual aggregate MCO financial experience. If however, an MCO, in its contracting with providers, makes higher payments to higher cost hospitals, this would be reflected in their financial experience. |
| AA.3.6. The contract must specify activities the MCO must perform for TPL. Rates must be adjusted for TPL. | **Third Party Liability (TPL)**  The trend adjustment uses revenue net of TPL to determine the appropriate increase in medical expenses incurred by the MCOs. The trend adjustment attempts to estimate what the true increase in cost and utilization is each year. |
| AA.3.7. If the base data includes or does not include cost-sharing, the rates developed must match or an adjustment made. | **Copayments, Coinsurance and Deductibles in Capitated Rates**  The State reduces the basic care rate component to reflect the amount of cost-sharing that enrollees will make directly to providers. This would reduce the MCO expenditures. The trend analysis for the upcoming year, which used 2013 MCO expenditure data, would thus take into account the effect of cost-sharing on MCO expenditures.  The MCOs offering MSHO have elected to waive collection of cost-sharing under MSHO. Since few cost-sharing payments were applicable to dual eligible persons and to people in institutions, and most MSHO enrollees are dually eligible and high numbers are in institutions, the value of this deduction is minimal but the MCOs are required to report it. The value of cost-sharing was excluded from the development of the Basic Care rates (see Attachment A, page 4). |
| AA.3.8.  Where the State makes GME payments directly to providers, the MCO rates must not also include GME. | **Graduate Medical Education (GME)**  Under the terms of Minnesota’s § 1115 PMAP+ demonstration (Prepaid Medical Assistance Project Plus, No. 11-W-0039/5) extension granted in December 2013, federal financial participation for GME spending will be limited to the amount claimed for FFP under the PMAP+ demonstration as Minnesota’s Medical Education and Research Cost (MERC) expenditures for SFY 2009. This aggregate limit applies to MERC (GME) payments authorized under the PMAP+ demonstration. This amount will constitute the limit for MERC funding for the demonstration in lieu of the limit expressed at 42 CFR §438.6(c)(5)(v). The waiver excludes MSHO (but not MSC+) from application of the MERC process. |
| AA.3.9 The State may pay only the equivalent rates as FFS for FQ/RHC. The rates must not include the FQ/RHC encounter rate, cost-settlement or PPS amounts. FQ/RHC payment must be no less than other providers receive. | **FQHC and RHC reimbursement**  By federal law, the State must pay these entities on a cost basis, and may use historical costs trended forward (prospective payment system). The FQHC and RHC costs generally exceed the payment rates of the MCOs.  The State has historically paid the difference between MCO payment rates and a cost-based rate with FQHCs and RHCs. For 2015, the contract now requires the MCOs to report claims paid to FQHCs and RHCs so that the State may pay the entire rate to FQHC and RHC providers directly. See sections 3.7.2 (S) and 3.8 of the contract. |
| AA.3.10  Factors are based on historical costs or applicable market basket costs. Factors are documented. | **Medical Cost/Trend Inflation**  The State’s methodologies for the basic care, NF and EW components do not use regional/national medical CPI information in developing cost and utilization trends. However the actuary does consult utilization and rates for the Medicare FFS program as described in Attachment A in calculating the benchmark trends blend, particularly with respect to the Medicare cost sharing.  Basic Care  Actual aggregate MCO cost experience is used. Attachment A, Section II is the actuary’s report detailing the assumptions and analysis that went in to the final trend factors for the basic care rate components for seniors.  EW Add-On  The upcoming year EW Add-On rates were developed using 2013 MCO experience for both EW and care coordination / case management (CC/CM) services. The rates were adjusted for subsequent benefit and trend changes. The rates include a risk adjustment component to allocate revenue for the EW population based on frailty characteristics. The risk adjustment factors were developed using MCO encounter and assessment data entered into the State’s MMIS system and 2013 MCO services costs submitted by the MCOs for the development of the upcoming year’s rates and are applied to the EW Waiver base rates to calculate the final CY EW Add-On rate.  Attachment A, Section III details the assumptions and analysis that went in to the final trend factors for the EW rate component.  NF Add-On  The NF rates were developed using both managed care and FFS experience, and payment and forecast information from DHS Reports and Forecasts of Average NF Charge per Day for the upcoming year. Attachment A, Section IV is the actuary’s report detailing the assumptions and analysis that went in to the final trend factors for the 180 NF rate component. |
