



MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

June 19, 2018

The Honorable Edward J. Kasemeyer
Chair
Senate Budget and Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD 21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD 21401-1991

Re: 2017 Joint Chairmen's Report (p. 92) – Report on Managed Care Rate-Setting

Dear Chairs Kasemeyer and McIntosh:

Pursuant to the requirements of the 2017 Joint Chairmen's Report (p. 92), please find enclosed a report on managed care rate-setting, including a review of potential improvements to Maryland's Medicaid managed care rate-setting system and a review of innovations in other states that have similar systems. MDH provided funding to the Hilltop Institute at the University of Maryland-Baltimore County to manage the procurement process and study. Through a competitive procurement process, Hilltop selected the consulting firms Milliman, Inc. and Mannatt Health Strategies to conduct the study and produce the enclosed report.

Thank you for your consideration of this information. If you have questions or need more information on the subjects included in this report, please contact Webster Ye, Deputy Chief of Staff at (410) 767-6480 or webster.ye@maryland.gov.

Sincerely,

Robert R. Neall
Secretary

Enclosure

manatt



**University of Maryland, Baltimore County
Medicaid Managed Care Rate Setting and Payment Innovation Study**

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I. FOREWORD

FY 2018 BUDGET REQUIREMENT

Maryland's FY 2018 budget legislation and associated 2017 Joint Chairmen's Report¹ required a study reviewing potential improvements to Maryland's Medicaid managed care rate setting system and appropriated funding to the Maryland Department of Health (MDH) for the analysis. The Joint Chairmen's Report specified that the study examine processes and methodologies for developing capitated payment rates for HealthChoice, Maryland's Medicaid managed care program; review rate setting systems and processes, and methodologies used in other states; examine innovations in Medicaid managed care rate settings in other states similar to Maryland that could inform rate setting in Maryland; and recommend strategies to promote greater efficiency, transparency, accountability, and cost-effectiveness in Medicaid managed care rate setting in Maryland. As required by The Joint Chairmen's Report, this study does not consider implementation of a competitive bidding process for Medicaid managed care since past studies have concluded such a process would not be beneficial.

COMPETITIVE PROCUREMENT AND MILLIMAN / MANATT SELECTION

Pursuant to the FY 2018 budget legislation, MDH provided funding to The Hilltop Institute at University of Maryland, Baltimore County (UMBC) to manage the procurement process and study. The Hilltop Institute has maintained a strong partnership with MDH, analyzing state health policies and developing solutions for the Maryland Medicaid program. Through a competitive procurement process, The Hilltop Institute selected consulting firms Milliman, Inc. (Milliman) and Manatt Health Strategies, LLC (Manatt) to conduct the study in December 2017.

ACKNOWLEDGEMENTS

Milliman and Manatt thank the individuals listed below for their contributions to this project. In particular, Milliman and Manatt appreciate The Hilltop Institute (Hilltop) and MDH for facilitating access to information on Maryland's Medicaid managed care system, assisting with scheduling interviews with Maryland stakeholders, and providing guidance and expertise. A number of Maryland stakeholders and officials from other states also participated in the interviews, providing insights and expertise that significantly broadened the depth and analysis of the report. We also would like to thank Robert Damler for providing oversight during this study and subject matter expert review.

¹ HB150 accessible at: <https://legiscan.com/MD/text/HB150/2017>; Report on the Fiscal 2018 State Operating Budget (HB 150) and the State Capital Budget (HB 151) and Related Recommendations accessible at: <http://mgaleg.maryland.gov/Pubs/BudgetFiscal/2017rs-budget-docs-jcr.pdf>.

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II. EXECUTIVE SUMMARY

PURPOSE OF THE STUDY

This report provides an assessment of Maryland's approach to rate setting for its Medicaid managed care program, with a focus on identifying recommendations for further promoting efficiency, transparency, accountability, and cost-effectiveness in Medicaid rate setting. The report includes a summary of federal and state regulations governing the Maryland rate setting process; an overview of Maryland's current approach to rate setting; a discussion of promising and innovative strategies from other states for producing a rate setting methodology that more efficiently promotes access to high-quality, cost-effective care; and a specific set of recommendations for Maryland decision-makers to consider. This report was prepared under UMBC Contract #BC-21083-R with oversight provided by The Hilltop Institute at UMBC.

Maryland's Medicaid managed care program, HealthChoice, provides coverage to approximately 1.2 million lives as of February 2018. Accessing coverage for a wide range of Medicaid services through the managed care delivery system of the HealthChoice program is mandatory for approximately 85 percent of Medicaid beneficiaries in the state. Capitation payments, representing the projected cost of providing care for the covered beneficiaries, represent the vehicle through which the risk of the Medicaid program is transferred from the State to the managed care organizations (MCOs).

The focus of this study is to help the State of Maryland identify processes and methodologies that can help the State achieve its broader goals of ensuring access to high quality, cost-effective health care for the state's most vulnerable populations.

This report provides a summary of federal and state regulations impacting the Maryland rate setting process; provides an overview of Maryland's current processes and strengths; identifies best practices in other states for producing an efficient and cost-effective rate setting methodology; and provides a set of recommendations for Maryland to consider implementing to improve its rate setting processes.

STUDY APPROACH

Following award of this contract, the Milliman and Manatt team conducted a detailed review of the regulations governing Maryland's rate setting process, including federal Medicaid managed care regulations and the State's Code of Maryland Regulations (COMAR). Simultaneously, the team worked with Hilltop to identify key stakeholders for interviews and to obtain documentation of Maryland's current rate setting process. Subsequently, Milliman and Manatt identified interviewees from three other states with mature Medicaid managed care programs (Michigan, New York, and Tennessee). These states were selected for the study due to their experience with Medicaid managed care and potential for and availability to share lessons learned and best practices with Maryland's Medicaid program. Interviews were conducted by the Milliman and Manatt team and used in conjunction with the regulatory analysis to develop a detailed description of the Maryland rate setting process and identify recommendations for further strengthening it.

FINDINGS AND RECOMMENDATIONS

The Maryland Medicaid HealthChoice managed care program has been providing health services since 1997. The program has been successful in creating viable capitation rates for participating MCOs while monitoring quality and patient access to care. Over the last fifteen years the HealthChoice program has been financially stable, producing capitation rates with an average underwriting margin of approximately 1.6%. Based on this review, Milliman and Manatt found the Maryland rate setting process is generally viewed positively, but certain aspects of the program could be improved to provide more focus on quality and efficiency. The unique partnership between MDH and Hilltop is beneficial and contributes additional continuity, program knowledge, and HealthChoice data expertise to the program. However, there are a limited number of strategies embedded in the current process for promoting value-based care. The program includes a Value Based Purchasing Program that helps to drive a focus on some key quality metrics, but it is relatively limited in nature. Given the size and scope of HealthChoice, state policymakers may want to

consider additional steps to drive greater performance consistent with the State's goals and objectives. Additionally, the state regulations governing the rate setting process are relatively prescriptive and detailed, potentially limiting the flexibility of MDH to adopt new initiatives to promote high quality, cost-effective care.

The following list enumerates key recommendations for further strengthening the Maryland rate setting process and integrating a greater focus on value through payment initiatives. These recommendations are discussed in more detail in Chapter 4 of the report.

Table 1: Summary of Recommendations

	Recommendation	Description
1	Define a vision and outline top priorities and goals for value and quality in Medicaid managed care	Define the State's goals for enhancing quality, value, and innovation in Medicaid managed care and pursue opportunities to embed these goals into the rate setting process.
2	Sustain and strengthen the existing quality incentive program	Establish a schedule to periodically examine and modify quality measures for alignment with the State's initiatives, and broaden the current incentive structure to consider continued improvements for high-performing MCOs as well as a trajectory of improvement for low-performing MCOs.
3	Evaluate whether to vary profit margin consistent with MCO performance on State's priorities	Explore varying future MCO profit margins to provide higher margins for MCOs that excel in meeting the State's objectives.
4	Improve encounter data and enhance use of encounter data to drive value	Develop and implement a process to reconcile MCO encounter data against financial data to assess the completeness and accuracy of the encounter data. Leverage these results to evaluate quality and incentivize the MCOs to provide high quality data.
5	Validate the existing outlier adjustment aligns with cost, quality, and value objectives	Evaluate and monitor the alignment between the current outlier adjustment applied to the base period rate setting data to eliminate MCO inefficiency and the State's objectives for MCO quality and performance.
6	Select the most recent and appropriate base data	Consider moving to a two-year lag between the base period and the contract period once MCO encounter data is fully incorporated into the rate setting data. This would be consistent with the rate setting methodology in most other states.
7	Include estimated midyear hospital unit cost changes in the initial rate development	Consider incorporating an estimate of the hospital unit cost changes on July 1, that are unknown at the time of the calendar year rate development process, into the initial capitation rates to decrease the likelihood of needing to make a midyear rate change.
8	Leverage available tools to develop and implement a standardized framework for evaluating and determining risk of high cost drugs	Design and implement a standardized analytical framework to determine how to manage, pay for, and mitigate the risk of high-cost drugs. The framework should consider the cost of the drug, as well as the predictability and distribution of users of the drug across MCOs.
9	Strengthen requirements for coordination of behavioral and physical health	Strengthen existing requirements for the coordination of behavioral and physical health benefits. Two options include defining minimum standards or features of required referral procedures and protocols in the state's contract, and establishing robust expectations on data sharing and use between the MCOs and administrative services organization (ASO).
10	Build more flexibility into state regulatory framework	Explore opportunities to streamline Maryland managed care regulations to the extent permissible under law and leverage the MCO contract for specific requirements that may evolve over time.

III. CHAPTER 1: FEDERAL AND STATE REGULATORY FRAMEWORK FOR MANAGED CARE RATE SETTING AND PAYMENT INNOVATION

INTRODUCTION

Maryland is one of 39 states that relies on managed care organizations (MCOs) for the delivery of services in its Medicaid program.² A detailed set of federal and state regulations govern Maryland's Medicaid managed care program, HealthChoice. This chapter explores the key federal and state provisions that provide the framework for Medicaid managed care rate setting and payment and the options under this framework that may be leveraged for advancing the goals of improved value and quality of care.

FEDERAL REGULATIONS

The federal government has established a comprehensive set of regulations governing Medicaid managed care. The regulations, which are primarily contained in Part 438 of title 42 of the Code of Federal Regulations (CFR), address all aspects of Medicaid managed care, from network adequacy to member enrollment to prescription drug coverage, and far more. In this report, the Milliman and Manatt team primarily review those aspects of the federal regulations that govern the Medicaid managed care rate setting process and state flexibility to encourage or require MCOs to adopt payment innovations.

The Centers for Medicare & Medicaid Services (CMS) significantly overhauled the federal regulations in 2016, the first substantial set of revisions to Medicaid managed care rules since 2002. Among the revisions was a more detailed regulatory structure for state Medicaid agencies around the development of actuarially sound capitation rates for MCOs, as well as clarification and expansion of state flexibility to use various fiscal tools to encourage higher performance among MCOs. At the time of this writing, the Medicaid managed care regulations are undergoing active review by the Trump Administration, which has indicated its intent to provide states with greater flexibility to operate their Medicaid managed care programs as they see fit. Indeed, the agency issued an Informational Bulletin in June 2017 that indicates it will exercise significant discretion in enforcing most of the provisions of the 2016 federal regulations.³ One notable exception in the guidance is a statement that CMS would enforce the federal requirements governing the rate setting process – a strong indication that the federal government is unlikely to propose significant changes to these particular provisions.

Rate Setting

The following section provides an overview of the key federal regulatory provisions that govern the Medicaid managed care rate setting process and related provisions that provide states with significant flexibility to use a range of tools to encourage MCOs to provide high-quality, cost-effective care.

Actuarial Soundness (42 CFR 438.4)

A core requirement of Medicaid managed care rates is that states' capitation payment rates to MCOs be "actuarially sound." Actuarial soundness standards in rate setting comprise three key principles:

- Payment levels are sufficient and projected to provide for all reasonable, appropriate, and attainable costs to provide the services and operations covered under the terms of the contract for the time period and population covered
- Rates are documented in sufficient detail to assess their reasonableness

² [Key Findings in Medicaid Managed Care: Highlights from the Medicaid Managed Care Market Tracker](#), Kaiser Family Foundation, December 2014.

³ [Medicaid Managed Care Regulations with July 1, 2017 Compliance Dates](#), Centers for Medicare & Medicaid Services, June 2017.

- Rates are developed in a transparent and uniform way to ensure protection of public funds and beneficiary access to care

The actuarial soundness requirements apply to all Medicaid managed care capitation rates. However, this does not mean the actuarially sound capitation rates must be appropriate for every MCO, or that every MCO is guaranteed to be profitable under actuarially sound capitation rates. In particular, an actuary is not certifying that the assumptions underlying the rates are appropriate for each MCO, but rather the assumptions are appropriate for the identified rate cell in the program.

Standard Contract Requirements (42 CFR 438.3), Rate Development Standards (42 CFR 438.5), and Rate Certification (42 CFR 438.7)

States must follow a set of standard actuarial procedures for the development, documentation, and certification of Medicaid managed care rates. Specifically, they must:

1. Identify and develop the base period data relying on the most recently completed three years of utilization and claims data – validated encounter data, fee-for-service (FFS) data as appropriate, and audited financial reports – with the potential for exemptions applied to states where the data are unavailable
2. Apply appropriate trend adjustments to the base data developed from actual Medicaid population experience or the experience of a similar population
3. Apply appropriate non-benefit costs, accounting for reasonable MCO expenses such as administration, taxes, licensing or regulatory fees, contribution to reserves, risk margin (or profit), cost of capital, and other operational costs associated with providing the services covered under the managed care contract
4. Make appropriate adjustments to the base data to reflect programmatic changes, acuity changes, or other projected changes between the base period and the contract period
5. Consider historical and projected medical loss ratio (MLR) results
6. Apply a generally accepted budget neutral risk adjustment methodology, if used

Rates must be developed using rate cells specific to particular populations, which enables the grouping together of similar beneficiaries and the assignment of each MCO enrollee to a specific rate cell. Each rate cell at the individual level must also be actuarially sound and not cross-subsidize other rate cells. States may use rate ranges in negotiations with MCOs but must ultimately certify actual payment rates to CMS. States that require approval of capitation of rates prior to the contract effective date must submit the rates and actuarial certification to CMS at least 90 days in advance to ensure rate approval prior to the contract period. In practice, many states choose to submit rates less than 90 days in advance and receive rate approval from CMS after the contract period begins; however, CMS rate certification and contract approval is required before states can claim federal match. Additionally, rates must be based on an anticipated program-wide MLR of at least 85 percent.

Encounter Data (42 CFR 438.242 and 438.818)

Given the critical role of encounter data in assessing MCO performance, ensuring accountability for federal and state Medicaid dollars, and setting rates, MCOs must collect and submit enrollee encounter data to the states. Upon receipt from the MCO, states must review and validate the encounter data for accuracy and completeness before submitting the data to CMS. The level of detail to be submitted includes enrollee and rendering provider information; service procedure and diagnosis codes; allowed, paid, cost-sharing, and third-party liability amounts; and, service claim submission, adjudication, and payment dates. As part of the quality control process, states must conduct an independent audit of the encounter data every three years

at minimum, but validation of the data is an optional External Quality Review (EQR) activity. Additionally, states are required to document encounter data reporting for each MCO as part of the annual managed care program report provided to CMS. Effective for contracts starting on or after July 1, 2018, incomplete, untimely, or inaccurate encounter data may result in deferred or disallowed federal financial participation (FFP). Based on contract time periods in Maryland, this requirement would be effective January 1, 2019, but states are still awaiting direction from CMS regarding the appropriate format for submission. Provided it is reported correctly and that it is complete, encounter data provides the most transparency in the MCO's provision of healthcare services; it is the primary basis for rate setting and risk adjustment, among other Medicaid managed care activities.

