

# Our Services Portfolio

## Mercer Government Ready for next. Together.



### MERCER GOVERNMENT HUMAN SERVICES CONSULTING



### Why Mercer?

Our role in our partnership means facing the demands and pace of change with data-driven pricing, clinically informed policies, and trusted, reliable strategies to manage and deliver care.

### CREDIBLE

For over 34 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multidisciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

### STANDARD-BEARERS

Mercer has a deep knowledge bank, with winning strategies, creative ideas, tested innovations and industry-recognized guidelines. This is our foundation, but our people bring everything to life, sharing their experience and knowledge to improve every outcome.

### TRUSTED

We believe trust accumulates over time. Each project is an opportunity to build a lasting, trust-based bond between our team and our clients. Our team is your team, and together we are collaborative, responsive and ready.

### DEFENSIBLE

Fact-based approaches bolstered by industry-leading experience, pricing and analytics. Our approach to every project is backed by rigorous analysis and market-leading experience.

### TESTIMONIALS

Throughout an engagement, Mercer draws on the extensive experience gained in working with numerous states to develop a strategy that fits the unique needs and specifications of each of our clients. For example:

- For 34 years, we have been serving a state client on the firstof-its-kind fully managed care program that has set the stage for transformation in numerous states.
- Since 1995, we have been working with a state that is home to the fifth-largest Medicaid enrollment base in the US to develop clinical studies, collect data and establish accurate analysis to positively impact policy design and program management.
- For almost 19 years, our service to another state has included work on their HCBS transition journey, including partnering to respond to specific CMS requirements, assessments and remediations to advance the state-wide transition plan. The state is now only the sixth state to receive final approval.

#### OVERVIEW OF OUR SOLUTIONS

- Actuarial consulting developing and reviewing rates, setting policy and methodology for future rate setting, and performing a range of financial and actuarial analyses, including risk adjustment. With the increased emphasis CMS is placing on actuarial expertise, Mercer is well positioned to assist clients on a variety of topics ranging from traditional capitated rate setting to program development and compliance with new healthcare delivery models.
- Behavioral health consulting –

assisting with program design, policy, procurement, implementation, and evaluation of substance abuse and mental health programs. Mercer assists states in meeting the national call to transform mental health systems and the increasing demand to improve access to evidencebased, cost-effective services.

#### Clinical quality consulting –

implementing unique strategies to improve program performance, contain costs, and enhance quality of care and services. We develop evidencedbased strategies to improve clinical quality and provide customized technical assistance to help states bridge learning gaps and teach teams to perform program evaluations that determine program effectiveness.

 Informatics – assisting in the interpretation and evaluation of detailed claims/encounter data, including data analysis and enhancement. Today's healthcare leaders are often data-rich, but information-poor – and laboring under tight time constraints. Accurate analysis and use of healthcare data can ensure effective policy design and program management, ultimately supporting the overall program goal and budget.

- Long-term care consulting developing alternative, high-quality solutions to meet the needs of Medicaid members and dual eligibles in the most cost-effective setting.
- Pharmacy management consulting designing and implementing effective pharmacy management for both fee-for-service and managed care programs. Public plan sponsors choose Mercer because of our demonstrated thought leadership in pharmacy consulting coupled with our proven ability to provide measurable, practical solutions.
- Reporting and monitoring —

developing comprehensive reporting and monitoring systems, and assessing health plan financial efficiency. We assist states in developing comprehensive operational and financial monitoring systems. Our staff experts understand the relationship of sound medical management and quality of care to financial performance and viability.

 Policy and operations – helping states successfully build programs within managed care and other service delivery models, and assisting in efforts to plan strategically and gain input from key stakeholders. States utilize our experience in leadership at the state and federal levels, and our understanding of the barriers and opportunities faced by those involved in systemic change. We have extensive experience in the design, implementation and operation of many state Medicaid and integrated programs. We help ready our clients for what's next: the next policy, the next budget, the next administration, the next opportunity.

We deliver an individualized focus, powered by industry-leading experience, integrated capabilities and passionate people. We help clients achieve better outcomes, develop and deploy defensible strategies, and reshape the delivery of healthcare.

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MERCER GOVERNMENT HUMAN SERVICES CONSULTING



# **Actuarial Consulting**

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

State, county, and local governments face numerous challenges as they work to continue providing quality health care to more people while dealing with tightly constrained budgets. Budget crises, increasing enrollment, escalating health care expenditures, challenges with splintered and lessthan-optimal health care delivery systems, and escalating demands for health plan oversight and accountability are some issues that present unique obstacles to each state and require innovative solutions.

In addition, the landscape of government-sponsored health care programs is changing. This is evidenced by the release of initiatives that came about primarily as a result of provisions under the Patient Protection and Affordable Care Act (PPACA). These initiatives are changing the delivery and financing of health care in the United States and include such topics as health home models, accountable care organizations, health insurance exchanges, and increased focus on duals integration and managed longterm care programs by the Centers for Medicare and Medicaid Services (CMS).

Mercer Government provides consulting assistance built on actuarial knowledge, consulting experience, and creativity to develop comprehensive solutions for its clients. With the increased emphasis CMS is placing on actuarial expertise, Mercer is wellpositioned to assist clients on a variety of topics ranging from traditional capitated rate setting to program development and compliance with these new health care delivery models.

Mercer's actuarial consultants have assisted with a variety of issues, including:

- Actuarially sound capitation rates and rate ranges, with CMS rate approval.
- Risk adjustment for capitation rates.
- Creative alternatives for full-risk and partial-risk contracting, including stop loss, reinsurance, and risk corridors.
- Cost effectiveness and budget neutrality analysis for 1915(b),

1915(c), and 1115 waivers.

- Managed long-term care capitated rate setting.
- Health home reimbursement analysis.
- Accountable Care Organization shared-savings target development.
- Financial analysis related to duals integration projects involving Medicaid and Medicare funding.
- Actuarial analysis to support the development of state exchange programs as well as the basic health plan option.
- Cost evaluation of expansion populations, including the expansion of Medicaid coverage under PPACA.
- Focused data-driven efficiency studies related to health plan management of emergency room utilization and potentially preventative inpatient admissions, as well as management of pharmacy.
- Health plan reviews for compliance and efficiency benchmarking.
- Financial impact of legislative changes and legislative testimony.
- Policy and program strategy, design, and development.

- Technical assistance sessions, including contract/rate negotiations with health plans.
- Primary Care Case Management program enhancement strategy.
- · Identification of efficient provider networks.





### SITUATION

As state-managed care programs have become reliant on managed care financial and encounter data as sources for rate-setting calculations, questions have been raised as to how the resulting rates reflect the concept of value-based purchasing, which is a key tenet of many states' purchasing strategies. To address these concerns, Mercer has performed medical efficiency analyses, using program encounter data, when developing Medicaid managed care capitation rates. Managed care organization (MCO) historical data are used as a base. If the historical MCO program experience contains evidence of inefficient medical management, efficiency adjustments are used to set appropriate rates. This approach ensures that using MCO historical experience does not result in cost-plus rate-setting. State Medicaid programs can demand optimal and achievable value from their contracted MCOs.



### Action is needed to make our health care system more efficient and to ensure more consistent delivery of high-quality care while improving patient safety. As one of the largest groups of health care purchasers, states play an important role in identifying opportunities for implementing successful costcontainment strategies and enhancing efficiencies in the delivery of care, which can free up dollars for other state priorities. By emphasizing care provision in physician offices and other community settings, patient safety is

also improved by avoiding escalations of manageable chronic conditions and preventing hospitalizations or unnecessary emergency room visits.

Mercer's medical efficiency analyses focus on drivers of health care costs and support value-based purchasing approaches that are consistent with a prudent purchasing strategy. These analyses are predicated on national guidelines/best practices and supported by national literature reviews and health services research. The underlying methodology was developed by an expert panel consisting of physicians, nurses, and pharmacists with managed care experience. Through this process, Mercer applies clinical expertise to various data-driven/analytical approaches using the managed care program encounter data to identify unnecessary health care expenditures that can be addressed through improved efficiencies and care management processes.



### Low Acuity Non-emergent (LANE) Emergency Room Analysis

Emergency room visits are expensive, costing two to three times as much as visits in a physician's office. Research published by the Centers for Disease Control and Prevention indicates that approximately 31% of ER visits in the United States are for nonurgent events or visits requiring immediate service.<sup>1</sup> Mercer's LANE analysis employs approximately 500 ICD-9 codes, which research indicates can be representative of instances in which an ER visit could have been avoided had effective outreach, care coordination, and access to preventive care been available. Based on industry best practices and supporting literature, Mercer developed a data-analytic procedure to identify low to moderate acuity diagnosis codes that could potentially be avoided. Some examples of conditions included in this type of analysis are fever, headache, cough, rash, and removal of sutures.

#### Potentially Preventable Admissions (PPA) Inpatient Analysis

Many hospitalizations represent ambulatory care failures. According to the Agency for Healthcare Research and Quality (AHRQ), one out of every 10 hospital stays was potentially preventable (based on 2008 data).<sup>2</sup> Mercer's PPA analysis identifies inpatient admissions that could have been avoided in the managed care programs through high-quality outpatient care and/or reflect conditions that could be less severe and not warrant an inpatient level of care if treated early and appropriately. These are identified through claims data using criteria from the AHRQ's Guide to Prevention Quality Indicators and Pediatric Data Indicators, with additional filters applied to better understand MCOs' ability to prevent the admissions in the Medicaid environment.