| AA.3.11 Utilization differences between base data and the proposed population are adjusted out. Changes in utilization (e.g. for new medical procedures) are adjusted and documented.  AA 3.11 continued | **Utilization Adjustments**  Basic Care Rate  For the basic care component of the rate, utilization adjustments are not made explicitly during the rate development. The State does not use FFS as a basis for the rates and adjusting for differences between FFS and managed care is not necessary. Trend factors derived from MCO experience have utilization embedded in them along with cost increases. When there are new sub-populations included in managed care, the State estimates the expected average cost of these individuals and adjusts the rates as appropriate. For the upcoming year, there are no new populations being added to this contract. Thus there are no utilization adjustments for this rating period.  EW Add-On  No new populations are being added to MSHO or MSC+ for the upcoming year. No utilization adjustments were assumed in the rates development for the upcoming year.  Attachment A, Section III shows the actuary’s report detailing the assumptions and analysis that went in to the final trend factors for the EW rate component.  NF Add-On  No utilization adjustment was assumed when projecting the admission frequency and average length-of-stay (ALOS). The starting point for the frequency of admissions and ALOS for the development of the NF Add-On rates was based on a blend of experience from CY 2011-2013 (see page 23 of Attachment A). For the upcoming year, there are no new populations being added to MSHO or MSC+. |
| AA.3.12 The State must document the data assumptions were appropriate for the known populations, base and proposed, and if the enrolling population is different from the base, must adjust. | **Utilization and Cost Assumptions**  Virtually all of the seniors enrolled in Minnesota’s managed care programs are now required to enroll on a mandatory basis. All costs and utilization are reflected in the MCO data that is the basis for the rates. |
| AA.3.13 The State must account for recipient liability. | **Post-Eligibility Treatment of Income (PETI)**  Not applicable for this population. |
| AA.3.14 The State must adjust to account for incomplete base data. | **Incomplete Data Adjustment**  Basic Care  Minnesota’s rate setting does not use FFS data as there is no longer any historical FFS base for the senior population, and claims completion factors do not pertain. However, the State’s actuary does require MCOs to update their financial filings with claims paid, and certify that data.  EW Add-On  2015 EW Add-On rates were based on 2013 MCO experience for both EW and care coordination / case management services. Since current data is being used, no direct adjustment was necessary to reflect claim lag. A description of the data used for the EW Add-On rates is included in Attachment A, Section III.  NF Add-On  NF Add-On rates are based on Statewide managed care and FFS utilization based on living arrangement as reflected in the State MMIS system. Living arrangement data is considered complete if pulled at least six months after the data period, which it was. The upcoming year charge per day information was developed using nursing facility MA charge per day information from the Department of Reports and Forecasting at DHS and is considered complete for this purpose. |
| AA.4.0-4.4 The State must create rate cells specific to the population subgroups (age, gender, etc.) | **Establish Rate Category Groupings (Age, Gender)**  Basic Care  The demographic rate category groupings that determine 100% of the basic care capitation payments to MCOs for seniors are delineated by age, gender, eligibility category, and geographic region of the state.  EW Add-On  The MSC+/MSHO EW Add-On rates were developed based on EW MCO experience statewide. Rate cells vary by age, gender and region. The rates include a risk adjustment component to allocate revenue for the EW population based on frailty measures, age, and metro/non-metro status.  NF Add-On  The MSHO / MSC+ 180 day NF Add-On was developed based on non-institutionalized member months and are paid for that same group of enrollees. Rate cells vary by age, gender, region, and Medicare/Non-Medicare. |
| AA.4.0-4.4 The State must create rate cells specific to the population subgroups (age, gender, etc.) | **Locality/Region**  For the upcoming year two geographic regions were used, defined as Metro and Non-Metro, as described on page 16 of Attachment A. |