Medical Loss Ratio Standards (42 CFR 438.8)

MLR formulas measure the ratio of MCO spending on medical and related benefits compared to total revenue, and it is typically used as a tool to help ensure that MCOs are spending a sufficient amount of their premium revenue on medical expenses and other high-impact initiatives. The federal regulations provide guidance on the MLR formula and which components should be included in the numerator and the denominator of the calculation. States must design managed care rates to anticipate an MLR of at least 85 percent, and MCOs must calculate and report on Medicaid MLR annually to inform the rate setting process. States have the option to set a minimum MLR of 85 percent or higher and require rebates from any MCOs that do not satisfy the minimum MLR. States have flexibility in determining the level of granularity for the MLR calculation, which may be established at the population level, some other level, or in aggregate. States may also allow new MCOs to waive MLR reporting requirements in their first year of participation.

Plan Performance and Payment Innovations

Beyond rate setting, federal regulations establish a range of tools that states can employ to encourage MCOs to better perform on areas of particular interest to a state. These tools include incentive and withhold payments, as well as state-directed provider payment options, outlined below. Notably, states may also set the algorithm that is used to determine auto-assignment of beneficiaries to MCOs, which can be an effective lever in driving program priorities.

Incentive and Withhold Arrangements (42 CFR 438.6)

States may apply incentives and withhold arrangements to drive MCOs towards Medicaid managed care program priorities. States must tie incentive and withhold arrangements to quality goals and performance outcome measures. Specifically, all incentive and withhold payment arrangements must support the goals and activities included in the state's managed care quality strategy. Under incentive arrangements, states provide an opportunity for MCOs to receive additional funds, exceeding the capitation payment, for meeting targets. Incentive arrangements may not exceed five percent of approved capitation payments (meaning incentive payments could total millions of dollars). Under withhold arrangements, a portion of an MCO's capitation payment is withheld pending achievement of particular goals. Unlike incentive arrangements, there is no explicit limit established on withhold arrangements; however the base rate minus any withhold that is not reasonably achievable must be certified as actuarially sound. The total withhold amounts themselves must also be reasonable. Often, the payback of any withholds are lagged by up to a year to allow for all reporting data to be collected. If the withholds are large, this lag can result in potential MCO cash flow issues.

Withholds and Actuarial Soundness

Certifying actuaries must consider the amount of the withhold that is reasonably achievable when developing actuarially sound capitation rates. Based on Actuarial Standard of Practice 49,⁴ the certification of the capitation rates should reflect the portion of the withhold targets that the MCOs can reasonably achieve. Capitation rates are to be certified as actuarially sound and reflect the portion of the withhold that can be reasonably achieved.

In establishing a provision for underwriting gain in the capitation rates, actuaries should also consider the effect of any performance withholds and incentives. However, the risk of not recouping those amounts does not need to be directly offset by risk margin. To the extent there are changes in the withhold amounts or quality measures, the underlying assumptions should be reviewed and incorporated into the actuarial soundness criteria.

Member Auto-Assignment Algorithm (42 CFR 438.43(d))

States must provide Medicaid beneficiaries an opportunity to make an active and informed decision about their MCO selection but are permitted to automatically assign beneficiaries to MCOs for enrollment in the absence of a decision. In setting the auto-assignment algorithm, states may consider criteria such as MCO quality and performance. A number of states currently leverage the auto-assignment algorithm as a tool to promote MCO performance in state Medicaid managed care program goals.

Sanctions (42 CFR 438.700)

States that contract with MCOs may establish sanctions founded on contractual violations, such as MCO discrimination or failure to provide medically necessary services. Sanctions or penalties require MCOs to pay damages to the State based on failure to meet established contractual requirements that are typically operational or administrative in nature. Unlike withholds and incentives, which typically are paid out only after a plan year has ended, sanctions may be used on a real time basis to address violations as they occur.

State-Directed Provider Payment Options and Other Opportunities for Innovation (42 CFR 438.6(c))

States have flexibility to direct MCOs to use provider payment methodologies for the purpose of advancing federal and state efforts to improve access, quality and efficiency in the Medicaid program. These options include directing MCOs to:

- Implement state-specified value-based payment (VBP) models such as bundled payments, shared savings or other arrangements intended to shift payment from volume to value.
- Implement multi-payer or Medicaid-specific delivery system or performance improvement initiatives, such as pay-for-performance arrangements or quality-based payments.
- Establish minimum or maximum provider reimbursement levels, such as payment tied to state Medicaid FFS or Medicare rate levels. Mandated payment rates or rate enhancements may be targeted at subclasses of providers, such as primary care providers or safety net hospitals. To the extent that states implement maximum provider reimbursement levels, they need to ensure the MCOs can reasonably manage the risk and have discretion in accomplishing the goals of the MCO contract.

In order to receive authorization from CMS for these arrangements, a state must demonstrate in writing that the arrangement meets certain requirements, including that it is based on utilization and delivery of services, advances the state's quality strategy, and does not condition provider participation on intergovernmental

⁴ [Actuarial Standard of Practice 49: Medicaid Managed Care Capitation Rate Development and Certification](#), Actuarial Standards Board, March 2015.

transfer (IGT) arrangements. At least one goal from the state's quality strategy must be linked to the payment arrangement, the state must develop an evaluation plan to assess the effectiveness of the directed payment, and CMS must grant approval prior to implementation. These state-directed provider payments are to be distinguished from supplemental or pass-through payments that must be phased out over time under the managed care regulations.⁵

STATE REGULATIONS

The core rate setting requirements for the Maryland HealthChoice program are codified in Maryland regulations, including the MCO requirements in COMAR §10.09.65.⁶⁷ Like the federal regulations, state regulations also address all aspects of the Maryland Medicaid managed care program. This section reviews the primary provisions related to HealthChoice rate setting and identifies the extent to which there are opportunities in the state regulations for alignment with, or optimization of, federal Medicaid managed care regulations.

Beyond federal and state regulations, another important basis for requirements are the states' contracts with Medicaid MCOs. And indeed, most states reflect their more detailed and specific requirements in their managed care contracts. Maryland relies heavily on its managed care contracts to delineate specific MCO requirements; however, unlike many states, Maryland also provides fairly specific and detailed MCO requirements in state regulations. Maryland regulations describe the rate setting methodology, annual rate levels for specific population, age and geographic groupings, and rate adjustment considerations. The regulations are incorporated in their entirety as an appendix to the State's contracts with Medicaid MCOs.

Table 2 summarizes the key provisions, and the subsequent paragraphs discuss the implications of these provisions for Maryland's opportunities to pursue new rate setting and VBP strategies.

Table 2: Summary of Key Provisions⁸

MCO Reimbursement COMAR §10.09.65.19	Requires payment to an MCO for each enrollee to be at a fixed capitation rate.
MCO Loss Ratio COMAR §10.09.65.19-5	The Health Service Cost Review Commission (HSCRC) governs Maryland's All-Payer rate setting system for inpatient and outpatient hospital services. COMAR §10.09.65.19(D) requires the HSCRC to be included in the rate setting process. On a fiscal year basis, HSCRC provides a hospital trend data file specific to Medicaid FFS and managed care, as well as an update factor for projections. The trends are incorporated into Medicaid managed care capitation rate development assumptions. Maryland may adjust capitation rates during the contract year to reflect service cost changes that result from HSCRC, as compared to data originally provided.
	Requires the state to determine an MCO's MLR. Describes the MLR process, components, and calculation.

⁵ States have leveraged the flexibility of "pass-through" payments to require MCOs to distribute supplemental payments to specific providers. Federal regulations phase out states' ability to use most pass-through payments by 2022 or 2027, depending on the type of payment, and eliminate the opportunity for states to put in place new supplemental payments.

⁶ [COMAR](#) serves as the official compilation of all regulations issued by Maryland's state agencies, including Maryland Department of Health (MDH).

⁷ [COMAR Online: Division of State Documents](#)

⁸ *Ibid.*

Table 2: Summary of Key Provisions⁹

<p>Quality Assessment and Improvement COMAR §10.09.65.03</p>	<p>Requires an MCO to have a continuous, systematic program designed to monitor, measure, evaluate, and improve the quality of health care services delivered to enrollees, emphasizing individuals with special health care needs. MCOs must comply with all access and quality standards established by the state and based on Healthcare Effectiveness Data and Information Set (HEDIS).</p>
<p>Sanctions COMAR §10.09.73.01A</p>	<p>Permits the state to impose sanctions on an MCO if the MCO has failed to comply with any applicable law, regulation, or contract term, or for other good cause shown.</p>
<p>Incentives COMAR §10.09.73.03</p>	<p>Requires all monies collected from the MCOs as a result of the imposition of a financial sanction to be deposited in the HealthChoice Performance Incentive Fund.</p>
<p>Referral to Behavioral Health Administrative Services Organization (ASO) COMAR §10.09.65.14</p>	<p>Requires MCOs to provide medically necessary primary behavioral health services to their enrollees, which may include referral to the behavioral health ASO. Requires MCOs to cooperate with behavioral health ASO to develop referral procedures and protocols.</p>

Rate Setting

MCO Reimbursement (COMAR §10.09.65.19)

Maryland uses a capitation rate setting methodology to determine per member per month (PMPM) payments to the HealthChoice MCOs based on an annual rate table. Maryland, in consultation with the Insurance Commissioner, may adjust capitation rates if an MCO’s MLR is less than 85 percent. The state must use the adjusted clinical group (ACG) system for eligible enrollees to determine an ACG assignment; define the risk adjustment categories; and assign individuals to risk adjustment categories based on age, gender, residence, and birth weight. Maryland is permitted to make interim rate adjustments that reflect changes in service costs due to program wide overpayment or underpayment of at least 0.2 percent. Maryland must also make specific rate adjustments for HIV/AIDS enrollees with Hepatitis C.

MCO Loss Ratio (COMAR §10.09.65.19-5)

The state must retain a contractor to review and determine the MCO loss ratio, commonly referred to as MLR, on an annual basis using data reported by each MCO through the HealthChoice Financial Monitoring Reports (HFMR). The components that make up Maryland’s MLR include total medical expense, total medical management, and utilization management. Maryland regulations describe the MLR calculation as well as the implications for insufficient annual MLRs (i.e., less than 85 percent), which may include the adjustment of an MCO’s capitation payment. This adjustment is, however, subject to a withholding limitation of no more than half of the total adjustment amount from a single monthly capitation payment, unless otherwise agreed upon by the MCO and the State.⁹ We understand Maryland is in the process of updating regulations to make the MLR calculations consistent with the federal Medicaid regulations in CFR 438.8.

⁹ While Maryland’s MLR regulations generally were in compliance with the federal regulations, they did not detail the specific revenue and expense items as required by the Final Rule. By providing additional clarification through itemization in the MLR template and in the state’s regulations, Maryland’s requirements are in the process of becoming consistent with the requirements for both federal and state calculations.

Plan Performance and Payment Innovations

Quality Assessment and Improvement (COMAR §10.09.65.03)

MCOs must comply with Maryland's access standards, quality standards, and levels of performance, which are outlined in the state regulations. MCOs are mandated to provide information on provider networks; utilization of services; and identification and management for individuals with special health care needs, as specified in COMAR §10.09.65.03. This section of the regulations also details a range of quality initiatives, including most notably the Value Based Purchasing program, which provides for financial incentives and disincentives of one percent of an MCO's total capitation for performance on quality measures. The quality measures are mostly related to HEDIS, but also include some state-specific measures. On an annual basis, the State must review HEDIS and other measures collected by the MCOs, including at least one measure from each bullet listed below:

- "Prenatal, perinatal, and postnatal care
- Screening and preventive services for women and children
- Children and adults with special health care needs"

Under the state regulations, Maryland must identify additional core performance measures and set performance targets on an annual basis, incorporating public input into the decision making process. The regulations specify a set of core performance measures. Each measure is evaluated separately and weighted as an equal proportion of one percent (e.g., one-tenth of one percent if there are ten measures) of the total capitation paid to the MCOs in the measurement year. Maryland has established three levels of performance for all measures: incentive, neutral, and disincentive. MCOs receive financial incentives of up to that amount for meeting or exceeding the incentive performance target for each measure. Conversely, MCOs face financial disincentives for failing to meet the minimum performance target for each measure. MCOs do not receive financial incentives or face financial disincentives for outcomes between the incentive and minimum performance targets. The four MCOs with the highest performance across the measures also have the opportunity to receive additional financial incentives of any remaining funds from the VBP program.

Effective January 1, 2017, the regulations specify 13 core performance measures. For each measure, MCOs receive up to 1/13 of one percent of total capitation for meeting or exceeding the incentive performance target and lose 1/13 of one percent of total capitation for failing to meet the minimum performance target.

2017 Core Performance Measures:

- Adolescent well care visits
- Adult Body Mass Index (BMI) assessment
- Ambulatory care for Supplemental Security Income (SSI) adults
- Ambulatory care for Supplemental Security Income (SSI) children
- Breast cancer screening
- Childhood immunizations — Combo 3
- Comprehensive diabetes care — HbA1c testing
- Controlling high blood pressure
- Immunization for adolescents
- Lead screening for children 12—23 months old
- Asthma medication ratio
- Postpartum care
- Well child visits, 3 to 6 years old

Effective January 1, 2019, the set of core performance measures decreases from 13 to 10, still allowing for the MCOs to receive financial incentives, face disincentives, or not be impacted. This change in policy comes in response to an evaluation of the HealthChoice incentive program conducted by Bailit Health

(Bailit) in 2016. Bailit recommended that Maryland reduce the number of quality measures to effectively increase the weight of each measure, which Maryland has since implemented.

2019 Core Performance Measures:

- Adolescent well care visits
- Ambulatory care for SSI adults
- Ambulatory care for SSI children
- Asthma medication ratio
- Breast cancer screening
- Comprehensive diabetes care — HbA1c control (<8.0%)
- Controlling high blood pressure
- Postpartum care
- Lead screening for children 12 through 23 months old
- Well child visits in the first 15 months of life

For each measure, MCOs will receive up to 1/10 of one percent of total capitation for meeting or exceeding the incentive performance target and lose 1/10 of one percent of total capitation for failing to meet the minimum performance target.

In addition to the Value Based Purchasing Program, other quality initiatives include the Consumer Assessment of Health Plans Survey (CAHPS); Maryland Healthy Kids/EPSTD audit; and performance improvement projects. Requiring NCQA accreditation for all Medicaid MCOs has also been a key component of Maryland's quality strategy.¹⁰

Based on a review of historical results, it is evident that the inclusion of a performance measure in the VBP program does have a positive impact on the particular measure and results in a higher percentage of members being provided those services. The results also show that the average percentage of members being provided those services by the MCOs is maintained while the measure stays part of the VBP program. However, it would also appear that once a measure is removed from the VBP program there is not as much focus by the MCOs to ensure those services are being provided at previously desired levels. A potential solution is to continue to refresh the list of performance measures every few years to ensure MCOs are providing appropriate coverage and performing functions that Maryland identifies as important.