### RESULTS

As a result of these clinically informed, data-driven analyses, Mercer actuaries have incorporated medical efficiency adjustments into the development of actuarially sound capitation rate ranges. These adjustments, based on sound clinical input, have reduced the MCO capitation rates to reflect clinical medical efficiency targets, even after factoring in the offset of expected increases in physician and other outpatient costs. The results vary by state, but the following ranges should help inform the magnitude of each measure:

- LANE adjustments: typically 5%–10% of total ER costs.
- PPA adjustments: typically 3%–5% of total inpatient hospital costs.

<sup>1</sup>Nawar EW, Niska RW, and Xu J. "National Hospital Ambulatory Medical Care Survey: 2005 Emergency Department Summary," Division of Health Care Statistics Advanced Data for Vital and Health Statistics, Number 386 (2007), available at www.cdc.gov/nchs/data/ad/ad386.pdf.

<sup>2</sup> Stranges E and Stocks C. "Potentially Avoidable Hospitalizations for Acute and Chronic Conditions, 2008," AHRQ's *Healthcare Cost and Utilization Project (HCUP) Statistical Brief*, Number 99 (2010), available at www.hcup-us.ahrq.gov/reports/statbriefs/sb99.pdf. We help ready our clients for what's next: the next policy, the next budget, the next administration, the next opportunity.

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State governments are facing increasingly complex budgetary, clinical, and regulatory challenges in the provision of behavioral health services to vulnerable populations. The national call to transform mental health systems increases the demands on state and local governments to improve access to evidence-based, cost-effective services. The everchanging regulatory environment requires significant planning and creativity on the part of government agencies tasked with monitoring and improving quality, access, and cost-effectiveness.

Many of Mercer's behavioral health specialists have public mental health system experience at the state and local levels, and understand the barriers and opportunities faced by those involved in systemic change. Our public sector and behavioral health experience is complemented by our expertise in Centers for Medicare & Medicaid Services (CMS) policy and federal regulations, and our experience in information systems, encounter data management, actuarial rate setting, strategic planning, and managed care. By teaming our clinical and policy experts with Mercer's actuarial and information planning consultants, we have the depth and breadth of experience to help our clients increase their financial and operational efficiencies.

We combine high-level strategic consulting with practical solutions to help states transform and manage their behavioral health programs. Our consultants are actively working in a number of states to bring evidencebased practices and care-initiative systems from concept to reality. Our capabilities and experience include:

 Strategic planning, including program design based on national trends and best practices, waiver development, and clinical-practice guidelines development and pay-forperformance initiative

Mercer Government Human Services Consulting helps government agencies design, implement, and monitor behavioral health programs that enhance the quality of care while controlling financial and operational burdens. Mercer's dedicated group of experienced psychiatrists, psychologists, psychiatric nurses, social workers, substance-abuse professionals, pharmacists, and former CMS policy experts provide varying levels of clinical, operational, policy, and strategic consulting.

- Policy and regulatory guidance and technical assistance related to 1915(b), 1915(c), and 1115 waivers as well as state plan amendments, including Section 1915(i), Home and Community-Based Services, and Section 1945, Health Home State Plan Options
- Procurement assistance, including development of program standards and requirements, and the technical questionnaire and evaluation criteria; design of performance guarantees and incentives; training, technical assistance, and oversight during the evaluation phase; and facilitation of site visits and finalist negotiations
- Behavioral health program management, including performance-based contracting, readiness, and clinical operational reviews of behavioral health managed care organizations; benchmarking studies; fidelity reviews; and related corrective-action plan development and monitoring
- Actuarial analysis, including financial analysis for waiver and state plan development (including review of other state-funded programs for potential Medicaid coverage), capitated rate setting for managed care programs, fee-for-service rate setting for fee schedules, and cost driver analyses integrated with behavioral health program management consulting



### SITUATION

The state sought to transform the healthcare delivery system from a feefor-service (FFS) chronic case model to a community-based Medicaid managed care model while improving health outcomes and reducing healthcare costs. Key objectives included promoting recovery-oriented services grounded in evidence-based practices and integrated across delivery systems and multiple state agencies.



The state's Medicaid behavioral health delivery system was largely unmanaged and the FFS payment structure lacked accountability for outcomes and led to fragmented care. The broad array of treatment options was difficult to navigate, and there were few incentives for coordinated or personcentered care. As a result of historical funding and local priorities, behavioral health services varied by region, and many MCOs did not have experience managing complex behavioral health populations. A comprehensive, efficient approach to a statewide rollout was necessary for successful implementation.



Mercer supported the state's crossagency workgroup by providing policy, program design and implementation assistance to support moving behavioral health services and populations from FFS to managed care. Phases of the project included:

- Analyzing federal authorities, facilitating strategy sessions and providing briefing documents to inform policy and program design decisions, including amending an 1115 demonstration waiver and integrating separate 1915c waivers into a single Home and Community-Based Services (HCBS) authority
- 2. Providing clinical and policy expertise to develop needs-based eligibility criteria, service definitions and staffing qualifications for HCBS
- 3. Providing financial support for budget projections, budget neutrality calculations, fee schedule development for new or revised services, and capitation rate impact analyses
- Drafting behavioral health-specific contract standards to support the state's key objectives



- 5. Developing a request for qualification and readiness review protocols with evaluation criteria to qualify existing MCOs to administer new behavioral health and HCBS benefits
- 6. Training state staff on evaluation criteria, readiness review protocols and HCBS requirements
- 7. Co-leading a team of clinical, member services, network, quality management, information systems, claims and financial subject-matter specialists to conduct desk and on-site readiness reviews at each MCO



### RESULTS

The state is on a clear path toward system transformation that supports recovery-oriented, person-centered care that is integrated at the point of service delivery. Financing links payment to outcomes and supports evidence-based and promising practices as well as services and supports to maintain individuals in their homes and communities. The service array and delivery system structure address the unique needs of individuals, including medically fragile children, transition-age youth and individuals with first-episode psychosis, serious emotional disturbance, serious mental illness and/or substance use disorders.

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### MERCER GOVERNMENT HUMAN SERVICES CONSULTING

# Behavioral Health Program Integrity Best Practices

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

Medicaid expenditures almost doubled during the past decade, from more than \$200 billion in 2000 to \$374 billion in 2009; many states have adopted managed care as a response to this growing expenditure. With this shift in health care come new challenges in containing costs and new opportunities for fraud, waste, and abuse to occur. The original thinking of many within the industry is that fraud did not exist in managed care; however, experience has proved that fraud does exist in many guises within a managed care environment.

In this environment, states are directly responsible for monitoring the operations of behavioral health managed care organizations (BH-MCO) and are required by federal mandate to have effective fraud, waste, and abuse detection and prevention programs. State Medicaid programs have implemented a variety of approved waivers to meet their unique populations' behavioral health needs and these unique waivers incorporate different types of services and operational practices. This diversity complicates the provision of effective program-integrity systems, which at times is further impacted by the lack of adherence to NPI standards for all vendors for in-home and community-based services. The likelihood of overlapping provider networks shared between different BH-MCOs and decentralized claim processing further impedes programintegrity oversight.



#### HOW MERCER CAN HELP

Mercer Government Human Services Consulting (Mercer) can help identify best practices in Medicaid BH-MCOs to maintain regulation compliance and effectiveness in program integrity.

- We have established review criteria to benchmark BH-MCO program-integrity efforts
- We have created BH-MCO report cards to establish a method to compare BH-MCOs
- We have identified promising practices in BH-MCO programintegrity efforts

#### OUR EXPERTISE

Mercer's program integrity team has experience in Special Investigations Unit operations, policy-setting at both the state and federal levels, data validation, and identification of program integrity best practices. We are experienced at designing evaluations that monitor BH-MCOs' programintegrity efforts, and we have evaluated and monitored several states' unique MCO program-integrity systems. This is built upon our deep understanding of Medicaid. Our extended team of behavioral health specialists has public mental health experience at both the state and local levels, and understands the barriers and opportunities faced by those working in Medicaid. Our public sector and health care experience is complemented by our expertise in CMS policy and federal regulations, information systems, encounter-data management, actuarial rate-setting, strategic planning, and managed care. Our multidimensional approach of teaming our clinical experience and policy experts with actuarial and information planning consultants provides a unique depth and breadth of experience to help our clients increase the operational effectiveness of their program integrity.

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MERCER GOVERNMENT HUMAN SERVICES CONSULTING



# Child/Youth Behavioral Health And Well-Being

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

State governments are facing increasingly complex budgetary, clinical and regulatory challenges in the provision of behavioral healthcare to vulnerable populations. The national call and local demand to transform health systems increases the demands on state and local governments to improve access to evidenced-based, cost-effective and outcomesdriven services. In particular, for the approximately 45,231,315<sup>1</sup> children/ youth enrolled in CHIP and Medicaid programs, there are added implications due to involvement from multiple state authorities (child welfare, special education, juvenile justice, etc.).

