Lindquist, April

Subject: Mercer Government Newsletter - July Edition

Government Human Services Consulting

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MERCER GOVERNMENT NEWSLETTER - JULY 2017

HELPING SUPPORT HEALTHCARE'S FOUNDATION DURING THIS TIME OF CHANGE

Mercer has been partnering with states and other stakeholder organizations for over 30 years to support health care programs for the low-income and most vulnerable populations in this country. We face an unprecedented environment of uncertainty and change in the Medicaid and CHIP programs, and yet, there is a need to keep moving forward. This newsletter shares information you need to move your health programs forward.

AFFORDABLE CARE ACT REPEAL AND REPLACE EFFORTS: UNCERTAIN TIMES

After a dramatic journey through the House and the Senate, Congressional efforts to repeal and replace the Affordable Care Act (ACA) are now stalled, with Medicaid a key focus of the Senate deliberations. At the time of the drafting of this article, Senate GOP leadership has announced plans to introduce a repeal and delay bill to repeal ACA but provide Congress...

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Overcoming the VBP Challenge

How will you maximize your Medicaid dollar while increasing access and quality in an uncertain healthcare environment?

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Quality Encounter Data

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Management of Specialty Drug Trend

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Mercer Government includes more than 15 former state and federal health care leaders and:
290+ Staff
27 ASAs
20 FSAs
5 CPAs
9 Clinicians
6 Pharmacists

QUESTIONS

Contact
April Lindquist
+1 612 642 8889
mercer.government@mercer.com

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MEDICAID/CHIP PARITY COMPLIANCE: INSIGHTS FROM THE FIELD

States with Medicaid managed care organizations (MCOs), alternative benefit plans (ABPs), and separate CHIP programs are focused on demonstrating compliance with parity requirements by October 2, 2017. For most states, it is a steep learning curve that requires interpreting the final Medicaid/CHIP parity rule and absorbing CMS guidance while simultaneously implementing a reasonable process to assess and document compliance by the October 2 deadline.

Given that most Medicaid MCO, ABP and CHIP policies and program operations predate the final Medicaid/CHIP parity rule, it is expected that at least some policies and operational protocols will need to change to demonstrate compliance with parity. All of this needs to occur while maintaining ongoing program operations with existing staff resources. It is no surprise that states are seeking to expedite understanding of the rule and to develop an efficient process that minimizes disruption to Medicaid/CHIP beneficiaries, contractors, and state staff.

FIVE CRITICAL STEPS

While the rule and guidance can seem daunting, the parity process really breaks down to five critical steps:

1. Identifying benefit packages
2. Defining mental health and substance use disorder (MH/SUD) and medical/surgical benefits
3. Defining benefit classifications (inpatient, outpatient, emergency care, and prescription drugs) and mapping benefits in each benefit package to the four classifications
4. Identifying and testing financial requirements (FRs), quantitative treatment limitations (QTLs), aggregate lifetime and annual dollar limits (AL/ADLs), and non-quantitative treatment limitations (NQTLs)
5. Addressing and documenting parity compliance

KEY ISSUES

Based on our experience assisting six states with determining parity compliance and as a subcontractor to Truven Health Analytics to help CMS provide parity technical assistance to states, some of the key issues related to the parity analysis include:

1) How to streamline the analysis for states with multiple managed care entities and/or benefit packages;
2) How to incorporate long term services and supports;
3) How to define MH/SUD benefits using a standard specified in the parity rule while being as consistent as possible with state practice;
4) How to identify and define NQTLs;
5) How to conduct the parity analysis when the Medicaid/CHIP program is undergoing delivery reform or changing managed care entities;
6) How to collect relevant information from managed care entities as efficiently as possible;
7) How much support and oversight to provide managed care organizations (MCOs) that are conducting the parity analysis for fully integrated benefit packages;
8) How to determine what changes are necessary to comply with parity; and
9) The level of detail needed for parity documentation.