MCOs are assessed annually in a Systems Performance Review (SPR) by an external quality review organization. Areas of review include enrollee rights, utilization review, or oversight of their delegated entities and process improvements in credentialing and recredentialing. MCOs that are found out of compliance with federal and state standards are subject to corrective action plans (CAPs) overseen by MDH.

Sanctions by the Department (COMAR §10.09.73.01)

Maryland may impose sanctions on MCOs that fail to meet applicable laws, regulations, or contract terms, or for other good cause shown. Sanctions may include fines, suspension of further enrollment, withholding of a portion of capitation, termination of the provider agreement, and disqualification from participation in HealthChoice.

Incentives (COMAR §10.09.73.03)

Maryland must deposit all money collected due to sanctions into the HealthChoice Performance Incentive Fund. This fund is designated to financially incentivize MCOs that meet or exceed performance targets.

¹⁰ [Maryland Medicaid Quality Strategy](#), Department of Health and Mental Hygiene, August 2015.

Referral to Behavioral Health ASO (COMAR §10.09.65.14)

Maryland currently carves out most behavioral health services from its MCO contracts, and the requirements applicable to Maryland and the MCOs are limited as compared to other provisions. Under Maryland regulations, HealthChoice MCOs are required to provide primary behavioral health services and to permit enrollees to self-refer to the ASO. While MCOs are required to “cooperate with the behavioral health ASO in developing referral procedures and protocols,” the regulatory language does not further define or prescribe requirements under this provision.

KEY TAKEAWAYS

Federal regulations outline relatively prescriptive standards for how states must establish their Medicaid managed care rates, reflecting the federal government’s financial interest in defensible rates. Maryland has also established a number of state-specific regulations that extend beyond minimum federal requirements such as the state’s Value Based Purchasing Program. While these state regulations offer significant transparency, they may also be a less flexible and more administratively burdensome vehicle for Maryland. Currently, the state must update several areas in the regulations annually – e.g., rate levels and performance measures – through the state rulemaking process. Maryland should explore re-focusing the state regulations to provide the overarching framework of general requirements while leveraging MCO contracts outside of the regulations for specific requirements that may evolve over time. Any effort to modify the rate setting process or to adopt new payment innovations will likely require changes to state regulations. Maryland has opportunities under federal and state regulations to leverage rate setting and value-based payment strategies to promote quality and value.

Regardless of the decision to administer via regulation or under administrative direction, Maryland should consider strengthening the requirements that govern the HealthChoice program. As discussed further in Chapter 4, there are a number of areas where Maryland should make more aggressive use of the existing tools to incentivize MCO performance. While Maryland has taken steps to incentivize quality performance by MCOs, the measures are limiting, and the incentive is fairly small for each, as compared to other states. Additionally, current requirements encourage payments from Maryland to MCOs, but does not explicitly incentivize providers. Levers such as the MLR requirements, withholds and incentives, sanctions, and the auto-assignment algorithm are already at Maryland’s disposal. Adding robust regulatory or contractual language around the quality performance provisions can help drive quality in Medicaid managed care.

IV. CHAPTER 2: MANAGED CARE RATE SETTING AND PAYMENT INNOVATION IN MARYLAND

OVERVIEW

Maryland implemented a Primary Care Case Management program in 1991, which when combined with a voluntary long standing HMO program evolved into its current form with the introduction of the HealthChoice program in 1997. Accessing coverage for a wide range of Medicaid services through the managed care delivery system of the HealthChoice program is mandatory for approximately 85 percent of Medicaid beneficiaries in the state.

MDH provides operational management and oversight of the HealthChoice program and contracts with MCOs to administer the care for Medicaid recipients. As of February 2018, the HealthChoice program includes nine MCOs overseeing care for approximately 1.2 million lives. Monthly capitation rate payments serve as the vehicle through which risk of the Medicaid program is transferred from the State to the MCOs. The capitation payments represent the projected cost of providing care for the covered beneficiaries and are developed using historical claims and encounters, eligibility, and diagnosis information.

As part of this Medicaid managed care study, Maryland requested that Milliman and Manatt review Maryland's rate setting methodology and examine the processes utilized in developing the capitated payment rates. During the course of Milliman and Manatt's review, members of MDH, Hilltop, other Maryland agency personnel and key stakeholders were interviewed to understand roles and responsibilities and the current rate setting process.

KEY TAKEAWAYS

Medicaid managed care programs across the country have many common characteristics, but the operation and structure of one state's Medicaid program is unique from any other. Milliman and Manatt identified aspects of Maryland's program and processes that, while unique, are utilized in similar capacities in other state Medicaid programs. The Milliman and Manatt teams believe that consideration or utilization of additional activities can help to improve upon the quality of care and functions of the rate setting process. Areas of focus include use of MCO encounter data, implementation of quality programs and technical improvements on base data and built-in assumptions. Additional details related to these and other recommendations are provided in Chapter 4 of this report.

The remainder of this section provides a description of the processes currently in place and discusses observations made during the study.

ROLES AND RESPONSIBILITIES

One of the main focal points in this study was developing a deep understanding of the different functions key stakeholders play in the rate development process to inform areas for potential modification or enhancement. Provided below is an overview of the different organizations in the State of Maryland and how they work together to develop the program's capitation rates.

Maryland Department of Health

Consisting of four major divisions, MDH's aim is to improve the health of Maryland residents and ensure access to quality health care. The Health Care Financing division is responsible for the implementation and operation of the state's Medicaid program. Working collaboratively with other parties, MDH and the Health Care Financing Division help to maintain the viability and sustainability of the Medicaid program.

MDH and other state representatives help structure the regulations that govern the Maryland Medicaid rate setting process. Maryland regulations identify the specific procedures and steps that must be followed for rate development. Most notably, COMAR §10.09.65.19 identifies how MCOs will be reimbursed. Two of MDH's main responsibilities in the rate setting process are to put these regulations into effect and ensure procedures are being followed.

MDH contracts development of the base data and projection of future experience to Hilltop. MDH works collaboratively with Hilltop and Optumas (the currently contracted actuarial services provider through UMBC's inter-agency agreement with MDH) to present the capitation rates to the MCOs and implement them in the rating system. MDH communicates with MCOs on a routine basis to keep stakeholders updated on the program and gather feedback on the overall status of the HealthChoice program. MDH also utilizes the services of other independent vendors to audit the program data and analyze aspects of the HealthChoice program.

The Hilltop Institute

The Hilltop Institute at the University of Maryland, Baltimore County (UMBC) is a non-partisan, university-based research organization. Hilltop was formed in 1994 in a unique collaboration with the Maryland Medicaid program. Hilltop provided technical assistance to the state in the development of the HealthChoice managed care program, launched in 1997, and since that time has played a lead role in the development of HealthChoice capitated payment rates. Over the years, Hilltop's role has evolved and today Hilltop provides a wide array of research, policy analysis, and data analytics to support MDH and other state agencies. To support rate development and other work for the state, Hilltop hosts an extensive data warehouse containing Medicaid eligibility data, claims, and encounters back to 1991, as well as Maryland hospital discharge data, Medicare claims, and nursing home assessment data. While Hilltop serves as the data analytics arm of the Maryland Medicaid program, the HealthChoice actuarial certification and rate calculations are performed by contracted actuaries.

Hilltop's relationship with MDH goes back to the beginning of Maryland's Medicaid managed care program, and Hilltop maintains the State's Medicaid and hospital discharge data warehouse dating back to 1991. This relationship provides quick and unfettered access to information that can be utilized by both MDH and its related entities. Hilltop also provides a source of continuity to the program since they have been involved in the program from the start, with certain staff being involved for over 20 years. Hilltop and MDH collaborate on most aspects of the rate setting process, and this unique state and university partnership brings strength to Maryland's program.

Working collaboratively with the State, Hilltop plays a vital role in the design and implementation of rate setting methodologies. Hilltop provides the bulk of the base data summary and analysis of program changes utilized in the capitation rate development. Additionally, Hilltop meets with MDH and the MCOs over the course of the rate setting process to deliver rate materials and present various data and program adjustments utilized in the capitation rate development.

Hilltop also performs the risk adjustment calculations and evaluates potential mid-year changes to the HealthChoice capitation payments. Discussion of the processes are provided in the following sections.

Certifying Actuary (Currently Optumas)

While Hilltop supports the majority of the Medicaid rate development, they contract with a competitively procured actuarial vendor, currently Optumas, to develop and certify the capitation rates. Utilizing summarized claims data and other financial information, Optumas is responsible for the development of trend assumptions, non-benefit expense adjustments, and creation of actuarially sound capitation rate ranges. MDH reviews the rate ranges and selects the final capitation rates that are submitted to CMS for review and approval.

Optumas also peer reviews the results of Hilltop's data summaries and other rate setting analysis. The evaluation of Hilltop's analysis allows Optumas to gain an understanding of program experience and be comfortable certifying the capitation rates without having access to the claim level information itself. In most other states, the certifying actuary typically receives detailed claims data from the state and performs the majority of the direct rate setting calculations.

Working collaboratively with Hilltop, Optumas develops the trend assumptions applied to the base experience and presents the trend analysis to the MCOs. Following development of the capitation rates, Optumas develops an actuarially sound rate range for the projected rating period and MDH selects the final capitation rates within this range. Along with Hilltop and MDH, Optumas presents information to the MCOs to illustrate the projected payments for the future period.

Health Services Cost Review Commission

The Maryland HSCRC operates as the State of Maryland's hospital rate setting authority, reviewing and establishing costs within the state's All-Payer Model that includes Medicaid. The HSCRC utilizes a Global Budget Revenue (GBR) approach to set annual spending targets for each hospital. Each hospital sets their reimbursement rates to align with their GBR, and the reimbursement rates are required to be consistent across all payers. The All-Payer model is required to demonstrate savings through reducing the total cost of care over time.

Each year, MDH provides member-level Medicaid eligibility data to the HSCRC. The HSCRC utilizes this information to develop Medicaid-specific hospital trend information. The state regulations require the HSCRC hospital trend file to be incorporated into the rate setting process. Optumas utilizes the HSCRC trend file, along with other data sources, to develop the annual trend assumptions used for rate development.

Individual MCOs and the MCO Association

The nine MCOs currently operating in the HealthChoice program vary in terms of size and coverage area. Additionally, they represent a mixture of local, provider-owned and national insurance organizations. The MCOs are responsible for administering the care management within the HealthChoice program and ensuring that requirements set forth by Maryland are being applied. The Maryland MCO Association was recently formed and is represented by Cornerstone Government Affairs. The MCOs work with an external actuarial firm (currently Wakely Consulting) to provide analysis and consulting on their behalf.

Auditors

Steps are taken to ensure the data being utilized in the rate setting process is appropriate and reasonable. MDH contracts with an external auditor to perform an agreed upon procedures audit of the HFMR data. The currently contracted company, Myers and Stauffer, reviews financial statement data against the reported HFMR information to verify consistency across the data sources. Additional auditing is performed on incurred but not reported estimates used to complete the base costs for historical time periods.

The remainder of this section provides a description of the processes currently in place and discusses observations made during this study.

GENERAL RATE SETTING PROCESS

The figure below provides a high level overview of the current operational procedures and methodologies being applied in the HealthChoice capitation rate development. Each step is described in detail in the following sections.



Base Data

Identifying and summarizing the base data used to develop future projected costs is at the core of any rate development process. As with most mature Medicaid managed care programs, Maryland relies heavily on the historical experience reported by the participating MCOs. Although the specific data sources may vary across states and programs, the best predictor of future costs are those borne out from past experience.

The main source of historical experience in the HealthChoice program is MCO reported financial data in the HFMR. Hilltop designs the HFMR templates, and the participating MCOs are required to report their financial data using the HFMR reporting template on an annual basis. The HFMR structure requires the MCOs to provide summarized cost and utilization counts (e.g., hospital days or number of services) for each of the specified HealthChoice rate cells. Table 3 provides a summary of the different rate cells present in the HealthChoice program. In addition to splits at the rate cell level, historical experience is provided for eight different regions across the state.

Table 3: Medicaid Capitation Rate Cell Summary		
Population	Rate Cell Category	Rate Cells
Families and Children	RAC Grouping – Children	RAC1G to RAC7G
Families and Children	RAC Grouping – Adults	RAC 1F to RAC7F
Families and Children	GEODEMS	Varies by age and gender
Disabled	RAC Grouping	RAC 10 to RAC18
Disabled	GEODEMS	Varies by age and gender
Childless Adults	RAC Grouping	RAC 1 (CA) to RAC 7 (CA)
Childless Adults	GEODEMS	Varies by age and gender
AIDS	N/A	N/A
HIV	F&C, Disabled, Childless Adults	N/A
SOBRA	N/A	N/A
Delivery / Newborn Event	Normal and Very Low Birth Weight (Kick Payment)	N/A
Hepatitis C Therapy	Kick Payment	Varies by treatment duration

The HFMR data is supplemented with MCO submitted encounter data, which historically has been limited to include utilization information but not unit cost information. The encounter data is currently utilized to perform reasonableness checks of the utilization information reported in the HFMR data, analyze historical utilization trends, and evaluate potential program changes to apply to the base period data to project the data to the contract period. The encounter data is also used directly for pharmacy rate development, since the data includes reliable utilization and cost information for pharmacy services. Finally, the diagnosis information in the MCO encounter data, in conjunction with FFS claims experience, is used to assign members to the risk adjustment categories discussed later in this section.

MDH indicated they began requiring MCOs to include financial (or cost) information in the encounter data submissions effective January 1, 2018. The inclusion of cost related information can be a critical component in validating the encounter data against the HFMR data and incorporating encounter data directly into the rate setting process. As this change is reflected in the submitted data there will be issues to address to ensure its credibility and use in rate setting. For example, it will be important to be able to identify sub-capitated encounters in the data and understand how the MCOs populate cost information for sub-capitated encounters.

The HFMR also includes non-benefit expenses, or administrative costs. The HFMR data is audited each year by Myers and Stauffer to assess the reasonableness of the MCO reporting in relation to audited financial statements. The audit results for each reporting MCO are communicated to MDH, Hilltop, and the individual MCOs.

Hilltop further adjusts the audited base data for any non-state plan services to be covered outside of the capitation rate. Hilltop receives the financial data twice a year, with preliminary information typically shared in May and the final information shared in subsequent months.

A number of services are not reported in the HFMR as they are not covered under the HealthChoice managed care contracts. The majority of these services fall under behavioral health, long-term care and some high-cost drugs.

Trend Adjustments

Trend assumptions are used to project the base period data to the contract period. Typically, in Medicaid rate development, the annual trend assumptions are developed separately to capture projected changes in utilization and unit cost (i.e., changes in unit cost reimbursement). Analyzing historical changes in cost and utilization patterns is a critical component in projecting future costs. However, other data sources, such as trend information from other states, national trend reports, and other information are often used to supplement historical trend analysis since future trends may vary materially from the historical trends.

Optumas is responsible for developing the annual trend assumptions for the HealthChoice capitation rates. The trend assumptions are set by broad service category. Separate trends are developed for the Medicaid expansion population, since the morbidity profile of this group varies from other HealthChoice covered lives.