Despite improvement across child well-being domains, there are increasing rates of poverty, singleparent households, numbers of young children not attending school and children/youth entering and remaining in foster care.<sup>2</sup> Across all indicators, there is wide racial disparity, in which African-American, American Indian and Hispanic children, youth and families fare worse than the national average.<sup>3</sup>

### HOW MERCER'S GOVERNMENT HUMAN SERVICES CONSULTING TEAM CAN HELP

Mercer's dedicated consulting teams bring states a wide variety of expertise, including clinical, operational, policy and strategic consulting across the spectrum of behavioral health and operations as well as specialization in EPSDT and child/youth-serving systems.

The Mercer team has helped several states design, implement and advance their children's service system initiatives. The children/youthfocused consulting, TA and training services are outlined below:

 System and program design based on trends and evidence-based practices, clinical practice guidelines, cross-system collaborative models and specialty population considerations (for example, birth to five, transitionage youth, children impacted by trauma)

- **Operational design**, including quality management, utilization management, care coordination, care management, pharmacy management, health homes and associated streamlining of functions and assessments to reduce duplication and support navigation for families
- Benefit design, policy and regulatory guidance and technical assistance related to eligibility, service array, waiver development (1915[b], [c], [i], 1115), state plan amendments (SPA), parity, CHIP and EPSDT
- Financing strategies and stewardship, such as maximizing federal match, leveraging cross-system financing (for example, Title IV-E), braiding funds, cost sharing and pay-forperformance initiatives
- Collaborative systems design, including development of agreements, committee and communication structures, and family/caregiver/ stakeholder inclusion and involvement

# **Case Study**

### MOVING TO MANAGED CARE TO TRANSFORM A STATEWIDE SYSTEM



### SITUATION

The state was tasked with restructuring the Medicaid program to achieve improvement in outcomes, sustain cost and build a more efficient administrative structure. Key features included moving behavioral health (BH) services from FFS into managed care and incorporating the ability to manage specialty BH services. Managed care organizations would now be responsible for managing integrated physical health, behavioral health and home- and community-based services (HCBS). For children/youth, the state's vision is a future in which managed care plans, service providers, family peers, youth peers and government partner to improve the health and wellness of children/youth with physical disabilities, intellectual/developmental disabilities (I/ DD) and mental illness and substance use disorders, regardless of entry point.



### CHALLENGE

The state decided to merge five existing waivers across multiple agencies into their 1115 waiver. This needed to be done without interrupting existing access, care and services for children currently enrolled in the waivers; resolve different eligibility and enrollment processes while managing cost; and address the varying needs of foster care, I/DD and medically fragile populations.



Mercer's team included federal policy and managed care experts as well as child/youth clinical specialists and actuaries. Mercer facilitated strategy discussions (including briefing documents) with state leadership to inform key design decisions, provided financial impact analyses and supported drafting the 1115 waiver and state plan amendment. Mercer provided extensive support with the development of HCBS functional criteria, contract standards specific to children/youth/families, a readiness review tool and rates.



RESULTS

The design resulted in multiple agencies working together on a common vision to break down silos between mental health, physical health and child welfare. Ultimately, the transformation will allow for streamlined cross-system coordination to deliver one integrated system, giving children/youth/families access to the level and array of services needed to meet their unique needs. We help ready our clients for what's next: the next policy, the next budget, the next administration, the next opportunity.

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### CREDIBLE TRUSTED STANDARD-BEARERS DEFENSIBLE

<sup>1</sup> Based on state-reported data as of 5/2/2016 from the table "FFY 2015 Number of Children Ever-Enrolled in Medicaid and CHIP," available at https://www.medicaid.gov/chip/downloads/ fy-2015-childrens-enrollment-report.pdf, accessed October 12, 2016.

<sup>2</sup> U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. The AFCARS Report, Issue 22, July 2015, available at http://www.acf.hhs. gov/sites/default/files/cb/afcarsreport22.pdf, accessed October 12, 2016.

<sup>3</sup> Annie E. Casey Foundation. 2016 KIDS COUNT Data Book: State Trends in Child Well-Being.



MERCER GOVERNMENT HUMAN SERVICES CONSULTING



# Intellectual/Developmental Disabilities (ID/DD)

Intellectual/developmental disabilities programs across the country are at a crossroads. State officials are being pressured to reconsider enrollment and eligibility criteria at a time when many states are addressing challenges with their budgets. There are also demands for improved government-sponsored programs, such as relief from high-cost prescription medications.

Administrators and public-policy officials are facing demands from consumers and advocacy groups to implement more creative systems that allow consumers more control, such as consumer-directed services and individualized budgets. The Centers for Medicare and Medicaid Services (CMS) is enforcing new federal requirements for Medicaid waiver programs. All of these demands are increasing the challenges of state ID/DD programs.

States currently spend most of their ID/DD dollars using fee for service, but ten states are using managed care and at least nine states are planning to transition people with ID/DD to integrated managed care programs to coordinate their acute medical care, behavioral health services, and long-term services and supports. Medicaid managed care is serving various population groups in one form or another and is present in virtually all states.

To address the issue of increased costs, states are downsizing institutional programs, outsourcing services such as case management, and developing waivers that capitate individuals' costs or limit the number of enrollees. States also must comply with CMS expectations to improve access to services for all enrolled individuals, encourage self-directed services, comply with the Home and Community-Based Services (HCBS) final rule, and support quality outcomes for eligible persons. The HCBS waiver programs within each state are being closely reviewed prior to renewal to ensure that the services promote individual choice and increase individual control over resources, and that all services and supports are provided in safe environments.

Mercer Government Human Services Consulting (Mercer) assists states in evaluating federal compliance;

developing and evaluating reform initiatives; linking strategic planning and policy changes to financial outcomes; and reviewing, revising, and establishing reimbursement methodologies and rates. Mercer has assisted many states in complete system reform, which integrates all functional areas, including personcentered planning, provider rate development, program design, procurement, performance-based contracting, staff training and development, systems enhancements, conversion from fee-for-service to a managed care delivery system, and budgeting and fiscal analyses.

Mercer has also assisted states in transforming specific segments of their programs, such as:

- Strategic program planning
- Assessment development for allocating public funds to individuals and families
- Review of individual and family budget systems for self-determination
- Actuarial rate setting and analysis
- Assessment of program quality, outcomes, and operations

- CMS waiver development
- Integration of public-funding streams
- Provider-network development
- Statutory compliance monitoring
- Request-for-proposal development
- Vendor evaluation, selection, and negotiation
- Risk assessment
- · Sampling and statistical modeling

# **Case Study**



### MOVING TO MANAGED CARE USING AN 1115 WAIVER TO REFINANCE, REPAIR, AND TRANSFORM A STATEWIDE SYSTEM



### SITUATION

A state ID/DD department was facing intense pressure from its stakeholders to make its patchwork of multiple waivers understandable and respond to continuous pressure to serve its large and growing waiting list. Simultaneously, state leaders wanted support coordination to inform and provide participants and their families' with information about their funding and array of services. The situation was amplified because of projected caseload growth without additional funding from the legislature, growing costs. 20 or more waiver fixes that each cost additional dollars, and individuals who had never received supports or services. The department of the state was leading the movement to managed care as soon as possible.



### CHALLENGE

The department wanted to expand and integrate the range of service offerings without waiver silos and improve and coordinate the efforts of its network of providers while creating a more flexible and understandable consumer-driven approach. The ID/ DD department wanted to improve behavioral support services, resolve gaps in the system, reduce the waitlist, review compensation to providers, and integrate services (including acute, behavioral, HCBS, and institutional services) without increasing overall costs while simplifying administration.

Mercer was called to assist in program design and development of a fair and equitable reimbursement-rate system that was consumer-driven, as well as a fair and equitable means of allocating resources using a level or tier system informed by the Supports Intensity Scale (SIS).

As an ongoing project, the state needs to shift spending by managing acute medical care, prescription drug, and institutional costs while also integrating case management and its behavioral health system to support the needed improvements. CMS must be convinced to help the state move toward an 1115 waiver to allow the state to meet these challenges and find a sustainable funding strategy for the next 10 years.



Mercer is approaching the challenge by bringing together former CMS staff, experienced managed care managers, ID/DD specialists and actuaries, and compensation specialists to work with the state. A standard rate schedule informed by the SIS is being developed based on the compensation costs for direct-care staff. Mercer is designing a resource-allocation protocol for the distribution of state funds and an individual and family budgeting tool to serve as the basis for purchasing services using the standard rate schedule. Individuals in the half-dozen ID/DD waiver programs, fee-forservice Medicaid, waitlists, and other programs were carefully counted and multi-year history and projection of the state's new architecture were created for review with state leaders.

As a final step, using this robust information, Mercer is helping the department develop a compelling presentation for CMS for an 1115 demonstration waiver.



The proposed system transformation and reform will allow users to customize services while compensating the service network fairly and assigning resources more efficiently. The state agency plans to implement the new system and the resource-allocation protocol without waiver silos pending CMS approval. The state is planning on moving from a situation of eternal crisis to an example of what carefully managed Medicaid ID/DD services can provide. Together, these tools allow the state to control expenditures by allowing for caseload growth while controlling budget growth. The stakeholder groups are actively involved in the new program design and are committed long term to the system changes.