IN CONCLUSION

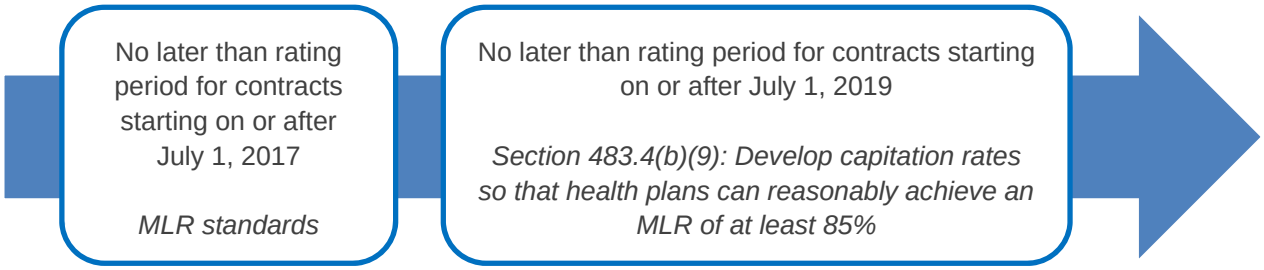
Our experience has shown that the parity analysis works best when our diverse team of policy, financial, clinical and pharmacy program operations specialists work together with the state to understand and implement the final rule. For most states, some MH/SUD or M/S services are carved out of the MCOs and administered fee-for-service or by behavioral health contractors. In these instances, we find that establishing a cross agency work group with regular key decision meetings promotes collaboration and drives the efficiency necessary to the compliance analysis process. It is also important for the state to have a good working relationship with its managed care vendors.

MEDICAL LOSS RATIO: NOT AS BAD AS IT SEEMS

New medical loss ratio (MLR) requirements play a prominent role in the Centers for Medicare and Medicaid Services (CMS) Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule, including impacts to capitation rate setting. With all the MLR provisions put forward, it suggests a lot of work ahead for states; however, things may not be as bad as they seem. While formal CMS MLR rules are new to Medicaid, they are in alignment with the Affordable Care Act private market and Medicare Advantage MLR standards, with minor deviations. Additionally, capitation rating processes may already be achieving the applicable MLR requirements.

MLR REQUIREMENTS

The CMS Medicaid and CHIP Managed Care Final Rule's MLR requirements go into effect for contract rating periods beginning on or after July 1, 2017. At least 85% of after-tax premium must go towards paying claims (including quality improvement activities). In other words, no more than 15% of after-tax premium can go towards administrative costs (which exclude taxes/fees) and underwriting gain (cost of capital and risk loading). For managed care contract rating periods starting July 1, 2019 or later, actuaries must certify that each capitation rate is set to reasonably achieve an MLR at or above an 85% minimum. Here is what Mercer is seeing evolve from these requirements.



WHAT ARE STATES CURRENTLY UP TO?

Updating MCO Contracts that start on or after July 1, 2017 and requiring the calculation and reporting of MLR by the MCOs within 12 months after the end of the contract year. Requirements of MCOs include providing calculation back-up detail; demonstrating consistency (or a comparison) with financial reports; attesting to calculation accuracy; and revising MLR if rates are adjusted retroactively.

Considerations made by states are time specific to when an MCO calculates, reports, and attests to its MLR; establishing a minimum MLR higher than 85%, such as for managed long-term services and supports populations that typically require lower administrative expenses on a percentage basis; and determining separation/aggregation of populations/contracts for measurement purposes, such as physical

health, long-term care, CHIP, and expansion populations. MCOs may prefer MLR standards be set at the highest level of aggregation so that low(er) MLRs on population segments can be offset by high(er) MLRs on other segments. A State's decision about the level of aggregation will be significant.

Developing MLR reporting templates and instructions to be used by MCOs, including determining details of the MLR calculation's numerator and denominator.

Considering requiring remittances from MCOs:

a) Having discretion to exempt newly contracted MCOs from MLR requirements during their first year
b) Applying a credibility adjustment, to be developed by CMS for smaller MCOs, where lower membership leads to higher MLR volatility due to random statistical variation

Preparing state oversight standards:

a) Reporting to CMS a summary of outcomes of MLR calculations
b) Public displaying of MCO MLR performance annually
c) Specifying a methodology for the repayment of the federal share of any remittances
d) Considering optional "auditing" of MCOs' MLR calculations and reporting

Making a list of challenging aspects of the MLR provisions. There may be alternatives, and states could be afforded flexibilities by engaging CMS in discussion:

a) For example, MCOs must submit MLR reports within 12 months of the end of the MLR reporting year. Is this enough time for states to reconcile incentive and withhold arrangements?
b) The calculation formula is relatively straightforward. However, CMS acknowledges that a lot goes on in Medicaid that is not part of the private market or Medicare Advantage. States may need more details. Here are a few examples of questions from states:

   *Should fiscal intermediary administrative costs for self-directed services be accounted for in the numerator of the calculation? How are services rendered in an Institution for Mental Disease accounted for in the calculation? If Medicaid and CHIP are accounted for in the same actuarial rate certification in a blended mann*er, *how is the CHIP MLR to be calculated and reported?*

WHAT'S NEXT

The Final Rule explicitly connects MLR to capitation rates. The good news is that capitation rating processes that use current Medicaid managed care base data experience are likely already achieving this Final Rule requirement. Generally, actuaries build in less than 15% of premium for administration and underwriting gain. On the flipside, capitation rating processes that use older Medicaid managed care base data, other base data sources such as fee-for-service data for newer managed care programs, or have historically had more than 15% of premium allocated to administration and underwriting gain for some rate cells will require special attention. Actuaries will be reviewing priced-for MLRs in rate development, but they will also consider that historical MLR is just one of many factors considered, and historical MLR results alone do not necessitate prospective rate adjustments. Higher targeted MLRs in capitation rates are allowable as long as rates "are adequate for reasonable, appropriate, and attainable non-benefit costs" 42 CFR 438.4(b)(9).

AFFORDABLE CARE ACT REPEAL AND REPLACE EFFORTS: UNCERTAIN TIMES

After a dramatic journey through the House and the Senate, Congressional efforts to repeal and replace the Affordable Care Act (ACA) are now stalled, with Medicaid a key focus of the Senate deliberations. At the time of the drafting of this article, Senate GOP leadership has announced plans to introduce a repeal and delay bill to repeal ACA but provide Congress with additional time to develop a replacement. Future repeal efforts may consider common elements of both the American Health Care Act passed by the House and the Better Care Reconciliation Act proposed by the Senate. The major Medicaid reforms considered by both bills included:

a) a phase-down of Medicaid expansion,
b) per-capita caps on federal Medicaid spending,
c) a block grant, and
d) a state plan option for work requirements.

While these proposed changes to Medicaid were controversial, it is likely that a replacement bill will include provisions that attempt to curb federal spending and enhance state flexibility. If a replacement bill includes changes to the federal funding of Medicaid programs, states will have to analyze the impact of these financing changes of their programs. To create meaningful estimates of the potential impacts, each state must account for its unique Medicaid population and subpopulations, historical spending and rate of spending growth, demographic trends, existing waivers or other financing arrangements, and program and benefit design. Each of these elements could change the degree to which federal financing mechanisms (e.g., per capita caps or block grants) might affect one state or another. Indeed, the compounding, year-over-year financial ramifications of these different calculations can be dramatic. Mercer's policy and actuarial consultants are available to help our state Medicaid clients assess how they would fare under legislative scenarios.

SO WHAT COMES NEXT?

In the absence of successful legislative changes, we may also see an uptick in states requesting waiver authority to operate their programs with some of these reforms, such as waivers to impose Medicaid work requirements. In addition, we will turn our attention to the pending expiration of funding for the Children's Health Insurance Program (CHIP) and community health center operating support on September 30. Although reauthorizing spending for each of these programs has strong bi-partisan support on its own, it may be difficult for Congress to address those funding issues now that ACA repeal and replace is uncertain. We will also be reviewing changes that are likely to come to the Department of Health and Human Services' budget (given that it assumed passage of repeal and replace legislation). Mercer is following congressional developments closely, and can help state Medicaid programs understand the implications of various proposals or alternatives that might emerge through the legislative process.

For More Information, email us at mercer.government@mercer.com

MANAGEMENT OF SPECIALTY DRUG TREND

Specialty drugs are generally considered to be high cost drugs that are used to treat complex, chronic, or rare medical conditions and that have special handling, storage, inventory, or distribution requirements. Patients receiving these drugs often require specialized education and treatment maintenance, such as complex dosing, intensive monitoring, and clinical oversight. It is no surprise that with specialty drugs like Spinraza™, used to treat spinal muscular atrophy (SMA), costing as much as $750,000 for the first year, these drugs have the potential to considerably increase pharmacy spend for a Medicaid program.