The current process utilized by Optumas considers multiple sources of trend information and also reviews longitudinal trend studies to ensure they monitor emerging trends and incorporate them into the prospective rates. As discussed in the HSCRC role section, components of the All-Payer Model unit cost trend factors are also used directly in the development of initial and mid-year hospital trend factors.

Optumas, along with Hilltop, presents the proposed draft trend ranges to the MCOs in advance of the final rate development.

Other Base Data Adjustments

Additional adjustments to the base data are applied to reflect changes in covered benefits or populations, changes in provider reimbursement, or other programmatic changes between the base period and the contract period. Hilltop typically develops the magnitude and factors for adjustment, with Optumas signing off following a thorough review of the development for each factor. Changes to the base data, either retrospectively or prospectively, are documented in the rate certification memorandum. The process for developing these adjustments is initially performed by Hilltop and discussed in detail with Optumas. Upon agreement, the issue or adjustment is presented to the participating MCOs.

The most notable adjustment applied to the base data is referred to as the cost containment or outlier adjustment. The purpose of this adjustment is to review MCOs' financial experience and identify those whose total costs are higher than an established relative benchmark of 102 percent of the statewide average. Both medical and administrative costs are combined and compared to total revenue to establish a combined loss ratio. MCOs with combined loss ratio values more than two percent above the HealthChoice MCO average are identified as outliers. The costs in excess of the two percent threshold are excluded from the base rate development and produce reductions to the overall base period experience. By comparing MCO financials on a ratio basis, the experience can be evaluated on a normalized basis, with the intention of removing excess costs of inefficient MCOs in developing future rates.

The relative benchmark is a moving target from year-to-year (with the result set on statewide averages) and may not fully account for potential lack of care management or higher than necessary utilization. It is important to monitor MCO performance and adjust as appropriate to accomplish the State's goals for improving quality in the Medicaid managed care program.

Final Capitation Rates

Non-benefit expenses and MCO profit and risk margin are added to the projected claims to develop the final capitation rates. The administrative expense assumptions are developed by reviewing the reported HFMR data and supplemental financial schedules. The administrative loads are developed by Optumas using the HFMR data and projected changes between the base period and the contract period. The projected administrative expenses are then examined to determine whether they exceed the maximum amount set by the State. The cap is a percentage of medical spend and varies each year. An additional allotment is made for MCO profit and risk margin.

Optumas develops an actuarially sound rate range by varying trend and administrative load assumptions. MDH then selects the point in the range used to calculate the final capitation rates that are certified, submitted, and documented to CMS.

Per COMAR §10.09.65.19, the capitation rates may be adjusted to reflect changes in service costs during the contract year. These changes may be based on certain assumptions utilized in the rate development process or the State Legislature enacted programmatic changes that affect the anticipated costs for services provided by the MCOs. The mid-year adjustment considers All-Payer Model information produced by the HSCRC and then incorporated into the rates to determine if a change is necessary. In addition to the All-Payer model adjustments provided by HSCRC, changes are considered per the noted HealthChoice regulations. Hilltop and the contracted actuary work to quantify the impact of those changes and develop adjusted results. If necessary, updates are made to the capitation rates and an amended certification report is provided to CMS and the MCOs.

Regional Adjustment

Capitation payment rates are initially developed at the statewide level, but further adjustments are made at the regional level. Hilltop conducts an analysis of the cost differential between the Families & Children and Disabled PMPM costs in each county of the State. Based on this analysis, regional groupings were developed for Baltimore City; Montgomery; and all other areas of the state.

Rural Access Incentive

Under federal rules, HealthChoice must provide a choice of at least two MCOs in any jurisdiction unless a region has been officially defined as a rural area. The Rural Access Incentive program (RAI) was implemented to ensure this requirement is met and to improve access to care and choice for individuals in historically underserved areas. Under current regulations governing RAI, MDH must allocate incentive payments to MCOs that operate in certain rural counties in the State in accordance with a specified methodology. COMAR §10.09.65.19-3 specifies the 13 counties and a maximum semi-annual amount of \$11 million based on the number of MCOs in a county and the total MCO enrollment in each county.

Risk Adjustment

Risk adjustment is used to reflect estimated acuity differences between enrolled members for each MCO. The application of risk adjustment is key to allowing for morbidity variances across MCOs to not adversely affect one MCO versus another. The application of risk adjustment in the Maryland Medicaid program varies depending upon rate cell and beneficiary eligibility. In addition to accounting for variances in risk profiles across MCOs, the application of risk adjustment in the HealthChoice program is utilized to group beneficiaries into common rate cells.

Risk adjustment methodologies in place within the HealthChoice program utilize Johns Hopkins University Adjusted Clinical Group (ACG) system, with the exception of identifying beneficiaries for the HIV and AIDS rate cells. The first role of the ACGs is to aid in grouping beneficiaries with similar risk profiles. Thus, beneficiaries with higher morbidity profiles will be placed into a rate cell with one another, separating them from groupings of lower cost profile members. The different rate cells are referred to as risk-adjusted cohorts (RACs). Across the HealthChoice program, 30 different RACs are utilized to categorize members in the Families & Children, Disabled, and Childless Adult populations. Members must have at least six months of eligibility during the assignment year to be assigned to a RAC. Diagnosis information is utilized to bucket the individuals into the different RACs. Members of the HealthChoice program with less than 6 months of eligibility are categorized into Geographic and Demographic Cells (GEODEMs) for the different populations.

Hilltop uses a hierarchy system to assign risk adjustment groupings. First, members with AIDS or HIV, as identified by the Maryland Prevention and Health Promotion Administration, are categorized separately. These members are in a separate rate cell and the payments are not risk adjusted at the individual level. Second, Hilltop identifies members in the SOBRA eligibility category. Then, members with at least six months of eligibility are assigned into a RAC, and the remainder are assigned into the GEODEM rate cells. Separate retrospective kick payments are established for members with Hepatitis C therapy drugs and members with newborn or delivery events. The application of this rate cell hierarchy is based on a two year lag from assignment year to payment year. For example, the 2018 capitation payment categories are based on 2016 diagnosis information and resulting RAC assignments.

In addition to utilizing risk adjustment to categorize members into rate cells, the ACGs are also utilized to adjust for risk within a rate cell. Members placed into the GEODEM rate cells receive a concurrent MCO risk score (adjusted for overall budget neutrality).

Further risk adjustment is applied to the HIV and AIDS rate cells across MCOs based upon the Hepatitis C mix of each MCO for each cohort. The delivery and newborn group is also split between Very Low Birth Weight and normal weight.

INTERACTION OF KEY STAKEHOLDERS DURING THE RATE SETTING PROCESS

MDH engages the MCOs in seven monthly meetings throughout the rate setting process, followed by one-on-one meetings with each MCO after the draft capitation rates are released. MDH works to achieve a strong sense of partnership with numerous opportunities for MCO engagement.

The development of the capitation rates is documented in a rate certification report produced by Optumas and disseminated to stakeholders in the HealthChoice program. Information related to adjustments from the base data and step-by-step calculation of the rates are illustrated for each rate cell.

During the course of the rate setting process, the MCOs have the ability to review the draft capitation rates, and any additional MCO concerns and questions are taken into consideration for the final rate development. Typically, these comments and questions are voiced during routine meetings with stakeholders throughout the course of the year.

V. CHAPTER 3: MANAGED CARE RATE SETTING AND PAYMENT INNOVATION IN OTHER STATES

OVERVIEW

An important component of this managed care study included interviews with state Medicaid agency staff from three different states. These discussions provide context to the analysis and form a backdrop for the recommendations. Before choosing which states to interview, Milliman and Manatt met with Hilltop and MDH to identify the policies, practices, and program characteristics of interest to Maryland:

- Mature Medicaid managed care program that has been in place for a number of years
- Mixture of national, local, and provider-led MCOs
- Emphasis on driving quality and value through the rate setting process and other initiatives
- Initiatives that target the integration of physical and behavioral health
- The willingness and availability of key state contacts to participate in interviews

Based on these factors, Milliman and Manatt selected three states to interview: Michigan, New York, and Tennessee. Table 4 shows some of the factors associated with each state that were of interest to the study.

Table 4	
State	Factors
Michigan	<ul style="list-style-type: none"> ▪ Many MCOs, including provider-led MCOs ▪ Focus on encounter data quality monitoring and improvement ▪ Efforts in the coordination and integration of behavioral and physical health
New York	<ul style="list-style-type: none"> ▪ Many MCOs, including provider-led MCOs ▪ Strong VBP initiatives, including a roadmap detailing the state's intended transition from volume-based to quality-based payments and rewarding MCOs with higher percentages of payments tied to value-based contracts that account for both quality and efficiency ▪ Transition of rate setting from financial data to encounter data
Tennessee	<ul style="list-style-type: none"> ▪ Long-standing Medicaid managed care program ▪ Focus on VBP initiatives, including the development and implementation of episode-based payments

Through the interview process, the Milliman and Manatt team identified operational processes that were successful in the comparator states. Rate setting innovations these states have considered, and in some cases implemented, were also identified.

GENERAL CHARACTERISTICS

Understanding the context of the Medicaid managed care programs in Michigan, New York, and Tennessee is helpful to provide context to the concepts addressed in the state interviews.

- Michigan currently contracts with 11 MCOs. Two of the MCOs are affiliated with hospital systems, and there is a mixture of local versus national MCOs. MCOs are not required to participate statewide, but their service area must include all counties in the rate regions in which they participate (i.e., they cannot selectively participate in a subset of counties within the region).
- Similar to Michigan, New York contracts with a mixture of local, provider-sponsored, and national MCOs. In total, there are 16 participating MCOs.¹¹

¹¹ The New York content is specific to its Mainstream Managed Care program only, and does not include Managed Long Term Care plan counts or rate setting methodology information.

- Tennessee contracted with many different MCOs, including a number of new MCOs, when the TennCare managed care program was first implemented. In their most recent MCO procurement, however, they intentionally selected only 3 MCOs and required each MCO to cover the entire state. The State has found that working with fewer statewide MCOs gives them more leverage and results in more operational efficiency since they are working with fewer MCOs.

OPERATIONAL PROCESSES

Because of the differences between states, some processes that are effective in one state may not be as effective in another state. However, understanding why different processes are effective can be useful in improving processes even within different constraints.

Primary Roles and Relationships of Key Stakeholders

The division of responsibilities in rate setting varies, often driven by department and agency structure as well as the types of resources available within the state. In Michigan and Tennessee, external actuaries are responsible for all aspects of calculating the capitation rates. The state provides the data to the actuaries and informs the actuaries of applicable policy changes. The actuaries process and validate the base data, develop the rating assumptions and risk score adjustments, and determine the capitation rates. The state also provides feedback about how the assumptions and adjustments align with the State's expectations, especially with regard to policy or operational changes.

In New York, the State has a more direct rate setting role. The external actuaries develop actuarially sound rate ranges, but state staff (along with actuarial support) is responsible for calculating the final capitation rates and ensuring they fall within the actuarially sound rate ranges. In all three states, the state and the external actuaries jointly present the capitation rates to the MCOs.

Michigan has found that operational issues and rate issues are frequently linked together; therefore, the actuarial and managed care divisions maintain a strong partnership. The actuarial division is responsible for maintaining regular contact with the external actuaries and providing encounter data on a regular basis, while the managed care division is responsible for day to day operational issues, contract management, and developing quality measures. Michigan's FFS policy division also provides support for MCO contracting, and often shares information on the impact of changes in Medicaid FFS reimbursement.

All three states place high importance on their relationship with the MCOs. For example, Michigan holds a kickoff meeting at the beginning of the rate setting process to discuss data and proposed methodology changes, and collect MCO feedback. The State continues to meet on a regular basis with the MCOs during the rate setting season to discuss operational, administrative, and rate setting issues. The state and its contracted actuaries present the draft rates to the MCOs and meet with individual MCOs to address questions upon request.

Stakeholder Engagement

States have taken different approaches to ensure stakeholders are engaged in program objectives, but each of the approaches identified in the course of this study consistently involved transparency and collaboration. In Michigan, for example, the state works collaboratively with the MCOs on quality measure updates to allow the MCOs time to address potentially impactful data concerns prior to the implementation of new measures. In New York, a significant majority of the state's work to improve quality and value in the Medicaid managed care program has centered on stakeholder engagement, with a focus on communication and providing a consistent message. New York's stakeholder engagement outreach has extended to MCOs in concert with individual physicians, representative associations and community based organizations based on the idea that consistent messaging to all stakeholders better enables the MCOs to incorporate the quality adjustments from the capitation rates directly into their contracts with providers. The benefit of this approach is that MCOs and providers can then work together to address a consistent set of quality metrics and incentives that exist between the State and the MCOs that are passed down to front line

provider groups. Tennessee works with MCOs frequently with respect to reporting and obtaining feedback on new ideas. Additionally, prior to implementing new quality initiatives, Tennessee requires MCOs to produce reports for providers to increase their awareness of their current quality measure outcomes and to engage the providers in quality improvement efforts.

Use of Encounter Data for Rate Setting

The extent to which states use encounter data in rate setting varies and is often related to the quality of the encounter data and state efforts to monitor and improve encounter data quality.

Michigan uses encounter data for rate setting and devotes significant time and effort to monitoring and validating the encounter data. Michigan utilizes an encounter quality initiative (EQI) whereby MCOs are required to submit financial reporting data every four months, and the financial data is compared to the encounter data warehouse. Historically, the use of the EQI reports helps drive what data is included in the rate setting process and assists in determining what costs are not credible and may not be reliable in developing base experience. Currently, the state does not have financial or membership consequences for MCOs that do not have reliable encounter data, however the State is working on incorporating the EQI results into their quality withhold measures to provide further incentives for MCOs to improve their encounter data completeness and quality.

New York's capitation rates are primarily developed from MCO financial data, although encounter data is used to develop pharmacy rates and to validate the financial data. Similar to issues found in other states, the Medicaid managed care encounter data in New York does not meet actuarial standards to be used for base data in rate setting given the number of participating MCOs (16) and some recent encounter intake system changes which have occurred. However, the State is working diligently with MCOs to improve the encounter data reporting quality so it can be utilized directly for future rate setting.

Similar to Michigan, Tennessee primarily relies on encounter data for rate setting. However, they also validate the encounter data against MCO financial data and make adjustments where necessary to bring the encounter data to the level of claims reported in the financial data.

In all three states, diagnoses from the MCO encounter data is used to develop risk score adjustments even if the encounter data is not utilized for capitation rate development.

Integration of Physical and Behavioral Health Care Coordination

States Included in Interviews

Although historically behavioral health care was often carved out separately from physical health care, states have recently begun exploring whether overall care coordination and outcomes are better when the provision of physical and behavioral health care services are fully integrated. However, several of the comparator states continue to maintain separate programs for members with severe behavioral health conditions due to the unique needs of this population.

Michigan currently carves out specialty behavioral health and substance abuse services to capitated pre-paid inpatient health plans (PIHPs) who work with community mental health organizations. Through its Pathway to Integration 1115 waiver, Michigan is developing pilot programs to improve physical and behavioral health care integration. The waiver includes funding for alternative payment models based on quality outcomes, shared savings / shared risk models, and care coordination payments for high utilizers. The state is working to develop three pilots, but these pilot programs are not yet clearly defined. The state anticipates beginning the pilot programs during calendar year 2019 through contracts between the state and MCOs operating in the selected regions of the state.