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# **Clinical Quality Consulting**

The delivery of high-quality, cost-effective healthcare is crucial to ensure our healthcare delivery system remains viable not just for today but for the future.

Providing government-sponsored healthcare to some of the sickest and most vulnerable populations – in a cost-efficient manner — can be especially challenging for states, and Medicaid agencies are often tasked with defining value and measuring clinical quality. Yet poor clinical quality can have lasting adverse effects on a Medicaid program. Delivery system fragmentation, poor care coordination, a lack of integrated care that supports both medical and physical health, and inconsistency in coordinating supports for those with functional, intellectual and developmental disabilities have resulted in many states turning to Managed Care Organizations (MCOs) to develop cost-efficient and coordinated high-quality healthcare models. States functioning under a managed care model now have an urgent need to understand if their managed care program and their MCO contractors are truly producing the best value.

High-quality healthcare should be cost-effective and utilize evidencedbased medicine to produce healthy outcomes. When you partner with Mercer, we ask the right questions to help you define the quality and value you desire in your program. We develop evidenced-based strategies to improve clinical quality and provide customized technical assistance to help you bridge learning gaps and teach your team to perform program evaluations that determine program effectiveness. Below are some of the questions we pose to help states improve and realize their goal of delivering clinical quality:

### MANAGED CARE OPERATIONS

- Though your MCOs are passing their compliance reviews, do you still have questions about the efficiency and effectiveness of their operations?
- Have the interventions implemented by the MCOs driven measurable and meaningful improvement in outcomes?
- Are your MCOs building, engaging and leveraging community-based organizations and partnerships to address social factors that

influence poor health outcomes (social determinants of health for your members)?

• Are perceived gains in quality clearly real and sustainable?

### VALUE-BASED MODELS OF CARE

- Do you use the carrots and sticks available to you to manage your MCO contractors to the best extent possible (that is, pay for performance and sanctions)?
- Are MCOs driving real innovation and developing strong provider partnerships?
- Do your providers feel a true partnership with your MCOs?
- Do your MCOs design value models that are sensitive to provider burden?
- Is your value-based purchasing model targeting the true drivers of healthcare quality?

#### QUALITY STRATEGY

- What story would you like to tell through your program's healthcare outcomes?
- Are your members really receiving person-centered care that empowers them to make the right healthcare choices and be engaged in their care?
- Are your quality activities and your MCO quality activities aligned to achieve the goals and objectives of the state's quality strategy?
- Is your monitoring and oversight program streamlined such that you can do more with less and can quickly allocate limited resources to the most problematic areas to ensure the greatest success?

### PERFORMANCE MEASUREMENT

- Are you measuring what matters or making what you measure matter?
- Are the reports your team reviews giving you actionable information on the successes and opportunity areas of your program?
- Do your selected performance indicators measure compliance or performance improvement?
- Are all your performance measures meeting established benchmarks and targets?
- Are your performance measures aligned across your quality strategy and your value-based purchasing model?

If you have answered "no" or "I'm not sure" to any of these questions, Mercer can help.

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#### OUR EXPERTISE

Mercer's value is in our strong, multidisciplinary team, which includes licensed clinicians (registered nurses, clinical social workers and psychologists, etc.) physicians, healthcare analysts and certified coders. We can assist in developing and implementing clinical quality-monitoring strategies, evaluating program achievements and assessing the value each managed care contractor contributes to program goal attainment. To support our analyses, our clinical team taps into the vast knowledge of our Mercer colleagues, including pharmacists, government policy experts, statisticians, informatics specialists, certified public accountants and actuarial experts.

Mercer can assist in the end-to-end process of overseeing and evaluating your program. We believe in using rapid-cycle quality improvement methodology to allow for real-time evaluation and interventions. We have more than 20 years of experience developing tools to create efficiencies, and we can help you move the needle on your clinical quality outcome goals.

### Mercer can help you focus on quality in the following areas:

- Preventive care
- Disease/chronic-care-specific programs
- Accessibility and availability of services
- MCO oversight
- Delivery system performance
- Member satisfaction
- Utilization strategy
- Integrated services
- Compliance with federal and state rules
- Performance vs. compliance measures
- Provider satisfaction
- Evidenced-based practices

#### We can provide the following support:

- Technical assistance to revise your quality strategy and your program evaluation criteria
- Performance measure selection, calculation and validation
- Development and implementation of value-based purchasing strategies
- Managed care plan reviews
- Survey administration
- Running of focused studies
- Development of monitoring and oversight tools and reports
- Provision of technical assistance to state staff and MCO contractors
- Evaluation of and recommendations for managed care contract revisions to support clinical quality activities



MERCER GOVERNMENT HUMAN SERVICES CONSULTING



# Addressing the Problem of Low Acuity Non-Emergent ED Visits

A Clinical Efficiency Analysis Approach To Influencing Quality Of Care Strategies and Reducing Avoidable Health Care Costs

# For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

Emergency departments (EDs) have become the front door to health care for many Americans — often for non-urgent and even routine health care problems. The costs of these low-acuity ED visits can be more than triple the cost of treatment in a primary or urgent care setting. In fact, according to medical- expenditure survey data from the Agency for Healthcare Research and Quality, the mean cost for ED visits in 2011 of \$1,354 was more than six times higher than the 2009 mean cost of a physician office visit (primary and specialty care average) of \$218. Overall, estimates of waste in the health care system related to unnecessary ED visits totaled approximately \$14 billion in 2010, not including replacement costs had services been delivered in a more appropriate setting.

As rising health care expenditures continue to contribute to both federal and state budget costs, many Medicaid directors, state policymakers, and stakeholders are interested in understanding and curtailing inappropriate and avoidable use of the ED. A January 2014 CMCS Informational Bulletin documented that Medicaid beneficiaries used the ED at almost a twofold higher rate than privately insured counterparts.<sup>1</sup>

From the perspective of achieving the triple aim (better health quality, better experience of care, and sustainable cost), consider that EDs were designed to treat the most critically ill and injured patients as well as to act as a safety net during public health emergencies such as catastrophic events, epidemic outbreaks, and even terrorist attacks. Inappropriate ED utilization can negatively impact hospital resources (resulting in overcrowding and long wait times), contribute to fragmented care, and cost health programs significantly more than alternative settings. A 2010 RAND Corporation study indicated that between 14% and 27% of all ED visits for non-urgent reasons could take place in an alternate location, resulting in potential cost savings of \$4.4 billion annually.<sup>2</sup> Additionally, fragmented care increases inefficiency, ineffectiveness, and inequality within the health system.<sup>3</sup>

#### A STANDARDIZED APPROACH

There is no lack of research on the topic of ED usage. However, nationally, there is a shortage of consistent terminology and methodology for studying inappropriate and/or avoidable/preventable ED usage. This makes it difficult for researchers, Medicaid program directors, hospital administrators, and even managed care organizations (MCOs) to analyze, compare, and study interventions to address aberrant ED utilization patterns.

Mercer's Low-Acuity, Non-Emergent (LANE) analysis was built specifically to identify and quantify the impact of LANE ED usage. Our analysis is underpinned by extensive healthservices research, with additional input from an expert panel that includes ED physicians, state Medicaid chief medical officers, and other clinical providers with Medicaid and MCO experience.

Mercer's LANE ED analysis provides a systematic and evidence-based approach for evaluating trends and patterns of ED utilization. Mercer's approach is differentiated in the marketplace, as we analyze a number of data points – such as diagnosis, physician evaluation and management coding, and treatment rendered during the ED event – to quantify the preventable LANE utilization in a given state or population. Mercer's analysis includes methodology to identify potentially unavoidable costs (that is, treatment cost for services such as laboratory and radiology testing that would have occurred regardless of treatment setting), considers the cost of providing the care in an alternate setting, and adjusts the results to account for these costs. Thus, our analysis identifies both the avoidable costs and the "replacement" costs for services provided at an alternate setting.

#### IMPACT AND INFLUENCE

Mercer's approach to management of LANE ED utilization is based on robust clinical and actuarial analysis. This approach can be used to assist states as they focus their attention on value-based purchasing strategies and eliminating inefficiency and waste. The LANE analysis provides objective data in a useful dashboard format for state Medicaid agencies to leverage in improving collaboration with their health care delivery partners such as MCOs, accountable care organizations, medical homes, and fee-for-service providers.



Through our extensive and ongoing research, we have identified consistent themes of actionable barriers that vested stakeholders, such as Medicaid MCOs and state Medicaid agencies, can focus on to make an impact. The most common include:

- · Access to providers (primary and specialty care)
- · Availability:
  - Lack of timely available appointments for providers
  - Lack of after-hours and weekend care with primary providers
- Inadequate or lack of chronic condition care coordination
- Lack of integrated electronic health information systems available for use by ED staff and physicians
- Payment strategies that do not promote use of alternative ED settings
- Travel/transportation to services
- Lack of enrollee education on signs and symptoms appropriate for an ED visit

Each of these causes can be addressed and appropriately managed to mitigate the inclination to seek care in an ED setting. Despite the complexities involved, LANE analysis can provide a standardized and consistent approach for measuring and quantifying the impact of LANE ED utilization on the health care system. This standardized approach facilitates meaningful discussion with multiple stakeholders to drive sustained improvement.