DEFINING SPECIALTY

With state definitions of "specialty" varying, a state-specific specialty percentage of overall prescription drug spend can be difficult to project without a detailed data analysis. However, Mercer estimates specialty drugs to be approximately 1/3 of overall pharmacy spend in 2017 and 2018. The 21st Century Cures Act signed into law in December 2016 provides a pathway for orphan drugs (often considered specialty drugs) to enter the market quickly and provides greater latitude for their use. In a 2017 study by EvaluatePharma, orphan drug sales are forecasted to reach around 20% of worldwide prescription drug sales by 2020. While orphan drugs have a positive lasting effect on patients with rare health conditions as well as for more common conditions such as rheumatoid arthritis and other inflammatory conditions, their market-share increase will also contribute to rising pharmacy costs.

Specialty pharmacy trends for Medicaid programs are forecasted to be up to 14%-18% for Calendar Years 2016-2017 and up to 10%-14% for Calendar Years 2017-2018. These double-digit trends require management strategies to mitigate such impacts. Reimbursement and utilization management strategies remain at the forefront to ensure that pharmacy services are provided in a clinically appropriate and cost effective manner.

Reimbursement strategies can align specialty drug reimbursement with national pricing benchmarks and other reimbursement rates to ensure appropriate payment. Utilization management strategies include adherence to Food and Drug Administration (FDA) approved dosages, diagnoses and duration of therapy for specialty drugs through prior authorization, step therapy and quantity limit programs.

PAYMENT MODELS

New payment models are emerging which can align payment for specialty drugs with valued outcomes. Determining value continues to be a challenge but is important when establishing these payment models.

Emerging value based payment strategies for specialty drugs can include the following:

- high performing pharmacy provider networks paid based on rewards and/or penalties for performance related to medication management, medication reconciliation, and adherence that drive patient health outcomes;
- contracts with manufacturers consistent with outcomes in clinical drug trials; and
- incorporation of value based purchasing requirements in managed care organization contracts and contracts with providers.

IN CONCLUSION

Specialty drug management strategies must be in place to address the potential double digit growth trends projected for specialty medications. Strategies should address both cost and utilization while ensuring provision of clinically appropriate services.

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Helping governments shape tomorrow's health care programs

OVERCOMING THE VBP CHALLENGE

How will you maximize your Medicaid dollar while increasing access and quality in an uncertain healthcare environment?

Medicaid Directors are challenged to answer this question and accelerate transition of their programs to value based payment models. Maximizing Medicaid funds, while improving access and quality, are critical at this time. Designing a value based purchasing (VBP) program in this environment can be difficult as states are expected to function with fewer resources. It is important that a VBP plan addresses the unique program needs, goals, and challenges particular to a state's Medicaid program.

In CMS' November 22, 2013 State Health Official letter (letter four in a series), five key components were outlined regarding designing and implementing care delivery and payment reforms in Medicaid and CHIP programs.

The Five Key Components

Goals	Interventions	Metrics	Targets	Transparency and Feedback

LET'S LOOK DEEPER

Goals

Defining your VBP goals is integral to developing your VBP plan and your quality strategy. Clear program goals lead to the identification of appropriate quality metrics to measure if value and quality goals are being met. It is important to identify goals that offer the greatest return on investment while navigating the complex stakeholder landscape, including gaining approval from state legislators and CMS. A well-defined quality strategy and VBP plan should incorporate short-term and long-term program goals

Interventions

Having the right tools and the right experience is critical for states during the implementation of interventions that achieve VBP goals. Understanding clinical quality and delivery system innovation ensures a smoother implementation and continuous improvement process. States will also need partners to help with translating interventions to policy, revising quality strategy documents and ensuring Managed Care contracts include VBP. States may want to consider building alternative payment methods from pay-for-performance to bundled payments and shared savings models.

Metrics

Selection of quality metrics is a deceptively complex process and one of the primary areas that can lead to VBP program success or failure. States may face barriers to measure selection due to incomplete and unreliable data or lack of availability of data or inability of providers to submit data, particularly in the early implementation stages of a VBP program. However, appropriate measure selection is critical to effectively assess the impact of the interventions and calculate savings or performance awards/penalties. While we advocate for the usage of nationally recognized measures, a state should also consider the development of state-specific technical specifications for outcome measures that evaluate preventable high-cost utilization including low-acuity non-emergent emergency department utilization, preventable admissions and readmissions, and address gaps in care and population health disparities.

Targets

Establishing the expectations for improvement in a VBP program and communicating those to stakeholders has proved critical in promoting the type of transparency that providers and other VBP partners demand. We believe it is important to model a variety of improvement scenarios and commensurate incentives/disincentives. These scenarios include improvement above set thresholds, percent and percentage point improvement and improvement relative to others in the market.