In both New York and Tennessee, physical and behavioral health are integrated with some exceptions, but both states continue to explore opportunities to improve care coordination. New York provides care for

members with select serious mental illness and substance use disorders through Health and Recovery Plans (HARPs). New York also employs a total care arrangement that focuses on a complete care spectrum, emphasizing the need to coordinate and integrate physical and behavioral health (including substance use disorder treatment). This model rewards based on avoidable hospital use and avoidable complications, which further requires providers to implement practical processes that integrate behavioral health and physical health (e.g., warm handoffs versus cold referrals). New York's integrated primary care (IPC) arrangement pools together services for primary care and 14 chronic conditions, of which half are behavioral health conditions. Similarly, Tennessee has a health homes program for members with severe mental illness (SMI). For non-SMI members, behavioral health is integrated into the state's episodic payment program. Tennessee also developed a care coordination tool for providers that includes real-time physical and behavioral health admission and discharge information to enhance care coordination efforts.

Other States

In a recent issue brief,¹² Kaiser Family Foundation indicated that 22 states have an approved or pending 1115 behavioral health waiver as of November 2017. Four states have current waivers that provide initiatives geared towards integrating behavioral and physical health benefits:

- Arizona provides coordinated benefits to children with specific behavioral conditions and adults with serious mental illness through specialized MCOs.
- California offers "Whole Person Care" pilot models which include additional funding to build infrastructure needed to support mental and physical health benefit integration, improve health outcomes, and reduce unnecessary spending for individuals for high-cost, high-risk individuals.
- Massachusetts' waiver will be used to create Accountable Care Organizations (ACOs) to integrate physical, behavioral health, and long term care benefits.
- New Hampshire's Delivery System Reform Incentive Payment waiver provides incentive payments to providers based on performance measures such as the integration of physical and behavioral health services. Over the course the demonstration, utilization and system transformation metrics will be used to measure Integrated Delivery Network (IDN) progress toward meeting targeted levels of improvement against outcome-based performance indicators. New Hampshire plans to calculate three sets of measures – mental health-focused HEDIS measures, physical health-focused HEDIS measures for the behavioral health population, and Adult Experience of Care Survey – over the course of the demonstration.¹³ The IDNs will also calculate the following measures for Calendar Year 2017: Use of Comprehensive Core Standardized Assessment; Follow-Up Plan for Positive Screenings for Potential Substance Use Disorder and / or Depression; Use of Selected U.S. Preventive Services Task Force A&B Services for Behavioral Health Population; and Smoking and Tobacco Cessation Screening and Counseling.¹⁴

Two other states (Illinois and North Carolina) have pending waivers that include initiatives to improve physical and behavioral health integration:

- Illinois plans to use waiver funding to develop training and technology to implement health homes and workforce development programs.
- North Carolina's waiver application includes several initiatives for integrating physical and behavioral health and improving behavioral health capacity. North Carolina intends to create specialized, integrated MCOs for individuals with significant behavioral health needs, intellectual / developmental disabilities (I/DD), and traumatic brain injury. Individuals enrolled in

¹² [Key Themes in Medicaid Section 1115 Behavioral Health Waivers](#), Kaiser Family Foundation, November 2017.

¹³ [DSRIP Composite Outcome Measures](#), New Hampshire Department of Health and Human Services, April 2017.

¹⁴ [Review of IDN Calculated DSRIP Outcome Measures](#), New Hampshire Department of Health and Human Services, April 2017.

these MCOs will have access to an expanded set of behavioral health benefits and enhanced care management. North Carolina is also planning to build behavioral health and I/DD-specific health homes and is seeking waiver funding to build care management capacity and workforce for these entities.

VALUE-BASED PAYMENT INNOVATIONS

Following CMS's endorsement of value-based payments in the Medicaid Managed Care Final Rule released in 2016, many states are exploring VBP mechanisms. One consistent goal of VBP initiatives is to base payments on the value (i.e., quality and cost) of care, rather than on the quantity of services provided.

In recent years, states have increased their emphasis on value-based payments and pursued VBP initiatives through managed care. This section reviews the role of VBP in the pursuit of improved quality and outcomes and reduced cost of care in Medicaid managed care, highlighting leading practices by states in state payments to Medicaid MCOs and MCO payments to providers. Beyond the states interviewed, Milliman and Manatt also drew from our knowledge and understanding developed from work in other states, as well as literature, to identify potential best practices and trends.

Value-Based Payment Methodologies

VBP methodologies can vary widely and include pay-for-performance programs that reward levels and improvement of quality measures, shared savings programs that allow providers to share in overall gains or losses based on the overall cost of care compared to benchmarks, and capitated arrangements that transfer full risk to providers.

Incentive and Withhold Payments

In a Medicaid managed care system, the State Medicaid agency makes capitated PMPM payments to MCOs to cover the cost of benefits the MCO must provide to Medicaid enrollees as well as the administrative costs associated with providing those benefits. Many states currently deploy incentive payments and withhold arrangements that can affect states' payments to MCOs. These arrangements, which apply to the financial relationship between the State and the MCOs, allow the State to financially reward MCOs for meeting performance targets specified in the contract. This means that some of the MCOs' payments from the State may be at risk.

- **Incentive payments** are any payment mechanism under which an MCO may receive additional funds, over and above its capitation payment, for meeting targets specified in the contract. Incentive payment arrangements may not allow payment to MCOs to exceed 105 percent of approved capitation payments. This means incentive payments can be up to 5 percent of an MCO's capitation revenue.
- **Withhold arrangements** are any payment mechanism under which a portion of an MCO's capitation payment is withheld from the MCO, and some or all of that withheld amount is paid when the MCO meets targets specified in the contract. The targets for a withhold arrangement are distinct from general operational requirements under the contract. (Arrangements that withhold a portion of a capitation rate for noncompliance with general operational requirements are a penalty, not a withhold arrangement.)

While states have long been able to utilize such payment arrangements, the Medicaid managed care regulations require states opting to do so to link payment made through these arrangements to the states' managed care quality strategies. Specifically, all incentive and withhold payment arrangements must support the goals and activities included in state's managed care quality strategy.¹⁵

¹⁵ [The Medicaid and CHIP Managed Care Final Rule](#), CMS, April 2016.

In October 2017, Kaiser Family Foundation released the *50-State Medicaid Budget Survey*¹⁶ which highlights the recent trend towards the adoption of VBP requirements in state MCO contracts. In the survey, 37 states reported one or more MCO quality initiatives in place during Fiscal Year (FY) 2017. Quality-based capitation withholds or penalties and pay-for-performance programs were common VBP strategies among states with managed care contracts. For acute care services, withhold amounts ranged from one percent in Michigan, Oregon, and Washington to five percent in Minnesota and Missouri. Looking ahead to FY 2018, 11 states plan to implement new or expanded quality initiatives with an emphasis on pay-for-performance.

Alternative Payment Models

A report by Bailit and the National Association of Medicaid Directors, *The Role of State Medicaid Programs in Improving the Value of the Health Care System*,¹⁷ details the wide array of VBP initiatives taking place across state Medicaid programs, with a focus on MCO payments to network providers. States are increasingly contractually requiring MCOs – often with financial consequences – to implement Alternative Payment Models (APMs), which shift provider reimbursement from FFS to value. The most frequently used APMs include:

- Additional payments that support delivery reform: Providers (typically primary care providers) receive a PMPM payment to be used for a wide variety of purposes, in exchange for meeting performance expectations. This approach is currently being implemented in at least 12 states.
- Episode-based payments: A specific provider is held accountable for the costs and quality of a defined period of time. Episode-based payments are currently being implemented in at least four states and considered by a number of others.
- Population-based payments: One or more providers are held accountable for spending targets that cover the vast majority of health care services to be delivered to a specific population. These payments are currently being implemented by at least nine states.

The report acknowledges that APM efforts present ample opportunity for multi-payer reform as well as a targeted focus on behavioral health services, long-term services and supports, and social determinants of health. However, effective implementation requires intensive resources, strong leadership, and data collection / sharing at the state level. Most notably, encounter data and sharing capabilities must be in place to build on VBP initiatives.

Kaiser Family Foundation's *50-State Medicaid Budget Survey*¹⁸ reports that 13 states identified a specific target in their MCO contracts for the minimum percentage of provider payments, network providers, members that MCOs must cover via APMs in FY2017 (compared to only five states in FY 2016). Of these 13 states, eight required MCOs to adopt specific APMs (e.g., episode of care payments, shared savings / shared risk, etc.). In FY 2018, four additional states plan to require specific APMs and five others will encourage specific APMs.

Specific State Efforts to Promote VBP

While most states have implemented, or plan to implement, some level of VBP requirements or incentives in their MCO contracts, states are highly variant in the level of risk passed on to providers, the level of prescriptiveness in defining qualifying VBP arrangements, and the degree of infrastructure support provided by the State. States with more prescriptive, higher risk VBP programs also tend to have more rigorous and

¹⁶ [Medicaid Moving Ahead in Uncertain Times](#), The Henry J. Kaiser Family Foundation and the National Association of Medicaid Directors, October, 2017.

¹⁷ [The Role of State Medicaid Programs in Improving the Value of the Health Care System](#), Bailit Health and the National Association of Medicaid Directors, March 2016.

¹⁸ [Medicaid Moving Ahead in Uncertain Times](#), The Henry J. Kaiser Family Foundation and the National Association of Medicaid Directors, October, 2017.

heavily funded stakeholder engagement processes. Table 5 outlines key efforts by specific states to promote VBP.

Table 5: VBP Examples of State Payments to MCOs	
State	Description
Michigan*	Michigan currently applies a one percent withhold to the capitation rates, and one quarter of the withhold amount must be attributed to value-based services. The withheld funds are fully paid back to MCOs in the aggregate, but they are redistributed such that better-performing MCOs are rewarded with a higher proportion of the withheld funds than lower-performing MCOs. In other words, high-performing MCOs can earn back in excess of their one percent withhold. The withhold distribution is currently based on MCO Healthcare Effectiveness Data and Information Set (HEDIS) scores, but Michigan is looking to incorporate other types of quality metrics, such as the (EQI) measures described above. Michigan also incorporates these same quality metrics into their auto-assignment algorithm, assigning a higher percentage of members to MCOs that achieve higher quality metrics.
Minnesota	The MCO contract puts five percent of MCO capitation payments at risk based on the MCO achieving certain performance metrics, which in 2018 include comprehensive dental services, compliance with the Minnesota Department of Health licensing requirements, emergency department utilization, hospital admission rates, and 30-day readmission rates. The State withholds these funds until July of the subsequent contract year and utilizes a point system to determine what portion of the withheld funds will be returned to individual MCOs. The MCO contract limits the amount of unreturned funds to 10 percent of the withhold, so ultimately 0.5 percent of capitation payments are at risk. ¹⁹
New York*	<p>New York currently pays quality incentives to MCOs equal to approximately 2.5 percent of capitation and based on National Committee for Quality Assurance (NCQA) and HEDIS metrics. Some programs, such as HIV, are excluded from the incentive payments. New York's Office of Quality and Patient Safety developed the metrics with significant stakeholder input, and adjustments are made over time as needed.</p> <p>New York recently worked with external consultants to develop a "VBP Roadmap" to transform the Medicaid reimbursement system into a value-based methodology.²⁰ Beginning in April 2018, MCOs will be assessed a penalty if they fail to transition a sufficient amount of their total managed care contracted dollars to a VBP arrangement (at one of three levels of risk sharing). Incentive payments for MCOs will vary based on the level of risk transferred to providers, with the highest incentive payments for capitated contracts and the lowest incentive payments for upside-only provider risk sharing arrangements. New York has set a goal to attain 80 percent VBP contracting by 2020, with full implementation of value-based quality and efficiency adjustments into the capitation rates by 2021.</p> <p>While New York is currently in the data collection and analysis stage, the State ultimately expects MCOs to incorporate the quality and efficiency metrics used in the capitation rate adjustments directly into their provider contracts so that MCOs and providers are working together towards the same quality goal. MCOs must also provide data to both the State and providers to support analysis and monitoring of the quality metrics.</p>

¹⁹ [Contract for Medical Assistance and MinnesotaCare Services](#), Minnesota Department of Human Services, January 2018.

²⁰ [A Path Toward Value-Based Payment: Annual Update](#), New York State Roadmap for Medicaid Payment Reform, June 2016.

Table 5: VBP Examples of State Payments to MCOs	
State	Description
Ohio	Medicaid MCOs must prepare and submit to the state Medicaid agency a strategy for ensuring that 50% of its payments to providers are “value-oriented” by 2020. Value-oriented payments are defined in the contract as payments designed to either reduce unnecessary payment and care or tie payments to provider performance on the quality and cost of care. ²¹
Pennsylvania	The MCO contract includes a pay-for-performance incentive program under which MCOs can earn up to 1.5 percent of their capitation and other revenue if they perform well on eight HEDIS measures, including adolescent well visits, frequency of ongoing prenatal care, post-partum care and comprehensive diabetes care, among others, and a state-specific measure aimed at reducing potentially preventable readmissions. In addition, to benchmark performance, the State rewards improvement on these measures, where the payment amount is tied to the degree of improvement. ²²
Tennessee*	<p>Tennessee has developed an episodic payment methodology into their Medicaid reimbursement, and MCOs are required to incorporate these episodic payments into their contracts with providers. For any of the seventy-five specific health events or conditions identified as episodes of care, a workgroup comprised of operational, technical, and clinical resources identifies the type of provider deemed to be in the best position to influence the member’s outcome. That provider is then given information designed to allow for effective management of the quality and cost of care. The objective of this program is to educate providers about the relative cost and quality of services to enable the providers to make more informed decisions about their patients’ care. Tennessee began with three episodes of care and has phased in other episodes over time. To improve stakeholder engagement, Tennessee implements a preview year for each new episode of care during which the MCOs provide reports to providers to allow comparisons to results for other providers. After the one-year preview period, the first performance year begins. Bonus payments and take-backs to and from providers are handled by the MCOs.</p> <p>Tennessee also makes incentive payments to MCOs with high performance on select HEDIS measures and year-over-year improvement against contract standards. However, the financial impact of this incentive program is small. Therefore, the State believes MCOs are more motivated by the competition with other MCOs versus the financial incentives.</p>
Texas	The State requires MCOs to conduct gain sharing pilots in collaboration with network physicians and hospitals aimed at reducing inappropriate service utilization, such as inappropriate admissions and readmissions. Under these pilots, network physicians and hospitals that meet certain performance targets share a portion of MCOs’ savings and may receive quality incentive payments. These pilots are described in the state’s current quality strategy, as well as in its model MCO contract. ²³

²¹ [Ohio Medical Assistance Provider Agreement for Managed Care Plan](#), Ohio Department of Medicaid, July 2016.

²² [Exhibit B HealthChoices MCO Pay for Performance Program](#), Health Choices Agreement Exhibits, Pennsylvania Department of Human Services, January 2016.

²³ [Texas Medicaid Managed Care Quality Strategy](#), Texas Health and Human Services Commission, 2012-2016; [Uniform Managed Care Terms & Conditions](#), Texas Health and Human Services Commission, September 2015.