#### APPLICATION OF THE LANE ANALYSIS

The LANE analysis can be applied in many ways. Some states choose to use LANE as part of the actuarial rate-setting process for managed care contractors, while others may use LANE as a measure within a pay-for-performance program or as a quantifiable measure within a performance-improvement project.

As states continue to implement innovative health care reform initiatives, Mercer's LANE analysis can play a critical role in informing health system performance, as uncontrolled ED utilization is often a signal for inefficiencies in other areas of the health care service delivery continuum. We help ready our clients for what's next: the next policy, the next budget, the next administration, the next opportunity.

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<sup>&</sup>lt;sup>1</sup> Center for Medicaid and CHIP Services. "Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings," *CMCS Informational Bulletin* (2014).

<sup>&</sup>lt;sup>2</sup> Rand Health Corporation. *The Evolving Role of Emergency Departments in the United States* (2013).

<sup>&</sup>lt;sup>3</sup> Stange KC. "The Problem of Fragmentation and the Need for Integrative Solutions," *Annals of Family Medicine*, Volume 7, Number 2 (2009).



MERCER GOVERNMENT HUMAN SERVICES CONSULTING

# Home And Community-Based Services Consulting

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

States are being driven to rethink home and community-based services (HCBS) and move in new directions, despite budget constraints and staffing limitations. States are also being challenged by consumers and advocates to move away from institutional services and, instead, create innovative ways to better facilitate community integration by regulators (to increase the transparency, oversight, and objectivity of HCBS waiver programs) and by the provider community (to improve the fairness and equity of their rate systems and fund program expansion.) The HCBS final rule presents yet additional challenges as well as opportunities for states to foster community integration and service delivery.

#### HOW WE CAN HELP

Mercer consultants have helped numerous states advance many HCBS program initiatives. The array of HCBS consulting services is outlined below:

- HCBS final rule implementation and compliance activities, including analyzing current HCBS settings through the use of tools such as provider surveys, analyzing personcentered care planning development and processes, and developing transition plans using Mercerdeveloped assessment review tools
- Strategy development to assist in redefining and rebasing HCBS rate systems to improve transparency, objectivity, fairness, and equity, including developing program and financial policies to support those systems
- Organizational design consulting to assist in operational restructuring and program oversight

- Financial consulting to design costcollection tools and to analyze the resulting cost data
- Actuarial consulting to assess financial risks and develop rates using cost data collected from providers, along with appropriate independent data sources
- Stakeholder engagement to ensure collaboration with advocates, providers, and consumers to create system changes and improve program quality and outcomes
- Policy design and waiver development to ensure advancement of program goals and compliance with requirements of the Centers for Medicare & Medicaid Services
- Program design consulting to align multiple HCBS waivers to ensure that goals are met across programs and do not compete against one another
- Clinical consulting that helps develop quality strategies and performance metrics
- Compensation analyses used to improve workforce issues for directcare service professionals

- Information technology consulting to help reduce administration, improve program compliance, and ensure that claims payment systems are capable of supporting rate system changes
- Balancing Incentive Program implementation, consulting, and financial reporting to assist the state with increasing access to home and communitybased services and to obtain higher federal financing participation
- Money Follows the Person implementation and reporting to help the state meet its grant requirements

The way the country utilizes and defines HCBS is undergoing dramatic change while current services grow at a doubledigit pace to meet demand. Mercer has extensive and broad experience to help clients move their programs into the future amid this change.





### SITUATION

The client wanted to undertake a comprehensive rebasing of its home and community-based rate system. The client had previously undergone a process of converting from individualized rates to one that used standardized rates and modifiers. In the client's first effort to rebase the standardized rates, the goal was to reestablish an objective price that was market-driven, experience-based, supported the client's policy goals, and incorporated several improvements to previous rate-setting initiatives.



#### The client:

- Had very little clinical, operational, or financial data to support the rate-setting process.
- Wanted to correct several assumptions made when the rates were originally set.
- Knew the process would be subjected to intense scrutiny from stakeholders.
- Needed to update and change rates to reflect new policy initiatives and direction.
- Did not have a project plan to rebase rates.



Mercer worked closely with the client and its partners to design and implement a comprehensive raterebasing process. Mercer sought to address all programmatic areas to ensure the final rates would be appropriate and reflect the client's goals. As part of this rate-setting process, Mercer:

- Reviewed data gathered through focus groups with client field staff to understand service-specific issues, problem areas in the rates, and the market for services.
- Incorporated data gathered through focus groups with consumers and families to understand issues with access, quality, and their

expectations of the client and providers.

- Reviewed, implemented, and analyzed a detailed cost report included data cleaning, validation, and remediation.
- Gathered and reviewed third-party data sources for use as independent benchmarks on areas such as food cost, transportation, direct-care wages, and utilities.
- Reviewed and suggested modifications to service definitions to align payment, scope, and consumer needs.
- Developed rates for services using cost report data.
- Performed several actuarial and financial analyses on budget, cost, and risk transference.
- Conducted numerous public meetings on the rates and impacts.



### RESULTS

The client was able to finalize and publish a set of rebased rates that recognized stakeholder needs, better aligned payments to consumers' needs and objectives, incorporated programmatic goals, and best matched payment to the risk borne by providers in delivering services.

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MERCER GOVERNMENT HUMAN SERVICES CONSULTING



# Assistance Implementing HCBS Transition Plans

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

With implementation of the Home and Community-Based Services (HCBS) final rule, published January, 16, 2014, the Centers for Medicare & Medicaid Services (CMS) codified long-standing policy governing expectations for HCBS program service delivery. The HCBS final rule, effective March 17, 2014, aligns federal requirements for HCBS programs across the following federal authorities: 1915(c) HCBS waivers, 1915(i) optional state plan benefit, and 1915(k) Community First Choice program. These authorities are specifically delineated in the HCBS final rule.

A growing number of states use the 1115 research and demonstration authority to operate their HCBS programs, particularly those with managed long-term services and support programs. Although the 1115 research and demonstration authority is not addressed in the HCBS final rule, CMS has since clarified that the requirements also apply to states operating HCBS programs under this federal authority. Therefore, every state operating an HCBS program is impacted by the HCBS final rule.

A primary objective of the HCBS final rule is to ensure that individuals receiving HCBS have full access to the benefits of community living and the opportunity to receive services in the most integrated setting possible. To accomplish this, CMS places particular emphasis in the HCBS final rule on the requirements for the care settings. New requirements in the HCBS final rule regarding appropriate home and community-based settings focus on the experience of the individual in the setting and include, for example, requirements such as the setting must:

- Support the individual's full access to the greater community
- Be selected by the individual from among setting options
- Ensure individual rights of privacy, dignity, respect, and freedom from coercion and restraint
- Optimize autonomy and independence in making life choices
- Facilitate choice regarding services and who provides them

HCBS programs developed after March 17, 2014, must meet all requirements prior to receiving CMS approval. Existing programs in operation prior to March 17, 2014, are provided a transitional period in order to comply with the new requirements. States were required to submit transition plans to CMS by March 17, 2015, for review and approval.

A state's transition plan should serve as the comprehensive and detailed roadmap noting the specific activities that will be implemented and the timeframes associated with each activity to demonstrate compliance with applicable federal



requirements for HCB settings. The transition plan should take into consideration all necessary steps to assess the adequacy of the comprehensive HCBS system of care and the necessary measures to remediate any identified issues, prior to March 17, 2019.

#### MERCER CAN HELP

Implementing transition plans can be a resource-intense exercise for states. Our wealth of experience working with states in designing, implementing, and monitoring HCBS programs as well as developing HCBS transition plans makes us valuable partners for states needing assistance with this heavy lift.

We are currently working with several clients to implement their transition plans. Mercer's assistance can include:

- Strategic planning for implementation
- Comprehensive management of all aspects of transition plan implementation
- Development and implementation of member, provider, and managed care organization surveys
- Survey data analysis
- Stakeholder engagement strategies and meeting facilitation
- Responses to CMS questions and negotiations
- Development of training materials and presentations
- Development of management tools, including but not limited to:
  - Project plan
  - Provider report card
  - Data analysis report
- Modifications of documents such as policy manuals, regulations, and HCBS waivers, as well as MCO contracts, based on outcome of comprehensive assessment

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# Home and Community-Based Services Resource Allocation

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

States face growing aged and disabled populations. Increases in home and community-based services (HCBS) evolution, needs, and costs, coupled with strained state budgets, require states to identify approaches that utilize funding efficiently and equitably.

The application of resource allocation methodologies through the use of assessment tools is one approach to consider. These methodologies enable the state to distribute HCBS resources in an objective manner across all HCBS members. Techniques are available for a variety of populations and can include self-directed motifs. Resource allocation can work in various program designs, including fee for service, managed care, and the increasingly common hybrid systems.