| AA.4.0-4.4 The State must create rate cells specific to the population subgroups (age, gender, etc.) | **Establish Rate Category Groupings (Age, Gender)**  Basic Care  Rate cells vary by Medicare versus non-Medicare status. For senior managed care payments, there are no other distinctions among rate cells having to do with eligibility categories.  EW Add-On  Rate cells for the EW Add-On do not vary by Medicare status. No consistent relationship of EW costs was observed for Medicare versus Non-Medicare clients.  NF Add-On  Rate cells for the NF Add-On rates vary by Medicare versus non-Medicare status. |
| AA.5.0. The State must examine the base data for distortions and adjust in a cost-neutral manner across rate cells if needed. | **Data Smoothing**  No data smoothing was required for the upcoming year. |
| AA.5.1 The State must assess the degree to which a small number of high-cost claims or enrollees may be distorting the data. | **Special Populations**  Basic Care  The cost experience of the MCOs for seniors includes a range of people with chronic diseases typical of the elderly population, and the State accommodates these higher costs in three ways: the demographic rate categories have different cost weights for enrollees who fall into institutional, community and age categories; the State adjusts these costs for dual eligible persons versus non-Medicare-eligible seniors, and additional costs needed for long term care are reflected through separate rate cells for NF, community and community EW enrollees.  NF and EW Add-On rates  Catastrophic claims are not an issue for NF and EW payments due to daily and monthly limits, respectively, placed on Medicaid payment for these services. In addition, the EW rate is risk adjusted. For this reason, no adjustment was necessary. |
| AA.5.2 If catastrophic claims are distorting the data then correction must be made (e.g. stop loss, kick payment, actuarial adjustment, etc.). | **Cost-neutral data smoothing adjustment**  No data smoothing adjustments have been made for the upcoming year rates. |
| AA.5.3 If the State adjusts payments for differential population risk among MCOs, the method must be cost-neutral, based on an accepted grouper, and documented. | **Risk Adjustment**  Basic Care and LTC  The Basic Care and NF Add-on rates are not risk adjusted (see sections 4.2.18 and 4.2.19 of the contract).  EW Add-On  The EW risk adjustment factors include area, ADL, age, and customized living / corporate foster care. The overall area, ADL, and age factors will be recalculated annually based on the MCO’s membership at the beginning of the contact year. EW risk adjustment is discussed on pages 20-21 of the actuarial memo. |
| AA.6.0-6.3 If these options are offered, they must be documented in the contract. | **Stop Loss, Reinsurance, or Risk-sharing arrangements**  The State of Minnesota does not offer MCOs risk sharing or general stop-loss insurance. However, as a condition of licensure, the State does require that MCOs have minimum financial reserves, reinsurance or a guarantor of the reserve requirements. |
| AA.7.0 Incentives must not result in more than 105% of the otherwise projected costs. Incentives must be documented, must be for a fixed period and cannot auto-renew. Incentives may not be conditioned on IGTs. | **Incentive Arrangements**  For the upcoming year, the State will withhold 5.0% of the capitation payments for all senior products as a performance incentive. MCOs have a number of performance targets that they must meet to get full return of the withheld funds. These targets are listed in section 4.6 of the contract. Initial estimates indicate that at least 95% of the withheld funds will be repaid to MCOs for 2014 results. As noted on page 14 of Attachment A withhold losses are limited to approximately 0.25% of total capitation by a loss limit.  The State withholds an additional percentage of the capitation payments, which will be paid to the MCOs in July of the year following the contract. The return of these withheld funds will not be contingent upon meeting performance targets.  In addition to the withheld funds, incentive payments over and above the capitation payments may be made as well. Incentive payments will be based on the number of selected services provided during the year as specified in section 7.14.4 of the Seniors contract. All incentives are based on approved State Plan services to Medicaid eligible beneficiaries. The incentives are for a one year contract period. Each year, the State determines whether the incentives should be continued and other incentives added. Incentives are not based upon intergovernmental transfer agreements. Incentives are available to both public and private MCOs.  Total incentive payments to the MCO will be calculated. It is not expected that these additional payments will exceed 5% of the total capitation payments in the specific rate cells covered by the incentive arrangement. However, if an adjustment is needed to bring the total below 5%, it will be done as required by section 7.14.2 of the Seniors contract. |

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