Table 5: VBP Examples of State Payments to MCOs	
State	Description
Virginia	MCOs must report annually to the State on its VBP agreements with providers, accompanied by a written strategy for increasing the share of its provider reimbursement made through VBP. MCOs are also required in their contracts to partner with providers to increase participation in integrated delivery systems, improve health outcomes and align administrative systems to improve efficiency and member experience. As part of this requirement, MCOs must enter into contractual arrangements with health home-like entities that include gain- and / or risk-sharing, performance-based incentives or other incentives tied to quality and cost state targets. These arrangements must integrate primary, acute and complex health services. ²⁴
Washington	In the most recent contract, MCOs are incentivized through a quality withhold program to have at least 30% of their provider payments made through VBP and make a certain amount of qualifying provider incentive payments tied to quality and / or cost. As part of the quality withhold program, the State will withhold a portion of MCOs' capitation payments if MCOs do not meet these provider payment requirements. ²⁵

* States interviewed as part of the study.

Although these payment reform efforts are fairly new to the healthcare infrastructure, early evaluations have begun to demonstrate that state-led VBP initiatives are improving health outcomes and containing costs in states such as Colorado, Missouri, and Oregon.²⁶ Despite state Medicaid programs facing uncertainty with the new Administration, it is clear that VBP will continue to play a significant role in the future of paying for health care services, as payers across markets continue to turn to value-driven models. The new Medicaid managed care regulations provide additional tools that states can leverage to advance payment and delivery system reforms.

Other State Medicaid Agency Tools to Incentivize MCO Performance and Quality

States use a variety of techniques, in addition to the models previously described, to encourage and reward MCO performance and quality. Michigan MCOs with higher quality scores will be assigned more new members than MCOs with lower scores through the State's auto-assignment algorithm. To improve the quality of encounter data, Michigan's EQI process compares financial data to encounter data every four months. Although the EQI program does not currently include incentives or penalties, Michigan intends to incorporate EQI results as a quality withhold in the future. In the meantime, Michigan has excluded encounter data that is found to be of low quality from the rate development base data. The potential for low-quality data to be excluded can provide an indirect incentive for MCOs to submit higher quality encounter data.

All three states interviewed – Michigan, New York and Tennessee – include managed care efficiency adjustments in the capitation rate development. Michigan's most recent efficiency adjustments were focused on reductions in unnecessary Emergency Department (ED) visits. Historically, Michigan has also projected changes in the mix between C-section and vaginal deliveries with the goal of reducing the number of elective C-sections, but that adjustment was not included in the most recent rate development. Michigan emphasized the importance of providing data to the MCOs in advance of implementing these types of adjustments, to provide the MCOs sufficient time to review their own data and incorporate potential care management changes where appropriate.

²⁴ [Medallion 3.0 Managed Care Contract](#), Commonwealth of Virginia Department of Medical Assistance Services, July 2016.

²⁵ [Washington Apple Health 2017 Managed Care Contract](#), Washington State Health Care Authority, January 2017.

²⁶ [Accountable Care Collaborative 2014 Annual Report](#), Colorado Department of Health Care Policy and Financing. [Progress Report: Missouri CMHC Healthcare Homes](#), MO HealthNet, 2013. [Oregon's Health System Transformation 2015 Performance Report](#), Oregon Health Authority, June 23, 2016.

New York currently incorporates managed care efficiency adjustments related to potentially preventable inpatient readmissions, reductions in unnecessary ED visits, and improvements in pharmacy utilization and contracting into their capitation rate development. These adjustments are not MCO-specific. However, the transformation to the new VBP program will include MCO-specific adjustments in the future.

Tennessee typically assumes managed care efficiency improvements, which in recent years have been equivalent to approximately one percent in the capitation rate development. Tennessee also incorporates extensive reporting and other contractual requirements into their MCO contracts. The State applies a 2.5 percent withhold that can be earned back based on contract compliance. Liquidated damages apply to MCOs that do not meet these terms, and withholds may also be increased to as needed to address non-compliance.

ADDRESSING HIGH COST SPECIALTY DRUGS IN THE RATE SETTING METHODOLOGY

In recent years, there has been a significant increase in the number of high cost drugs approved for use that would benefit the population enrolled in HealthChoice. Both states and MCOs are concerned about the overall funding level in the capitation rates for these new drugs, as well as the funding for individual MCOs whose members utilize these drugs. Given the uncertainty around the potential number of members who may be utilizing these drugs, many states are developing processes to evaluate the additional pharmacy costs for new drugs and strategies to address these costs in the capitation rate development process.

When selecting overall pharmacy trends for capitation rate development, actuaries typically consider recently approved drugs and drugs still in development that the FDA is expected to approve in the new rate year. However, drugs approved by the FDA *during* the rate year may result in unaccounted costs above the trend used in capitation rate development if the overall treatment costs, combined with the utilization of the new drug, are significantly higher than those treatments in the historical data or in the pharmacy trend estimates. Subsequently, specific rate groups or populations may incur additional costs related to using the new drug relative to the historical data and industry knowledge used to set trend, such that individual MCOs may incur a disproportionate share of the costs.

Payment Options for Newly Approved Drugs

There is not a one-size-fits-all solution when it comes to paying for high cost medications in a Medicaid managed care program. Selecting a methodology that meets the goals of the program and can be handled by the program's systems requires considerations of several factors. Table 6 provides a summary of potential payment options for newly approved drugs that may be applicable given the current structure of the HealthChoice rate development process. More than one option may be applicable in any given situation.

Table 6 Summary of Selected Reimbursement Options for High Cost Drugs					
	Option 1	Option 2	Option 3	Option 4	Option 5
	Include in Capitation Rates	Kick Payment	Risk Pool (budget- neutral)	Risk Pool (non-budget- neutral)	FFS Carve Out
Addresses unanticipated cost increases	-	0	-	+	+
Addresses disparities by MCO	-	+	+	+	+
Addresses risk of over / underpayments to MCOs in total	-	+	-	+	+
Provides cost certainty for State	+	-	+	-	-
Comprehensive approach	+	-	+	+	-
Minimizes administrative complexity	+	-	-	-	+

Key:

- + positive attribute to State
- o neutral to State
- negative attribute to State

As can be observed from the table above, the different options each have characteristics that, from the State's perspective, may be viewed as positive or negative. Although no listed option provides positive results for all attributes, states can deem those of highest importance and decide which approach best aligns with the State's goals. Additionally, selecting a particular option does not mean that drugs categorized under that option will be administratively handled in that manner for perpetuity. In the case of a risk pool, it could be considered to move a drug under the capitation rate if sufficient experience and better predictability can be developed after a certain passage of time.

Other considerations states should make when evaluating payment options for newly covered drugs include the following:

- Remaining time left in the current capitation rate year
- Sufficiency of capitation revenue program-wide given uncertainty in the number of utilizers of high cost drugs in the rate year
- Changes in access to the new drug for members under a given reimbursement method
- Differences in overall costs between the trends selected for pharmacy in the initial rate development process and the expected costs by MCO for new treatments
- Federal CMS guidelines, restrictions, and funding policies

Below are some sample situations and recommended options for each situation:

- If the State is interested in covering all high cost drugs (including medications previously approved where the costs are in the historical baseline period) in a consistent manner, then Options 3, 4, and 5 could be selected.
- If a drug is newly approved towards the end of a rate year, the impact on the projected costs due to coverage of the new drug on the current rate year would be dampened since it would only affect a small portion of the rate year. For example, costs for a drug approved in the last month of the rate year would effectively have a 1/12 impact on the overall projected costs for the rate year, given that the costs only apply to one of the twelve months. Therefore, Option 1 could be selected in this scenario.
- If the rate group or rate groups expected to be the most significantly impacted is unknown, or a drug will primarily impact a non-risk adjusted population, then Options 2 or 5 can be selected.
- For a drug with low utilization but extremely high per patient treatment costs, Options 2, 4, or 5 would prevent MCO financial results from being negatively impacted by a few specific treatments.

The following provides additional detail regarding each of the listed options.

Option 1: Include in Capitation Rates

Under this option, there would be no additional adjustments to the capitation rates during the rate year. Consideration of new drugs can be handled in future rating periods, but any fluctuations in the pharmacy costs between those assumed in rate development and actual costs of newly approved drugs would be the responsibility of the MCOs. When rates for the next rate year are set, consideration should be given to any additional drugs that have been approved (or are expected to be approved) since the previous rate setting process.

- Advantages:
 - Overall funding for new drugs in the capitation rates is consistent with historical observed MCO costs and projected utilization and unit cost increases.
 - This approach does not increase the administrative complexity of the program or change the timing or process for capitation rate payment because the capitation rate and risk adjustment structure will not change.
 - This approach is in line with the at-risk nature of capitation rate development, and any fluctuation in costs are the responsibility of capitated MCOs.
- Disadvantages:
 - This approach does not mitigate MCO risk tied to uncertainty surrounding changes in the number of total utilizers for new drugs, or the average cost per utilizer, in the rate year relative to historical experience. If costs for new drugs are significantly different than the trend set in capitation rate development, then the capitation rates may not be sufficient to cover the costs. Similarly, if fewer drugs are approved in the future, then capitation rates may be higher than those assumed based on expected historical utilization.
 - Payments may not be directed to the specific MCOs with expected higher costs for members using the drugs.

Option 2: Kick Payment

The State could implement a kick payment to be paid once per month for each MCO recipient who utilizes certain high cost drugs during that month. The kick payment would be paid in addition to the normal monthly capitation rates.

- Advantages:
 - This approach mitigates MCO risk tied to uncertainty surrounding the number of utilizers of newly approved drugs during the rate year by paying MCOs a fixed amount for each unique utilizer per month. If more (or fewer) individuals need to use the drug, then state expenditures will automatically adjust accordingly.
 - Payments will be directed to the specific MCOs that cover individuals utilizing new drugs.
- Disadvantages:
 - The monthly capitation rates (exclusive of drugs paid on a kick payment basis) can be paid on the State's usual schedule, but the pharmacy kick payments cannot be paid until after the claims for a given month have been reported by MCOs.
 - Multiple kick payments would need to be developed if there are multiple high cost drugs.
 - There will be increased administrative complexity to define, communicate, and implement the kick payment(s) into the reimbursement structure initially, as well as to process each kick payment on an ongoing basis.
 - Similar to the capitation rates, if the cost per utilizer across the program changes significantly compared to the assumptions used in developing the kick payment, the kick payment may be set either too high or too low.
 - This approach may not be budget-neutral since the total kick payments will depend on actual drug utilization.

Option 3: High Pharmacy Cost Risk Pool (Budget-Neutral)

The State could implement a budget-neutral risk pool for members with high drug costs during the year. This option would not be targeted towards newly approved high cost drugs, but it would cover any new drugs with high costs per treatment in addition to any current drugs with high costs per treatment.

An example of this option is the upcoming Medallion 4.0 program in Virginia. Virginia will set an annual attachment point (\$175,000 in FY 2018) for pharmacy costs per individual during the rate year. The State withholds a portion of the capitation rates and uses the withheld amounts to fund a pool that pays 90% of capitated plan expenditures for member costs over the attachment point for the rate year. Beginning with the Medallion 4.0 program, if the funds are inadequate to reimburse all pooled claims, the pooled claims will be funded on a proportional basis to each MCO. Any remaining funds in the reinsurance pool at the end of the year after all claims are paid could be refunded to the MCOs. Prior to the Medallion 4.0 program, the State reimbursed each MCO regardless of the cost, resulting in a methodology that was not budget-neutral.

- Advantages:
 - This method directs more funding to MCOs with higher total costs of drugs, whether those costs are based on the number of utilizers or the average acuity level per utilizer.

- The monthly capitation rates (exclusive of the withheld amounts) can be paid on the State's usual schedule with any high cost pharmacy service risk pool payments occurring on a regular schedule (e.g., quarterly, annually, etc.) after pharmacy costs by plan are known.
- Overall funding for pharmacy services in the capitation rates is consistent with recent observed MCO costs and access to services.
- Disadvantages:
 - The pool needs to be fully funded in order to make this a successful approach. If the pool is not fully funded, overall funding for pharmacy services in the Medicaid managed care program may not be adequate and may remove MCOs' financial incentive to provide adequate pharmacy services.
 - This approach does not mitigate MCO risk tied to uncertainty surrounding high cost therapies, or the average cost per utilizer, during the rate year.
 - There will be an additional administrative burden for several aspects of a high pharmacy cost risk pool approach:
 - Defining the cost threshold at which point a recipient becomes eligible for the high pharmacy cost risk pool, as well as the relative financial responsibility for the State and MCOs above that threshold.
 - Applying withholds on the capitation rates, which could be complicated with a large number of rate cells. The certifying actuary would also need to certify that the withheld amounts are actuarially sound prior to finalizing the rate year capitation rates.
 - Subsequently calculating and paying out the appropriate funds to each MCO based on their portion of the pool. Additionally, MCOs would review the calculation and have additional questions prior to finalizing that would need to be addressed.

Option 4: High Pharmacy Cost Risk Pool (Non-Budget Neutral)

This option is similar to Option 3, with the exception of guaranteeing reimbursement of a portion of MCO costs for members with pharmacy costs above a threshold. The advantages and disadvantages would be similar to the previous option, except that some of the risk for members with high pharmacy costs would shift to the State. If pharmacy costs above the threshold are lower than the projected costs, the State would have less expenditures than projected for the rate year. Conversely, if pharmacy costs above the threshold are higher than the projected costs, the State would have more expenditures than projected for the rate year. Therefore, this process would not be viewed as budget neutral as the cost layout from the State will vary depending upon actual member expenditures.

Option 5: Carve Out Costs for New Drugs with a High Cost per Treatment

The State could directly reimburse pharmacies for certain high cost drugs on a FFS basis. The capitation rates would be reduced to remove expected costs for these drugs. Considerations in identifying the list of prescription drugs (or classes of drugs) to carve-out may include average cost, aggregate expenditures associated with a drug (or class of drugs), number of utilizers, and variance in member costs on a specific drug (or class of drugs).

- **Advantages:**
 - This approach removes MCO risk tied to uncertainty surrounding the number of total utilizers of new high cost drugs, and the average cost per utilizer by removing these costs from the capitation rates entirely.
 - Similarly, the distribution of high cost drugs by MCO is not a concern under this approach, since MCOs will not be responsible for covering these costs.
 - Under this approach, there are no concerns about timing or lags associated with capitation payment rates.
 - Pharmacy trend related to high cost drugs used in capitation rate setting would be analyzed and could be reduced to reflect this carve out.
- **Disadvantages:**
 - There will be an increased administrative burden in order to process each of these claims through the FFS system.
 - The list of carved out drugs would need to be regularly reviewed and updated.
 - This approach may not be budget-neutral since the total payments will depend on actual drug utilization.
 - It is possible that carving out specific drugs from the capitation rate could lower the MCO's responsibility for managing costs. However, this outcome is not likely since the MCOs would still be managing the medical costs for members that utilize high-cost drugs not included in the capitation rate.

RISK ADJUSTMENT

Risk Adjustment in Michigan, New York, and Tennessee

Most states use some type of risk adjustment to account for material differences in overall member acuity between MCOs. Incorporating risk adjustment into the capitation rates mitigates the incentives for MCOs to selectively enroll healthier members. Risk adjustment also provides higher revenue to MCOs who tend to enroll sicker than average members due to their provider networks or geographic location. States utilize various approaches to risk adjustment, and each approach has different strengths and weaknesses.