### HOW MERCER'S TEAM CAN HELP

Mercer consultants have helped numerous states in determining

whether a resource allocation methodology is beneficial. Different resource allocation methodologies that would be considered individually or in various combinations include:

- Individual Budget Amount: Establishes a budget threshold based on individual assessment results. Allows individuals to make choices within the budget limit established
- Individual Service Limits: Establishes a threshold of total service hours or total units of service a member receives from a combined number of services

Each of these methodologies can be tailored to meet the specific needs of the population served and strengthened through the following considerations:

- Use of acuity-based fees/rates
- Use of resource allocation across the entire HCBS service array for a subset of services
- Development of an exceptional needs process

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### MERCER GOVERNMENT HUMAN SERVICES CONSULTING



# LTSS Payment System Reform

Many states are looking broadly across their health care ecosystem to improve opportunities for independence, better health, greater community integration, and more opportunities for gainful employment. States have come to Mercer with questions and challenges such as:

"Our providers and stakeholders continually challenge our decisions for payment/policy changes."

"We have more individuals on waiting lists than currently enrolled in our programs."

"We are looking for alternatives to regular fee-for-service (FFS), as budget predictability is a challenge."

"How can we add value-based purchasing to our managed care program?"

"The Centers for Medicare & Medicaid Services (CMS) is asking us about our Home and Community-Based Services (HCBS) provider fee methodologies, and nobody here knows how these fees were developed years ago."

For some states, these types of questions or goals of payment reform represent a major paradigm shift in the current long-term services and supports (LTSS) culture and can be overwhelming. Mercer can help.

### MOVING FROM VOLUME TO VALUE

LTSS encompasses everything from mandatory Medicaid services, such as home health, to facility-based care and HCBS. Broadly speaking, two primary payment strategies can be used to reform some or all aspects of LTSS: managed fee for service FFS and riskbased capitation.

- Managed FFS: Includes accountable care organizations, episodes of care/bundled payments, health homes, medical homes, and other payment systems; and also encompasses some risk transfer to providers – for example, using an episode of care payment or relying on standard FFS – but with increased focus, requirements, and structure around care coordination, care integration, transition of care, data sharing, and/or whole-person medical, social, behavioral, medical, nutritional, and housing needs.
- Risk-Based Managed Care Capitation: Includes either full or partial risk, depending on the state's population, policies, politics, and priorities. Transitioning to riskbased capitated managed care is a shift away from traditional FFS and requires states to take on new responsibilities and oversight/ enforcement duties. Through selective procurement of qualified vendor and strong managed care contract requirements, states can "buy" into payment reform and innovation as opposed to "building" the capabilities in-house under an FFS system.

### MODERNIZING FFS PROVIDER PAYMENT RATES

Some LTSS payment reforms are less about creating a new payment system and more about reforming and modernizing the current payment methodology to ensure that it is objective and complies with all federal/ state regulations. For example, Mercer has been assisting states with modernizing their HCBS provider FFS payment rates to use objective, quantifiable methodologies and inputs. We bring an independent, fiscally disciplined perspective paired with policy and regulation expertise to partner with states on developing reasonable and defensible FFS provider payment rates using a market-based, cost-based or hybrid payment methodology.

#### MERCER CAN HELP

Whether you need help with a single issue, such as responding to questions from CMS or providers, or perhaps technical assistance in designing a new provider payment model, Mercer is your best choice for help with:

- Strategic planning for payment reform and implementation
- Provider fee modeling, financial impact analyses, and fee creation
- Navigation of federal waivers, creation of state plan amendments or updates to policy manuals
- Development of and conducting provider training/ orientation to new payment system
- · Actuarial rate development for risk-based managed care
- Quality and/or financial reporting, monitoring, and evaluation

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#### **Benefits of LTSS Reform**

In a report to a federal government agency, Mercer documented success in LTSS rebalancing in three state Medicaid programs over a three- to five-year period of increasing the percentage of individuals and expenditures associated with HCBS settings relative to institutionalization.

The populations included developmentally disabled, Medicare/Medicaid dualeligible, and Medicaid-only enrollees. Although the analyzed populations were not sexactly the same for each state, the change in population mix across care settings can be analyzed and compared.

One state increased the percentage of members served in community-based HCBS settings from 55.5% to 60.0% while increasing the portion to total LTSS per member per month (PMPM) attributable to HCBS settings from 42.50% to 47.25%.

Another state experienced a twopoint increase in members served in community-based HCBS settings, going from 37.75% to 39.75%, while increasing the portion to total LTSS PMPM attributable to HCBS settings from 20.0% to 23.5%.

The third state improved its percentage of members served in community-based HCBS settings from 50.25% to 55.50%, and its percentage of expenditures increased from 32.0% to 33.75% of total LTSS PMPM.



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# Medicaid Managed Long-Term Care

The Medicaid population, like that of the United States as a whole, is steadily aging. Even though people are generally living longer, it is a statistical fact that as people age, the prevalence of disabilities and disease increases. Typically, individuals with disabilities require more assistance and supportive services - whether from unpaid or paid caregivers, private health insurance, or government-sponsored programs such as Medicaid. As state populations age and Medicaid budgets continue to expand, states are faced with increasing costs from this growing cohort but have limited resources to meet the growing need.

Furthermore, surveys and studies of consumers indicate the same result: **People prefer to remain in their homes and communities rather than be institutionalized.** Despite their preferences, consumers may be directed toward institutional services because of public funding or publicpolicy preferences. Many policymakers have looked to managed care as a tool to help improve long-term care (LTC) and the overall health care systems, including institutional and home and community-based services (HCBS). Many see the benefits of having a dynamic and consumer-friendly care delivery system in which the needs of the elderly and individuals with disabilities are met through various community-based care settings, with quality of life, functional health status, and consumer input promoted, measured, and evaluated. The goal is to improve the quality of life and health status of individuals who lack the financial, physical, or cognitive resources and abilities to completely care for themselves.

Managed LTC models have been effective in a number of states in reducing unnecessary hospitalizations and nursing home utilization, increasing access to HCBS, streamlining administration, increasing consumer satisfaction, and developing capitation rates and contracts to reflect and incentivize the provision of HCBS. Removing system fragmentation, rebalancing nursing home utilization with HCBS alternatives, and improving the quality of care through better care coordination are reasons cited by many states for considering integrated managed care models for their Medicaid-eligible populations. Some programs focus on individuals needing LTC services and support, while others focus on those services, while additionally integrating services for healthy enrollees (that is, physical and/or behavioral health services).

#### A benefit of Medicaid-capitated managed care is the

flexibility to adjust the capitation rates and contracts to create incentives for the provision of HCBS. This approach can be accomplished in multiple ways, such as:

- Using specific waiver authority and provisions to use savings in state plan services to contractually require plans to provide additional non-state plan services, such as HCBS
- Building non-state plan community-based services into managed care rates, considering cost-effective alternatives, such as HCBS, to more costly covered state plan services, such as institutional care
- Including community-based services in managed care contracts and rates if separate waivers or state plan provisions make such services available

#### MERCER CAN HELP

With an interdisciplinary team of policy consultants, actuaries, accountants, clinicians, and information technology experts. Mercer can help bring an entirely new managed care program to reality or assist states in expanding or improving existing programs. Mercer has assisted states with the following:

- Strategic program planning, including program design and waiver development
- Support in Centers for Medicare and Medicaid Services (CMS) negotiations
- Facilitation of stakeholder meetings to determine the level of support and identify potential barriers
- Development of budget and savings estimates
- Procurement assistance
- · Actuarial rate development and analysis
- Health plan financial reporting and monitoring
- Review and assistance in the modification of assessment instruments
- Contractor readiness reviews
- Design of an encounter data collection system and evaluation of encounter data
- Financial reporting tools
- Development and monitoring of performance measures for the LTC population

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# **Case Study**





### SITUATION

The state governor and Medicaid agency had approved exploration of a statewide Medicaid managed care model to serve Medicaid eligibles, with full service coordination including acute and LTC services. The costs for LTC services were rapidly increasing, creating additional strains on the state Medicaid budget.



### CHALLENGE

The state policymakers wanted to start managed LTC for Medicaid eligibles very quickly after obtaining approval. The state already provided Medicaid managed care for physical health services.



Mercer worked with the state, potential managed care plans, and the CMS to make the Medicaid managed LTC program fully operational.

The project included:

- Developing an options paper for review by state policymakers
- Facilitating an options discussion and developing a better understanding of option implications
- Developing the concept paper and waiver application, participating in negotiations with CMS and the state
- Revising contract language, adding LTC service requirements
- Conducting readiness reviews to confirm that contractors were ready to provide LTC services
- Calculating the actuarially sound rates to ensure appropriate payments to the contractors
- Creating strategies to overcome implementation and operational challenges



The state successfully implemented the Medicaid managed care model, meeting state policymaker requirements. The state received approval from CMS on the waiver and was able to add the additional services to currently functional managed care plans.



MERCER GOVERNMENT HUMAN SERVICES CONSULTING



# LTSS - Program Strategy and Design Options

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

Many states are seeking new and innovative ways to deliver, pay for, and manage their long-term service and support (LTSS) programs. But there is no "one size fits all" solution: Each state has a different LTSS infrastructure, legacy programs, populations/health risk factors, and an appetite for change. Instead, states have to critically assess the current status of their LTSS delivery system as well as its advantages and challenges, and develop a strategy for implementing change either incrementally or through comprehensive reforms. Finding the most beneficial design based on state goals and objectives is where Mercer can help.