Transparency and feedback

Accurate, consistent and timely feedback is needed to ensure that all stakeholders in a VBP program are aware of the trajectory of their performance. This could include developing interim reporting to VBP partners to ensure they are able to address healthcare gaps, population health drivers, racial disparities and other key quality and utilization metrics. Transparency and feedback considerations must be designed to meet providers where they are at, and may require building provider readiness — only then can providers take the necessary steps to improve. Thus, developing reporting solutions that provide VBP partners with the information they need to achieve the VBP goals is essential as is, demonstrating VBP program success to stakeholders. We have learned that it is critical to provide clear data and actionable information in a dynamic presentation for a wide variety of audiences.

IN CONCLUSION

Value based purchasing and alternative payment models are complex and require significant expertise and resources to develop a plan that ensures State value and quality goals are met while appreciating the pressure on providers to transform their care delivery model. Now is the time to prepare for these goals even when the healthcare environment is fluid and unsure.

QUALITY ENCOUNTER DATA: NOT SO ELUSIVE

Quality encounter data can seem like an elusive unicorn in the health care world. However, having complete, accurate, and timely data is not only a useful tool but a necessity in building quality health care programs which provide members with needed services, ensure provider costs are being met, and maintain a viable program going forward. Quality data is comprised of all the necessary components from claims or encounters delivered in a consistent format by each of the reporting entities.

Once we have complete, accurate, and timely encounters, what can we do with that data? Below are a few areas in which encounter data can have an impact.

- granular utilization analysis
- cost analysis
- accurate rate setting
- value based purchasing
- utilization management
- quality management
- risk adjusted rates

ELEMENTS FOR QUALITY DATA

Capturing the elusive unicorn requires planning, oversight, and tools. The following items can be used individually; however, applying more of these elements increases the strength of the encounter data.

Health Plan Contracts

Strong, clear, and detailed encounter sections drive the expectations and accountability of the health plan. Consequences for not complying with submitting complete and accurate data should be outlined and adhered to. In addition to the encounter section of the contract, some specific requirements such as requiring a facility that acts as both a nursing facility and adult day health provider to have separate Medicaid provider IDs for each purpose can help to insure that encounters are properly bucketed by service.

National Standards

While national standards *seem* straight forward, it is important to remember that the standards cover all forms of health insurance including commercial, Medicare, and Medicaid. It is important for the state to use the flexibility provided within the national standards to align the data with programmatic needs. For example, while "Paid Amount" is "optional" for 837 formatted files, it is intended to be optional due to sub-contracted, bundled or global payments. Those encounters should also include other indicators to show that these encounters have other payment arrangements.

Encounter System Edits

Efficient and helpful edits can be a useful tool for guiding health plans toward better encounters. Medicaid programs vary by state and using 'off the shelf' edits may not meet the needs of each state. Additionally, using edits designed for fee-for-service claims may not meet the needs or may cause other problems for encounter submissions.

Manuals

States should provide encounter manuals when possible. Encounter manuals provide direction to health plans including data specifications and how to resolve rejections due to encounter edits.

EQR ISCA or Plan Reviews

An in-depth review of the health plan's information systems and processes can be instrumental in identifying gaps, omissions, or errors in the data or organizational processes. These gaps may result in missing or incomplete encounters. States may choose to have reviews more often than required, or choose to have reviews that vary in scope from the basics outlined by CMS. Reviews also offer the opportunity to work with health plans to improve their processes and become more efficient overall.

Technical Assistance

Regular technical assistance provides health plans the opportunity to discuss challenges with encounter submissions as well as develop action plans and resolutions.

Communication

States that provide more communication tend to have better encounter data. This communication can take the form of posted website updates, broadcast emails, and regularly scheduled meetings. For example, if a problem is found in an encounter system edit, notification should be broadcast to the health plans to advise them that an error has been found, the time frame needed to update the edit logic, and what actions the health plan should take. Notification shouldn't be limited to a few plans but to all health plans that submit encounters.

IN CONCLUSION

Clean, accurate and complete data is the cornerstone of good data analytics. Spending time and effort early on to ensure that data is functional and that health plans are supplying comparable data makes future analysis more efficient and insightful. Constant vigilance over the quality of data is necessary to guarantee continued success with reporting and data visualizations. Through the use of outlined strategies and a continual focus on quality, encounter data can inform many inquiries and is the basis for positive research and will bring that unicorn to you. Mercer can help your organization with all the elements listed above.