Report to the Legislature

Mental Health Managed Care Rate-Setting Approach

Section 204(4)(d) of State Operating Budget

August 1, 2013

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Department of Social and Health Services Administration
Mental Health Managed Care Rate-Setting Approach

This document has been prepared in accordance with the requirement of Section 204(4)(d) of State Operating Budget which states:

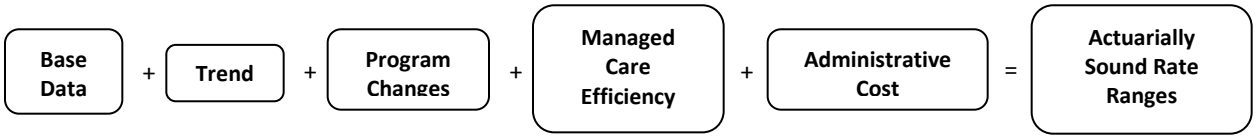
In developing the new Medicaid managed care rates under which the public mental health managed care system will operate, the department must seek to estimate the reasonable and necessary cost of efficiently and effectively providing a comparable set of medically necessary mental health benefits to persons of different acuity levels regardless of where in the state they live. The department must report to the office of financial management and to the relevant fiscal and policy committees of the legislature on its proposed new mental health managed care rate-setting approach by August 1, 2013, and again at least sixty days prior to implementation of new capitation rates.

Background

The state provides mental health services to Medicaid recipients through its Regional Support Networks (RSNs) under a capitation arrangement. The process described in this report encompasses a rebasing of the underlying service utilization data to capture the more recent utilization patterns of the Medicaid consumers eligible for the mental health managed care program. In addition to the rebasing of the actuarially sound rate ranges, the State is reviewing the required reserve levels for the RSNs as part of the process.

Rate Methodology Approach

The schematic below summarizes the key components of a rate methodology.



Base Data

Mercer, in conjunction with the state and the RSNs, determined the appropriate data sources to be used as the base for developing rates. The process relies on the inpatient fee-for-service (FFS) data and outpatient and evaluation and treatment (E&T) encounter data as the primary utilization data sources for rate setting. The State's client eligibility files are utilized to determine Medicaid eligibility and rate cells for eligible members. The revenue and expenditure (R&E) reports are a supplemental data sources, specifically to support financial analysis and the administrative cost review.

Utilization Data Review

The incorporation of new underlying utilization data requires detailed analysis to confirm the services included in the data are all covered in the State Plan (or under 1915(b)(3) authority) and the services are for Medicaid eligibles. Adjustments are also necessary to ensure the underlying base data is representative of the services and costs included in the RSN contract. This includes ensuring the encounters provided by the RSNs do not include claims paid by other payors, including FFS, Healthy Options, Medicare and other third-party payors. Mercer will work with the state to capture all necessary data to calculate adjustments to the raw FFS or encounter data.

The state and Mercer determined a process that provided the RSNs an opportunity to review the 2011 encounter and inpatient data used for rate setting. To the extent the RSNs determined a gap in the encounter data, the RSN was afforded the opportunity to submit detailed, person-level encounter records directly to Mercer for any missing encounters.

Upon conclusion of the data determination and reconciliation phase, Mercer will summarize the encounter and inpatient claims data from 2011 by modality or covered service category to create the utilization statistics for the data book.

Unit Cost Review

For inpatient services, the State makes payments directly to the hospitals and charges the respective RSN. As such, the inpatient claims data captures the necessary information on utilization and cost per day to support the inpatient analysis. The outpatient and E&T encounter data captures utilization of services, but does not capture the information on how the RSNs reimburse providers. Mercer followed a similar approach as used in the development of the 2008 Data Book. For the per diem services, which generally capture the E&T, residential and high-intensity treatment services, Mercer prepared a data request template to facilitate collection of this information directly from the RSNs and their providers.

For the outpatient encounters typically documented on a per 15-minute basis, Mercer is conducting a cost modeling analysis based on a compensation study looking at the typical practitioners involved in providing mental health services, comparisons to other state's fee schedules, and productivity specific to the use of evidenced-based methods. This approach allows Mercer to build the unit cost information based on updated salaries, as well as consider typical provider expenses for employee benefits and overhead. This approach is consistent with the last round of rate setting and was a point of contention with the RSNs and their provider groups. Mercer will present the results of this analysis during a meeting in early September. The resulting hourly unit cost figures will be used to assign costs to the outpatient encounter data.

Rate Cell Review

The current federal regulations require a review of the capitated rate structure every time rates are rebased using new underlying utilization data. Mercer is reviewing the capitated rate structure to ensure it is the most accurate structure to match payment to risk, and that it remains actuarially sound. The current rate cell structure includes four rate cohorts split by children and adults between disabled and non-disabled populations. Mercer is performing a detailed review of current data to determine whether modifications are necessary to better match payment to risk. During the last rate rebase, Mercer recommended the children in Foster Care be moved from the non-disabled to disabled children rate cell. Mercer, during this process, will also be looking at the possibility of creating a new rate cell specifically to capture the newly Medicaid eligible group under Medicaid Expansion beginning in January 2014.