With an interdisciplinary team of policy consultants, strategists, actuaries, accountants, clinicians, behavioral health specialists, and information technology experts, Mercer can bring an entirely new LTSS program to fruition or assist states in expanding or improving existing programs.

### PROGRAM MODEL STRATEGY

Changes to delivery models can impact consumers, providers, state operations, reporting processes, data collection, policies and procedures, organizational/staffing structures, and interaction with the Centers for Medicare & Medicaid Services (CMS) and other stakeholders. Notably, changes often have a financial impact on states, providers, and even consumers. Depending on the level of change and complexity of the new delivery model, the intersection and integration of these financial, actuarial, clinical, policy, and operations issues are where Mercer helps solve the challenges that arise in these and other LTSS models:

- · Fee-for-service
- · Fee-for-value
- Risk-based managed care
- Dual demonstrations
- Health homes for individuals with chronic conditions
- Accountable care organizations

### PROGRAM DESIGN STRATEGY

Mercer's real-world, handson experience in designing and implementing programs in a successful and systematic manner is our strength. Simply put, we know how to get it done. We know the questions to ask and options to consider for various decision points, and we have the demonstrated ability to help guide our clients through the process from start to finish. Samplings of the program design issues that will arise include:

- Population and subpopulation eligibility and how to accurately identify individuals for continuity of coverage, systems, payment, and reporting purposes
- Geographic service areas, which include provider market and practice pattern influences or potential regional rollout impacts
- Services included/excluded and finding complementary services to help reduce uncoordinated care

- - Program enrollment, assignment, or attribution
  - Maintaining (or expanding) self-direction
  - Clinical and care management model options to address quality of care and outcomes
  - Rate/payment structure to support program goals and incentivize improved outcomes
  - Considerations for federal authorities
  - Performance measurement and monitoring

# PROGRAM IMPLEMENTATION AND OPERATIONS SUPPORT

Mercer helps states bring a well-designed delivery model planned out with thoughtful program design to reality. In addition to our subject-matter specialists, Mercer also employs former CMS, state, provider, and plan staff who can provide our clients insights into how to navigate through the implementation into successful, ongoing operations. This forethought and planning enables us to partner with our clients through the entire process, including the following operations touchpoints:

- Stakeholder engagement and issue resolution
- Navigation through federal authorities and negotiations with CMS (state plan and waiver strategy and development, including financial tests)
- Revisions to state rules and policies
- Contractor and provider readiness reviews, procurement, and contract writing
- State readiness review planning
- Federal claiming (including enhanced match for initiatives such as Money Follows the Person)
- Financial consulting to design cost-collection tools and analyze resulting cost data for reporting and monitoring
- Review and assistance in the modification of assessment instruments
- External quality review

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# Managed Long-Term Services and Supports

Developing an Overarching Quality Enterprise

Many states are looking to integrate their home and community-based services (HCBS) waivers into managed care models of service delivery. Such transitions by nature can result in significant challenges for the state in terms of oversight and monitoring.

States should build synergies to support quality processes that integrate the HCBS quality framework into broader Medicaid managed care quality requirements. This often means that state staff must become educated on the different quality models in order to build synergies, and decrease redundancy in the design and implementation of the state's quality assessment and performance improvement program.

States have come to Mercer with questions and challenges such as:

"CMS is asking for a comprehensive and overarching quality strategy. How do we need to amend our existing quality strategy to meet that requirement?"

"What performance measures should we look at so we know that the program is functioning as designed?" "Many of the enrollees are dually eligible. How does this impact performance measure calculation, benchmarking, and evaluation?"

Mercer's cross-disciplinary team has experience assisting states in these areas and more.

### ENSURING STATE READINESS FOR MONITORING AND OVERSIGHT

Medicaid managed care authorities and HCBS waivers have unique quality frameworks, and while their underlying principles are the same, there are fundamental differences. These differences must be united into a comprehensive quality enterprise.

**State Readiness Review:** This process explores the state's readiness to assume management, oversight, and monitoring activities for the managed long-term services and supports (MLTSS) program. During the course of the review, technical assistance is provided to help guide the state toward best practices and opportunities to streamline and/or enhance program management and oversight functions.

Building the Quality Enterprise: The Centers for Medicare & Medicaid Services (CMS) has indicated that states should develop comprehensive quality strategies that address all aspects of the state's Medicaid program. This requires thoughtful consideration of staff resources, programmatic goals, and organizational structure. Quality isn't a static process – the iterative nature of the quality cycle necessitates continual enhancement, improvement, and development of strong infrastructure and competencies to support that evolution.

### QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

When integrating LTSS into managed care delivery systems, there is often interest in improving organizational efficiency at the state level. The new system should also incent rebalancing efforts while maintaining specific competencies that have been developed over time in caring for very unique and vulnerable individuals.

Performance Measurement: Includes identification of metrics suitable to determine whether the program is operating as designed. Performance measures should include both lead and lag measures, providing for an early warning system as well as retrospective analysis. Establishing benchmarks or baselines to compare results, before and after MLTSS program implementation is important, as is developing integrated and meaningful performance measures which can evolve over time.

Value-Based Payment: Incenting the right outcomes is important and can help drive improved performance across the system. There is a wide array of opportunities to integrate MLTSS value-based payment (VBP) strategies, but choosing the right mix of measures can be an arduous and overwhelming task.

#### MERCER CAN HELP

States seeking to integrate HCBS waivers into managed care delivery models need to recognize and address the fundamental shift that needs to occur that allows for integrating HCBS concepts into managed care operating principles. These changes will significantly impact how the state develops a comprehensive and overarching quality enterprise to monitor and oversee its managed care contractors.

States may face challenges in determining how to allocate limited resources and build synergies across sister agencies, divisions, or business units for quality oversight and monitoring purposes. The unique depth and breadth within Mercer can bring the combined knowledge and experience of former CMS officials, ex-state Medicaid operational staff, credentialed actuaries, financial analysts, certified public accountants, clinicians, and data analysts.

Whether you need help with a single issue or more complex concerns, Mercer is your best choice for help with:

- Assessment of state readiness for MLTSS program implementation, including areas such as information systems readiness, beneficiary protections, quality assurance, and performance improvement
- Analysis of organizational structure to ensure the efficiency and effectiveness of new MLTSS program oversight and monitoring operations
- Technical assistance to develop a comprehensive, integrated, and overarching quality strategy
- Development, calculation, and implementation of pay-forperformance and other value-based payment approaches to incent quality outcomes for MLTSS recipients
- Outcomes-based quality/performance monitoring and dashboarding
- Using assessment data to inform weightings between quality measures and resource allocation

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## MERCER GOVERNMENT HUMAN SERVICES CONSULTING



# **Money Follows The Person Program**

## **Reflecting Back and Looking Forward**

The delivery of high-quality, cost-effective health care is crucial to ensure our health care delivery system remains viable. Not just for today but also for the future.

## REFLECTING BACK

In 2007, funds were made available to states by the Centers for Medicare & Medicaid Services (CMS) for the Money Follows the Person (MFP) Rebalancing Demonstration Grant program. Nearly every state and the District of Columbia participated in the demonstration, receiving a total of close to \$3.7 billion in grant funding to support the transition of more than 75,000 individuals from facility based settings back to their home communities.

In September 2016, the final allocation of grant funding was awarded which enabled states to continue transitions through 2018 and supported program sustainability and integration efforts through Federal Fiscal Year (FFY) 2020. While additional funding may be available in the future through a bill under consideration in Congress, there is no guarantee of long-term support. States should evaluate the positive impacts of MFP for individuals as well as the cost effectiveness of the program that results when serving individuals in the community rather than institutions. In the event that the re-authorizing language does not pass, states will need this information to develop and implement strategies for integrating MFP program elements into their Medicaid long-term services and supports (LTSS) programs.

Historically, the primary objectives of the MFP program were to provide people in need of LTSS more choices about where they live and receive care, and to increase the capacity of state home and community based services (HCBS) within LTSS programs.

## KEY MFP PROGRAM OUTCOMES

- On average, total Medicare and Medicaid per-beneficiary per month (PBPM) expenditures declined by approximately 23% for older adults and people with physical disabilities during the first year following transition from a nursing home and by 30% for the first year following transition for participants with an intellectual disability
- Second year costs (13-24 months' post transition) declined because first year one-time transition related costs were no longer applicable
- Formal evaluations of the MFP program conducted by Mathematica show the establishment of formal transition and rebalancing programs emphasizing choice, dignity and independence (that did not exist previously) have improved quality of life and lowered the cost of HCBS services

- Promotion of interagency collaboration between state agencies and community partners to integrate health related and housing programs helps to identify and secure affordable and accessible housing
- Campaigns to promote awareness of transition services, addressing workforce capacity issues, nursing facility (NF) in-reach, direct support worker registries, enhanced employment supports and investments in information systems and data collection capabilities
- While not consistently identified as an issue, managing the growth of nursing facility services is also critical to the state balancing efforts. In 2015, Balancing Incentive Program states participated in a Survey that found that the number one way to impact the growth of nursing facilities was a strong transition program like MFP

Through the MFP program states have identified the primary barriers to transition. These include:

- Availability of affordable and accessible housing;
- Insufficient supply of HCB LTSS (e.g., transportation, home modifications and self directed services); and
- Deficits in LTSS Workforce Capacity

## LOOKING FORWARD

While Delaware, Kansas, Michigan, New Hampshire, Texas Vermont and Virginia ended their MFP programs and conducted their final transitions in 2016 and 2017, most states are transitioning individuals until December 31, 2018. Even though transitions under the program will end in 2018, all states are required to ensure appropriate oversight and monitoring of MFP participants for 365 days following discharge from a facility. As a result, MFP activities will continue through the end of 2019. Many states are currently considering how to maintain transition activities as the grant comes to a close in 2020.