Michigan and Tennessee both use the Chronic Illness and Disability Payment System plus Prescription Drug model (CDPS+Rx) created by the University of California – San Diego, which is the most commonly used risk adjustment method for Medicaid populations. The CDPS+Rx model utilizes diagnosis and pharmacy information to assign each member to one or more of approximately 60 possible medical condition categories, each of which is assigned an additive cost value. For each health condition reflected in a member's claims data, the member's risk score is increased by the additive cost value. The CDPS+Rx model is dependent upon accurate and complete claims coding, and the relative cost values for the most extreme health conditions are more difficult to predict with accuracy. However, the CDPS+Rx model is inexpensive to implement (particularly for MCOs, many of which download the CDPS model and perform their own analysis) and the additive model makes it fairly easy to understand.

While Michigan and Tennessee use the same risk score model, the risk score adjustments are incorporated into the capitation rates in different ways. In Michigan, individual members are assigned a prospective risk score using the most recent year of diagnosis and pharmacy data available (i.e., 2016 data is used to calculate 2018 risk score adjustments).

Then each MCO is assigned a budget-neutral relative risk score based on a recent snapshot of enrollment data. The risk score is adjusted after six months based on more recent enrollment data. In Tennessee, the initial capitation rates do not reflect any risk score adjustments. Instead, the risk score adjustments are applied near the end of the rate year based on the most recent diagnosis and pharmacy claims data available, and are retroactive to the beginning of the rate year. Using this method, the final risk score adjustments may more accurately reflect the risk of enrolled members since the risk scores are calculated using more recent data; however, the adjustments are unknown at the start of the rate year which may make it more difficult for MCOs to project their capitation revenue. Additionally, this methodology may provide more incentive for MCOs to improve their diagnosis coding than to manage utilization.

New York uses the Clinical Risk Group (CRG) model licensed by 3M. CRGs are a categorical clinical model which assign each member of a population to a single mutually exclusive risk category. Each CRG is clinically meaningful and provides the basis for the prediction of health care utilization and cost. Cost weights are developed by the State for each CRG based on MCO submitted encounter data. MCOs are paid a regional average premium, which is adjusted by the mix of acuity profiles across the MCOs. The application of this risk adjustment methodology is projected to be budget neutral.

Incorporating Social Determinants of Health into Risk Adjustment

As noted above, risk adjustment is typically based on an individual's diagnosed conditions and prescription drug use, but a handful of states are exploring whether it also makes sense to incorporate socioeconomic status into the risk adjustment model. This approach could increase revenue for MCOs with members associated with higher socioeconomic needs, and could provide these MCOs with additional resources to offer care to members whose health care expenditures are higher due to the presence of socioeconomic factors.

Massachusetts was not interviewed for this study. However, in October of 2016, Massachusetts became the first state to incorporate social and economic factors into its Medicaid managed care risk adjustment model.²⁷ Developed by Dr. Arlene Ash at the University of Massachusetts Center for Statistics, the model builds on the prior risk adjustment model (based on diagnosis and pharmacy data) and considers variables such as unstable housing or whether the member resides in an area with a high prevalence of socioeconomic factors or "neighborhood stress score". Individuals were classified as having unstable housing if they changed addresses more than three times per year. The "neighborhood stress score" was calculated by linking an individual's current address with data from the Census Bureau on the poverty rate, unemployment rate, public assistance usage, car ownership levels, rate of single-parent families, and the level of educational status of neighborhood residents in the individual's neighborhood. These factors were combined to calculate a neighborhood stress score for each area.

The model intended to provide higher capitation payments to MCOs for key subgroups of members with high social needs, creating the possibility the MCO can use these additional resources to work with providers to address those needs. For example, an MCO serving a large number of individuals in a particularly impoverished neighborhood may be able to work with a community health center or community-based organization to tackle neighborhood-specific issues, such as a need for a food bank or healthy food options. Of course, since the risk adjustment methodology is required to be budget neutral, increasing payments to some MCOs means that other MCOs will receive lower capitation payments. Additionally, it is important to consider the availability, quality, and consistency of socioeconomic data sources before incorporating this information into risk adjustment modeling.

²⁷ [MassHealth Risk Adjustment Model: Social Determinants of Health](#), Massachusetts Executive Office of Health & Human Services, October 2016.

OTHER COMMON PRACTICES IN MEDICAID

Health Plan Financial Monitoring

Most states regularly monitor MCO financials, at least annually but often semi-annually or even quarterly. Monitoring health plan financials serves several purposes. Regular monitoring allows the State to identify variances in how each MCO reports costs early to reduce the need for substantial restatements during the rate setting process. Periodic monitoring of financials also facilitates timely discussion regarding outlier costs or emerging trends. As noted earlier in this report, financial data is also used to validate MCO encounter data used for rate setting and estimate the impact of potential encounter data issues such as under-reporting.

Detailed Rate Setting Reports

The rate development reports provided to MCOs by many states include substantial detail with respect to both the base data and the assumptions reflected in the capitation rates. In addition to facilitating communication and trust between the states and the MCOs, detailed reports often provide MCOs with additional insights that help MCOs improve efficiency and achieve the state's desired outcomes.

Predictable Recurring Changes to Costs

States often choose to reflect recurring programmatic or fee schedule changes in trends, rather than as separate adjustments within the rate development. For example, states that update fee schedules each year according to a regular schedule frequently embed the anticipated fee schedule changes into the trend assumptions applied during the initial rate development in such a way that minor variances from year to year will balance out over time. This approach can reduce the administrative burden associated with rate adjustments while providing MCOs with more predictable cash flows. States that choose this approach also must monitor the year-to-year variances to ensure that they do balance out over time. Regular over-estimation of trends will inadvertently result in the State paying too much; however, regular under-estimation of trends may erode trust between the MCOs and the State.

State Medicaid Agency Staffing and Support

Most states do not have the resources to ensure that processes and operations can be performed by multiple people or teams in the event that the primary resources are unavailable. Additionally, many states are not able to equip internal staff with sufficient time or resources to keep pace with the constant new developments. With access to industry conferences or publications, or by participating in Medicaid workgroups with representatives from other states, internal staff can stay abreast of many emerging rate setting trends, but practically speaking, internal staff has limited time to devote to these activities. States that lack sufficient staff to fully manage the rate setting process often turn to external consultants to provide timely access to the most current rate setting trends and the transfer of knowledge to additional resources. Through support from consultants in key rate development activities, many states improve stability by ensuring key knowledge and information is available even when personnel resources are strained. In the absence of sufficient staffing levels, cross training and succession planning, consultants help states navigate the complex rate setting processes. External consultants further assist states by transferring institutional knowledge to state staff and maintaining sufficient staffing levels to provide a consistent level of support throughout each project.

Encounter Data Workgroups

Some states facilitate encounter data workgroups that meet periodically, such as monthly or bi-weekly, where MCOs, state staff, and the certifying actuary discuss questions about recent changes or proactively address how to code upcoming changes in the encounter data. These workgroups can be an effective tool to improve transparency and collaboration between the MCOs and the State by demonstrating that the State is invested in working with MCOs.

Additionally, these workshops improve the efficiency of the rate setting process by improving the consistency of MCO encounter data reporting. This ongoing communication is helpful to address minor nuances and changes, but frequent workgroup meetings could be particularly advantageous in states that are actively working to improve the quality of encounter data.

Competitive Procurement

Several states select the MCOs that will participate in the state's Medicaid managed care program through a competitive bid process. Often times, this is done through MCOs submission of a Request For Proposal (RFP) which specifies a number of requirements the bidding MCOs will be evaluated on for final selection. States will focus on ensuring MCOs have adequate networks to provide members access to covered services, have operational capabilities that will work with state systems, and can produce quality outcomes for the covered population. Another consideration in the procurement process can be what cost the MCOs project to spend on covering the specified managed care populations, but not all procurement processes consider this when evaluating and selecting MCOs. More recently, the RFPs being released by states are increasing the focus on value-based approaches, integration and coordination across programs, and ability to handle special populations that may transition into managed care.

VI. CHAPTER 4: FINDINGS AND RECOMMENDATIONS FOR MARYLAND

Drawing on the review and analysis of federal and state regulations and Maryland rate setting operational documents, and interviews with Maryland state officials, key stakeholders, and other managed care states, the Milliman and Manatt team developed the following recommendations for Maryland to consider to improve the Medicaid managed care rate setting process and innovate payment approaches.

Recommendation #1: Define a Vision and Outline Top Priorities and Goals for Value and Quality in Medicaid Managed Care

Description / Justification

The State has undertaken a number of initiatives but not a collective and concerted effort to develop a unified vision through which managed care value and quality initiatives could be rooted. In the states interviewed as part of the study, a common feature was a clear articulation of vision, goals and priorities to anchor, organize and drive state initiatives. For example:

- **Michigan.** In its most recent Medicaid managed care procurement, Michigan identified key program objectives that served as the pillars of the request for proposal (RFP). These “pillars” shifted the focus from the operational capacity of the MCOs to an assessment of each bidder’s ability to address program goals. While Maryland does not utilize competitive bidding, the State can embed its goals into payment initiative or rate setting strategy.
- **New York.** New York has established a robust VBP strategy rooted in a detailed roadmap that defines specific annual goals for VBP between MCOs and providers as well as penalties for MCOs that do not achieve the specified goals. This overarching strategy is then incorporated and featured in various aspects of the State’s Medicaid program, including administration and oversight of the managed care delivery system.

Maryland should seek to engage in a deliberate and focused effort to define the State’s vision, goals and priorities relating to enhancing quality, value and innovation in Medicaid managed care. Then, Maryland should pursue opportunities to embed this vision, goals and priorities into contracting, rate setting, and ongoing MCO monitoring and compliance and coordinate with other related state initiatives. Several opportunities in managed care contracting and rate development are discussed in further detail in the subsequent recommendations. In terms of other state initiatives, an opportunity for alignment exists in developing a Progression Plan to extend the All-Payer Model beyond 2018. The Progression Plan is intended to update and advance Maryland’s strategies to improve care and health outcomes, while limiting spending growth over time. At the time of the writing of this report, Medicaid and the role of HealthChoice have not been a focus of planning, nor addressed in the available public information. Maryland should explore critical alignment between Medicaid goals and the significant lever of the Maryland All-Payer Model to support desired priorities.

Anticipated Impact on Efficiency, Cost, Quality, and Access to Care

With a clearly defined vision, the State can more efficiently consider and assess the payment initiatives and rate setting modifications to support improvements in cost, quality and access to care in Medicaid managed care.

Implementation Considerations

States have shared lessons learned on the time and complexity to engineer and effectuate change. The development of a clear vision, set of goals and priorities and implementation roadmap will take dedicated state resources and time for development and necessary stakeholder engagement. Michigan deployed a survey completed by 317 stakeholder groups and then worked with independent consultants to shape the four pillars ultimately included in its Medicaid managed care procurement.

New York has invested significantly in the stakeholder engagement process, convening a VBP workgroup and clinical advisory groups for over seven months to develop the initial detailed VBP roadmap. The process included boot camps as well as quarterly meetings. Tennessee's VBP approach included identifying episodes in consultation with the Governor's office and a technical advisory group to best fit Medicaid managed care program goals. Adoption of these efforts will also require continued engagement and support across a range of HealthChoice leadership and stakeholders, including state staff and MCOs.

Recommendation #2: Sustain and Strengthen the Existing Quality Incentive Program

Description / Justification

HealthChoice has a longstanding quality incentive program, which provides incentives and disincentives based on MCO performance on a set of HEDIS measures. The State has undertaken efforts to assess and rationalize the quality incentive system, employing Bailit Health (Bailit) to conduct an evaluation on the HealthChoice incentive program. Bailit suggested that Maryland review and update the applicable measures and reduce the number of quality measures from 13 to 10 measures to effectively increase the weight of each measure, which the state has since implemented.

Maryland should establish a schedule to periodically examine and modify measures for alignment with the State's initiatives. In addition, Maryland should broaden the current incentive structure, which provides an incentive and disincentive against a certain performance benchmark but is not sensitive to continued improvements for high performing MCOs as well as trajectory of improvement for low performing MCOs. Finally, Maryland should consider incorporating incentives to reward significant improvement year-over-year as well as significant continual improvement for low-performing MCOs.

For example, Michigan applies a withhold of one percent of capitation that is used for MCO performance incentives linked to approximately 25 HEDIS quality measures. MCOs may earn incentives not only for meeting targets – which the State has set at the MCO meeting the 75th and 90th percentile of NCQA Medicaid standards – but as well as for showing statistically significant improvements from the MCO's prior year performance – which the State has set at 10% improvement. Michigan also evaluates its metrics and considers replacement of those metrics where the State as a whole is performing better than the national average.

Anticipated Impact on Efficiency, Cost, Quality, and Access to Care

Periodic evaluation of the measures to ensure they are best targeted to the State's current priorities as well as modifications to the current methodology to support continued quality improvement regardless of level are anticipated to enhance quality overall.

Implementation Considerations

Maryland will be able to leverage lessons from the recently completed work to streamline the quality measure selection process. Maryland will need to establish a process and cycle for the periodic evaluation as well as modifications to the incentive structure and should engage with MCOs regularly in this process.

Recommendation #3: Evaluate Whether to Vary Profit Margin Consistent with MCO Performance on State's Priorities

Description / Justification

Actuaries have significant discretion in setting the profit margin (including risk margin for non-profit MCOs and underwriting gain) built into the Medicaid managed care capitation rates. Most set the profit margin between 1 and 2 percent and typically provide the same margin to all MCOs. Some states, however, are recognizing they are not obligated to provide each MCO with the same profit margin and, indeed, can vary the margin based on factors such as an MCO's performance on key state plan objectives.

New York, for example, is planning to pay capitation rates with varying MCO margin based on the prevalence of VBP contracts with providers. There may be less flexibility in Maryland to vary the profit margin than other states because the capitation rates are already set at a relatively low level (i.e., near the bottom of the actuarially sound rate range developed by Optumas). Even so, Maryland can discuss varying the profit margin in future years with its certifying actuary, such as if an MCO has excelled in meeting the State's objectives. Currently, there are not examples of states removing MCOs for continual under-performance or reporting underwriting losses, but this strategy may assist in pushing those poor performing MCOs to increase their value to the state's program.

Anticipated Impact on Efficiency, Cost, Quality, and Access to Care

Tying the profit margin included in the capitation rates to MCO performance would provide a direct financial incentive for MCOs to improve their performance on the state's key performance and quality measures. Ideally, these improvements should also reduce claim trend over time. Allowing high-performing MCOs to obtain additional profit margin could also dampen the impact of reduced claim trends lowering future capitation rates.

It is also possible that, over time, MCOs that are unable to achieve the metrics necessary to obtain higher margin may opt to leave HealthChoice. While exiting MCOs could cause some short-term member disruption, this type of attrition might also improve the overall efficiency of the program by streamlining care to fewer, but more high-performing, MCOs.

Implementation Considerations

The State will need to identify the criteria for MCOs to receive a lower and higher profit margin and determine how best to monitor and evaluate MCO compliance and what levels may be accommodated in current rates. With the current rates at the low end of the rate range, the State may also face some challenges from MCOs if structured as a significant disincentive that further reduces the profit margin.