Data Book

Once Mercer has determined the rate cell structure, the utilization and unit cost data will be summarized by major service category for each rate cell and RSN. Adjustments may be necessary to account for incurred-but-not-reported (IBNR) encounters, and possibly other adjustments identified through discussions with the State. The final adjusted data will be summarized into a data book that will serve as the basis for rate setting. Once the historical data is summarized, Mercer will apply a number of adjustments to project the expenses into the upcoming contract period.

Trend

In order to determine trend, Mercer is analyzing all available data from the state, including state-generated reports. Mercer is reviewing utilization trends from the available inpatient claims and outpatient encounter data as the primary source for trend analysis. In addition, Mercer is reviewing numerous national or regional trend studies. This analysis will include data from Mercer's experience with many other state Medicaid behavioral health programs.

Program Changes/RSN Rate Issues

Mercer will apply adjustments for any programmatic changes in the managed care program not fully captured in the current rates. These changes may be the result of policy clarifications within the Medicaid program, decisions passed down by the Legislature (such as increased use of evidence-based practices) or items included in the final state budget. Mercer also requested from the RSNs any RSN-specific program changes that have occurred during or after 2011 that should be considered in the rate analysis.

Managed Care Efficiency Adjustment

An important consideration in any actuarial rate review is whether the rate promotes efficient delivery of the covered benefits. The major area of efficiency review is the utilization of services. Mercer is reviewing inpatient claims and outpatient encounter data statistics with their clinicians to pinpoint areas for improved efficiencies. Areas of adjustment may include a review of inpatient lengths of stay or readmission rates and adherence to best practices in the authorization and management of outpatient care. In the end, any adjustments will provide the state with assurance that we are purchasing efficient care from the RSNs.

Administrative Cost Review

In order to operate an efficient managed care program, the RSN must expend resources on administrative functions. These functions span provider relations, finance, utilization management and many other areas. It is important that the administrative assumption accounts for reasonable costs for an efficient RSN. Mercer has developed an administrative cost model that considers the staff and costs of an efficient behavioral health managed care organization. Mercer is considering this model, as well as the historical costs of the RSNs as represented in the R&E reports, to develop the administrative cost assumption. This step is important given the increases in Medicaid enrollment, which when multiplied by the per member per month rates, may be generating increased administrative revenue for the RSNs.

Rate Ranges and Documentation

Ultimately, Mercer will develop rate ranges for the state to use in contracting with each RSN. These ranges will be developed in order to reflect statistical uncertainty in the assumptions and also varying levels of RSN efficiency. Mercer views the rate range as representing varying levels of RSN efficiency. Ultimately, the state will be able to utilize the rate ranges in negotiations with the RSNs.

Mercer will provide documentation to the state to outline the assumptions included in the rate range development. In order to satisfy Centers for Medicare and Medicaid Services (CMS) requirements, Mercer also will provide actuarial certification letter documenting the rate-setting methodology and the actuarial soundness of the rates. Mercer also will assist the state in ensuring these rates are within the cost projections outlined in the current waiver.

TIMELINE

Below is the current timeline for the completion of the rate rebase process. Mercer met with the Department and the RSNs to go over the process in detail. Also attached, is the Power Point presentation detailing further the process to reach actuarially sound rates on _____ for January 1, 2014.

Task	Target Date
Encounter data collection and validation	
– DBHR provides data to Mercer and RSNs	May 21, 2013
– RSNs complete data validation and reconciliation against internal records	May 31, 2013
– RSNs submit any missing records to Mercer and DBHR	May 31, 2013
– Mercer, DBHR and RSNs discuss data, as necessary	June 21, 2013
Per diem data collection	
– Mercer distributes template for collection of information including final response from RSNs during 2009 analysis for reference	June 5, 2013
– RSNs collect and submit per diem information	June 28, 2013
– Mercer follows-up with any questions	July 2013
New program rate issue information collection	
– Mercer sends request for collection of information to RSNs	June 14, 2013
– RSNs submit rate issue information	July 19, 2013
– Mercer follows-up with any questions	Weekly
Hourly Rate Development	
– Mercer compiles regional salary information on health care providers	May 31, 2013
– Mercer completes unit cost development by modality	July 31, 2013
Discuss data and Data Book process with RSNs, Mercer and State	July 2013
Mercer completes draft of Data Book	Aug 30, 2013
Data Book meeting with RSNs, Mercer and State	Early Sept 2013
Mercer prepares draft rate ranges for discussion with State	Oct 11, 2013
Rate meeting with RSNs, Mercer and State	Late Oct 2013
Mercer prepares actuarial certification of rates for CMS	Nov 2013
State submits actuarial certification to CMS	TBD