Recommendation #4: Improve Encounter Data and Enhance Use of Encounter Data to Drive Value

Description / Justification

Currently, MCO encounter data is used in Maryland for risk adjustment and pharmacy rate development, but not utilized as the main data source for rate development. Maryland should partner with the MCOs to improve the quality of encounter data so it can be more widely used to drive value in rate setting and quality. Maryland can achieve this objective by developing and implementing a process to reconcile encounter data against HFMR data on a recurring basis as a method of assessing the completeness and accuracy of the encounter data. The results of those reconciliations can be leveraged in several ways to evaluate quality and incentivize the MCOs to provide high quality data.

The State can explicitly reward or penalize MCOs for encounter data quality by including encounter data completeness and accuracy as a contractual requirement and assessing penalties for MCOs that do not comply with these contractual requirements. Alternatively, the State could incorporate metrics from the encounter data reconciliation directly into the quality withhold metrics or update its auto assignment algorithm to assign more members to MCOs with higher quality encounter data.

In addition to quality monitoring, utilizing encounter data directly in the rate setting process provides a direct incentive for MCOs to provide higher quality data. The State can encourage higher quality encounter data by setting a future date by which capitation rates will reflect encounter data, rather than HFMR data, in the base data. To facilitate the transition, the State could consider blending the base data between encounter data and financial data and increasing the blending weight assigned to the encounter data over time.

Anticipated Impact on Efficiency, Cost, Quality, and Access to Care

With quality encounter data, Maryland will eliminate some of the timing challenges incurred by using financial data to develop rates, and Maryland will be better positioned to evaluate managed care efficiencies by gaining insight into the utilization and unit cost patterns of each MCO. Furthermore, Maryland can link quality initiatives to encounter data to drive value and improve outcomes as detailed in Recommendation #5.

Implementation Considerations

MCO support and compliance are critical for a successful implementation. Regardless of the specific approach taken, Maryland should collaborate with the MCOs to define metrics and timelines well in advance of the implementation of any changes with a financial impact to encourage MCOs to meet the objectives. The states interviewed reported easier and more effective implementations when MCOs were included early in the process.

Recommendation #5: Validate the Existing Outlier Adjustment Aligns with Cost, Quality, and Value Objectives

Description / Justification

The relationship between utilization patterns, unit cost trends and quality initiatives likely have changed, and will continue to evolve, over time. Therefore, Maryland should evaluate and continue to monitor the alignment between the current outlier adjustment applied to the base HFMR data and the State's objectives by analyzing the three key components of MCO cost: unit cost, utilization and administrative expense.

Thoroughly Analyze Unit Cost Variances and Their Drivers

Maryland should evaluate historical and current unit costs paid by each MCO to providers to identify variances in the base period data and measure historical trends. This analysis would primarily be based on professional and pharmacy costs, since facility unit costs are set as part of the Maryland All-Payer Model. However, average facility unit cost analyses by MCO could be useful for assessing how network selection impacts MCO costs. The analysis should account for differences in membership mix and acuity. A unit cost analysis will identify differences between MCOs as well as between providers.

When unit cost variances are attributable to less aggressive contracting by a small subset of the MCOs, base data adjustments to reflect prevalent unit costs may be appropriate. For example, if most MCOs pay physicians at 105 percent of Medicaid reimbursement rates on average and another MCO in the same geographic area pays 110 percent of Medicaid rates, Maryland may be justified to adjust the high-paying MCO's base claims to 105 percent of the Medicaid rates.

If unit cost variances are attributable to other factors, such as member mix or significant leverage of specific providers in a certain market segment, then Maryland might consider alternate approaches to address the State's cost containment objectives. If unit cost variances are attributable to member mix differences, a unit cost adjustment may not be reasonable. However, if a provider is the only provider in a geographic area that offers certain services, or if the provider's market share is substantial enough that its participation is necessary to meet network adequacy requirements, that provider may insist that MCOs pay rates substantially higher than the Medicaid rates in order to contract with that provider. If Maryland finds that unit costs are being driven upward due to provider leverage, the State might consider implementing policy changes to constrain the impact of this leverage rather than adjusting the base period data directly. For example, Maryland could require MCOs to contract at or below a specific percentage of Medicaid fees (as long as this requirement would not put the MCOs at materially increased financial risk).

Evaluate the Opportunity for Managed Care Savings and Provider-Based Quality Incentives

Maryland can evaluate member utilization patterns to identify the potential for additional savings based on more effective care management. The analysis should account for differences in membership mix and acuity. In addition to evaluating utilization by MCO, this analysis could also be performed at the provider level and incorporated into provider-led quality initiatives such as those in Tennessee.

Many states include managed care efficiency adjustments into their rate setting methodology that focus on reducing unnecessary Emergency Department visits, reducing the number of hospital readmissions, projecting increases in the percentage of vaginal versus C-section deliveries, or assuming improvement in pharmacy generic dispensing rates or contracting levels. Maryland can identify managed care savings opportunities based on relative performance (such as setting targets based on percentile results across all MCOs) or direct comparison to the clinical benchmarks. Capitation rate adjustments based on relative MCO performance might be appropriate if the overall capitation rates are being driven upward because a small number of MCOs have markedly higher utilization and the higher utilization is not explained by other factors, such as member mix or acuity.

Maryland's All-Payer hospital reimbursement model includes many of the quality measures noted above. However, this recommendation includes measuring the MCO base data and incorporating managed care efficiency adjustments directly into the Medicaid managed care rate setting process.

Monitor Administrative Expenses and Relationship to Medical Costs

Maryland should examine MCO administrative expenses to ensure that non-medical expenses are efficient and support the State's quality initiatives. Administrative expenses should be compared by MCO and Category of Aid since there can be substantial variation in administrative costs for different types of populations. However, keep in mind that it can be difficult for MCOs to accurately allocate their administrative expenses by population.

Maryland can also investigate the drivers of significant variances in administrative costs among MCOs for each Category of Aid. For example, effective care management often results in higher administrative expenses, but those higher administrative expenses may be more than offset by reduced medical costs.

Validate Outlier Adjustment against Component Analyses to Ensure Alignment with Objectives

Maryland should compare the results of these three component analyses to the historical outlier adjustments, which are based on revenue-to-expense ratio relativities between MCOs. By comparing the component-based analyses to the outlier adjustments for multiple rate periods, Maryland can quantify how well and how consistently the outlier adjustment supports Maryland's goals. If Maryland is satisfied that the outlier adjustment is appropriate going forward, Maryland should revisit the component analyses at least every three to five years, or whenever significant programmatic changes occur, to ensure it is still appropriate.

Anticipated Impact on Efficiency, Cost, Quality, and Access to Care

Maryland should ensure that rate adjustments align with program objectives as these objectives evolve over time. Furthermore, MCOs will be better positioned to achieve savings targets when those targets correspond to clearly defined encounter data metrics.

Implementation Considerations

The suggested approaches depend upon achieving the encounter data quality improvements included in Recommendation #4. If Maryland decides to make changes to the outlier adjustment or to implement any managed care savings, Maryland should ensure the adjustments are reasonable in aggregate.

Maryland should engage with MCOs well in advance of making changes to the outlier adjustment or implementing managed care efficiency adjustments. By being included in the discussion as early as possible, MCOs will be able to raise any operational concerns that might be barriers to achieving the savings targets, and MCOs will also have more opportunity to implement any operational changes necessary to achieve the targets. Maryland will also need to consider the reliability of MCO reporting, particularly with respect to the allocation of administrative expenses as allocation methods can vary significantly.

Recommendation #6: Select the Most Recent and Appropriate Base Data

Description / Justification

The Medicaid Final Rule requires states to use base data from within three years of the rating period. Most states use data from two years prior to the rating period because, while this data may require a fairly small adjustment for anticipated claims runout, it also requires fewer adjustments, for factors such as trend and programmatic changes, than data from three years prior to the rating period. Currently, Maryland uses base data from three years prior to the rating period, but develops the first year trend assumptions using experience from the following year. While this approach meets CMS requirements, it results in older base data being used compared to most other states.

Maryland should consider using base data from two years prior to the rating period to reduce the risk of embedded discrepancies due to differences between rate development assumptions and actual experience in that extra year, or material eligibility or program changes that occurred between the base year and the following year that cannot easily be captured in the first year trend assumptions. Maryland's HFMR audit process is robust and should remain a key part of the encounter data validation process. However, if Maryland is able to transition to primarily using encounter data for rate development, selecting data from two years prior to the rating period represents a best practice for state Medicaid programs.

Anticipated Impact on Efficiency, Cost, Quality, and Access to Care

Maryland should ensure that MCO encounter data selected for the base period experience data used for rate setting aligns well with the HFMR data. Any identified encounter data issues would need to be estimated and summarized in the rate certification and report submitted to CMS.

Implementation Considerations

Changing the base data period will be more feasible when priced encounter data is available for rate development, but Maryland can expedite the process by setting a future date when encounter data will be phased into the base data and holding MCOs accountable to provide quality data by that time.

Recommendation #7: Include Estimated Midyear Hospital Unit Cost Changes in the Initial Rate Development

Description / Justification

Maryland could consider reflecting projected mid-year hospital unit cost adjustments, occurring annually on July 1st, in the trend assumptions utilized in the initial rate development. To the extent that predictable changes can be incorporated, this would reduce the likelihood and the associated administrative burden associated with the mid-year adjustment and provide MCOs with more predictable revenue streams.

This approach would not preclude Maryland from making mid-year unit cost adjustments if actual changes differ materially from projected adjustments.

Anticipated Impact on Efficiency, Cost, Quality, and Access to Care

By making these procedural changes, Maryland may be able to reduce administrative burden and will be more consistent with other state Medicaid programs.

Implementation Considerations

Maryland should evaluate the pros and cons – including administrative burden, financial risk, and MCO perceptions – to determine whether Maryland would like to reflect anticipated unit cost changes during the rating period in the trend assumptions.

Recommendation #8: Develop and Implement a Standardized Framework for Evaluating and Determining Risk of High Cost Drugs and Payment Approach

Description / Justification

Coverage of prescription drugs is Maryland's fastest growing expenditure under Medicaid managed care. Like other states, Maryland has confronted particular challenges in managing high cost specialty prescription drugs such as Sovaldi, used for the treatment of Hepatitis C, and Spinraza, used for the treatment of spinal muscular atrophy. Historically, the State has taken various approaches to address reimbursement: HIV/AIDS drugs are carved out from the managed care benefit and reimbursed on a FFS basis, while Hepatitis C drugs are delivered through managed care but MCOs receive a kick payment to support the additional costs associated with the drug.

Using the framework outlined in Chapter 3 / Table 6, Maryland should design and implement a standardized analytical framework that could be applied more systematically when determining how to manage, pay for, and mitigate the risk of high-cost drugs.

Anticipated Impact on Efficiency, Cost, Quality, and Access to Care

There are several options presented in Table 6 that Maryland can use to evaluate how to address the cost of newly covered high cost drugs in the rate development process. The most appropriate solution for each drug will depend on the level of risk willing to be assumed by the MCOs and the State, the ability to incorporate potentially complex solutions into Maryland's capitation payment systems, and the ability to monitor new treatments as they become available and quickly incorporate them into the pharmacy trend development.

Implementation Considerations

Planning, development and operationalization between the State, Hilltop, the MCOs, and the State's actuaries will be required in order to implement the chosen approach.

Recommendation #9: Strengthen Requirements for Coordination of Behavioral and Physical Health

Description / Justification

Currently, physical health benefits are managed and delivered by the MCOs while behavioral health benefits are managed delivered by the behavioral health administrative services organization (ASO), Beacon Health Options (Beacon). HealthChoice MCOs are required to cooperate with the behavioral health ASO and develop referral procedures and protocols.

Maryland could explore a range of options to strengthen these requirements. One option is defining minimum standards or features of required referral procedures and protocols in the State's contract. Another area of focus could be establishing robust expectations on data sharing and use between the MCOs and ASO. Prior to their January 1, 2018 carve-in of behavioral health, Ohio's managed care contract required MCOs to refer and link members to Community Behavioral Health Centers. As part of Ohio's care management strategy, MCOs were required to develop a model of care that addressed the behavioral health population stream, submitting risk stratification level and care management data files for specified members. Another option would be to fully integrate both behavioral and physical health benefits into one managed care program, as is currently done in many states. In integrated states, MCOs may still be held accountable to articulate plans for and provide data on integration of behavioral and physical health services including implementation of clinical strategies (e.g., co-location of behavioral health in primary care settings and vice versa or application of specific clinical care models).

Anticipated Impact on Efficiency, Cost, Quality, and Access to Care

Increased coordination of physical and behavioral health services could lead to higher quality of care delivered to members with behavioral health needs and less confusion surrounding their Medicaid benefits.

Implementation Considerations

The coordination of behavioral health benefits with physical health benefits has been a historically contentious area and successful implementation of these changes will require additional stakeholder engagement, including MCO buy-in, and potentially coupling of these changes with additional state oversight and compliance action. The State has a key opportunity to introduce strengthened requirements in the upcoming ASO RFP.

Recommendation #10: Build More Flexibility into State Regulatory Framework

Description / Justification

As discussed in Chapter 1, Maryland relies heavily on state regulations to establish MCO requirements. To the extent permissible under law, Maryland should explore opportunities to streamline Maryland regulations to provide the overarching framework of general requirements, while leveraging more flexible MCO contracts for specific requirements that may evolve over time.

Anticipated Impact on Efficiency, Cost, Quality, and Access to Care

Increased flexibility in the state regulatory framework could improve operational efficiency, provide oversight flexibility and reduce the administrative burden on MDH staff. Rather than preparing a substantial regulatory change package annually, MDH can leverage the more flexible framework and develop and issue programmatic guidance and contract amendments as necessary.

Implementation Considerations

Using the analysis from this report as a starting point, the State will need to undergo a process to map current regulations to the managed care contract. The State will then need to reshape current regulatory language and develop managed care contract language, though much of the current regulatory language can be leveraged and adapted for the contract terms.

CONCLUSION

The rate setting process used for HealthChoice has generally worked well and, in particular, the unique partnership between Hilltop and MDH has added a measure of validation and deeper data analysis than is available in many other states. Moreover, the existing quality withhold offers the opportunity to link some level of funding to plan performance and should be retained and expanded. At the same time, there clearly are a number of additional steps that the State could take to leverage rate setting and value-based payment strategies to strengthen the HealthChoice program. These include structural and technical changes to the rate setting process, but also a broader effort to clearly define the State's top priorities for HealthChoice and integrate them into the rate setting process and related payment initiatives.

VII. CAVEATS, LIMITATIONS, AND QUALIFICATIONS

This report was developed to help UMBC and The Hilltop Institute identify potential improvements to the Maryland HealthChoice Medicaid managed care rate setting system. This information may not be appropriate, and should not be used, for other purposes.

The information presented in this report is provided for UMBC. UMBC may share this information with outside entities with Milliman's permission. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work product. Any third party recipient of this work product who desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its own specific needs. Any releases of this report to a third party should be in its entirety.

We relied on interviews with key stakeholders and supporting documents provided by UMBC / Hilltop and others to develop the recommendations in this report. To the extent this information is inadequate or incomplete, our recommendations may likewise be inadequate or incomplete.

Shelly Brandel and Chris Pettit are actuaries for Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of our knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

This report outlines the review and opinions of the authors and not necessarily that of Milliman. The terms of Milliman's Consulting Service Agreement with UMBC, effective December 4, 2017, apply to this information and its use.