Participating MFP states were asked to submit to CMS an MFP Sustainability Plan to help integrate the program into the Medicaid LTSS system after grant funds are no longer available. These plans describe how systems put in place during the grant might be supported or enhanced heading into the final years of the program. The plans include detail around what portions of a state's MFP program will be sustained outside of the grant and how they will be sustained as well as how states will utilize any remaining rebalancing funds. While CMS ultimately was not able to fully fund the plans in most states, over \$1.5 billion in MFP grant funding was allocated through 2020 to support sustainability activities.

Mercer understands that each state may be in a different place on the MFP planning continuum and recognizes the barriers that implementation presents. Based on our experience working with states on MFP Sustainability we have developed tools and designed our approach to help meet implementation goals regardless of where clients are in the process.

## QUESTIONS YOU MAY POSE TO STATES AS THEY CONSIDER HOW TO SUSTAIN THEIR MFP PROGRAM:

Is the state still transitioning individuals under the MFP program? Is the state interested in continuing its transition related activities?

- Are you familiar with the state's MFP sustainability plan and how it is being acted upon? Does the Plan need to be modified due to funding limitations or changes in priorities?
- Has the state identified the components of its MFP program it wishes to maintain and has it identified the authorities by which it can receive FFP?
- Are there rebalancing funds available in your state to support implementation of the MFP Sustainability Plan?
- Is there a need to add MFP demonstration and/or supplemental services to the state's HCBS waiver(s), managed long term services and support program, or other programs to replace those no longer available under MFP?
- How does the state ensure the systems put in place during the MFP program have the capacity to continue to support transitions and how can these systems be a catalyst for the state's rebalancing efforts?
- Has the state considered how MFP requirements might be incorporated into waiver performance measures or value-based payment strategies?

## MERCER HAS DEVELOPED AN MFP SUSTAINABILITY TOOLKIT

This includes a variety of documents to help support states with their sustainability efforts.

- Strategies for effective MFP Sustainability Plan implementation
- Aggregate MDS data analysis for states regarding Section Q responses
- Surveys for eliciting feedback and sustainability recommendations from Local Contact Agencies (LCAs) and Transition Coordinators (TAs)
- Approaches to analyze the broader LTSS continuum and determine the cost-effectiveness of the program
- Consideration of options available for the continued measurement of the Quality of Life indicators
- Federal authorities that can be used to draw FFP for transition coordination activities
- Diversion and transition best practice literature reviews

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CREDIBLE TRUSTED STANDARD-BEARERS DEFENSIBLE

## MFP FUNDING HAS BEEN UTILIZED TO:

- Build infrastructure to support the LTSS systems needed to facilitate movement from facility-based to community-based settings
- Develop systems for capturing, reporting and following up on minimum data set (MDS) Section Q responses which indicate an NF resident's desire to move back to the community
- Fund staff for administrative purposes and to identify and assist participants with transitions
- Fund the development and implementation of an array of innovative housing pilot programs through the use of MFP-enhanced Federal Medical Assistance Percentage (commonly referred to as "rebalancing" funds for home- and community-based LTSS services)
- Help states understand the impact of the program on the Quality of Life of individuals who transitioned

# IT IS IMPORTANT MOVING FORWARD BECAUSE:

- Failure to sustain the LTSS infrastructure built through MFP could slow states' rebalancing efforts and put states at risk for Olmstead challenges
- The Section Q process allows individuals to make their preferences known, ensures they receive information about their LTSS options and serves as a source of referrals to MFP programs
- Loss of staff with expertise and knowledge of cross population transition activities could erode intellectual property developed throughout the program and lead to the atrophy of grassroots systems that have produced a program with reduced Medicaid costs
- Existing rebalancing funds can be leveraged to help sustain the program. Many states have available funding to assist transitioning the program into the Medicaid HCBS LTSS system. This will help sustain existing relationships with critical housing development resources that cannot be funded by Medicaid
- States will no longer be required to capture Quality of Life survey data. Administration of a quality of life survey is the cornerstone of determining the effectiveness of transition as well as diversion programs



MERCER GOVERNMENT HUMAN SERVICES CONSULTING



# Informatics: Putting Your Data To Work For You

Today's health care leaders are often data-rich but information-poor, and laboring under tight time constraints. Accurate analysis and use of health care data can ensure effective policy design and program management, ultimately supporting the overall program goal and budget.

Mercer Government Human Services Consulting (Mercer) understands the critical role health care data plays in key decisions around measuring, reporting, and policy-making within Medicaid and other health care programs. Our expert team has more than 15 years of experience assisting many of the nation's largest Medicaid programs in how to better use their detailed and summarized encounter and fee-for-service (FFS) data.

Mercer's expertise is unique because we are able to work side by side with actuaries, clinicians, pharmacists, and consultants to ensure an integrated approach to addressing a client's data-related issues. Our experience includes using and analyzing encounter and FFS data in a wide array of analyses and reporting.

## ACTUARIAL

- Perform validation and analysis of encounter data.
- Manipulate and summarize detailed data for capitation- rate development.
- Analyze data to assess proposed or pending policy or legislative changes.
- Analyze validity and feasibility of data for use in developing risk-adjusted rates.
- Perform risk adjustment and risk profiling.
- Analyze and compare health plan efficiency.
- Shadow price data and perform benchmarking.
- Conduct predictive modeling.
- · Complete claim grouping.

## CLINICAL/QUALITY IMPROVEMENT

- Identify and analyze populations to target disease management programs.
- Analyze the effectiveness of disease management programs.
- Assess health status of FFS or managed care recipients via disease-based risk scoring.
- Complete HEDIS performance
  measurements and validation.

#### PHARMACY

- Model the impact of reimbursement methodology changes and drug utilization trends.
- Identify patterns of overusage or improper pharmacy usage based on clinical guidelines.
- Evaluate pharmacy usage patterns and projections under different reimbursement benchmarks.

## DATA CONSULTING

- · Perform health plan claims- system-readiness reviews for new systems or programs.
- Perform health plan operational reviews.
- Compare encounters to claims data through onsite reviews.
- Analyze claims data for quality and missing data.
- · Assist with MMIS implementation with edits for encounter data and system requirements.
- · Improve encounter data through recommendations for best practices.
- Perform external quality review in conjunction with the clinical team to perform the Information Systems Capabilities Assessment and encounter data validation.
- Assist in writing and scoring request for proposals.

In addition to the support that we provide directly to our clients, we can also offer solutions for clients to use and manipulate the data themselves.



## S S

## SITUATION

The state hired a new data vendor to process its FFS and managed care data. However, the managed care encounter data lacked some key information, such as payment data.



## CHALLENGE

The state has six health plans running on different systems. The current data vendor was not able to collect all the required data, process the information, and upload it to the state's data warehouse in time for rate-setting activities.



Mercer developed master data requests and liaised with multiple contractors to identify the data elements that satisfied the various required efficiency analyses. Mercer worked directly with the state's managed care organizations to ensure that data submission was consistent and accurate.



The data collection process provided complete and accurate data necessary to perform actuarial rate-setting analyses and efficiency analyses. The process identified existing inefficiencies — providing direct savings for the state. The state has used the collected data to update its data warehouse and to further instruct its health plans on the process of sending data directly to the state. The state has asked Mercer to perform the process again while the data warehouse issues are resolved.

# Case Study 2



## SITUATION

The state compared financial data to encounters and found differences between the two sources. In particular, there were large differences for one specific health plan. The state wanted to know the reasons for the differences and to understand other concerns with encounterdata submissions.



CHALLENGE

The root cause(s) of the data issues needed to be determined. The data were necessary for important project work.



1111 2

Mercer performed onsite reviews at all health plans to determine whether encounter-submission issues existed. A data request went out to the plans in preparation for the meetings, which were to include a health plan demonstration of the plans' claims systems. Mercer extracted sample encounters to examine during the meetings.



The review found multiple issues, the biggest of which was a misunderstanding of the process for submitting adjustment encounter records to the State. Rather than voiding and replacing the original encounter, one health plan was submitting only the incremental adjustment, causing a dollar shortage. The state has now engaged Mercer to perform more regular onsite meetings with the health plans. We help ready our clients for what's next: the next policy, the next budget, the next administration, the next opportunity.

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## MERCER GOVERNMENT HUMAN SERVICES CONSULTING

# **Quality Encounter Data**

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

Quality encounter data can seem like an elusive unicorn in the healthcare world. However, having complete, accurate and timely data not only a useful tool but a necessity in building quality healthcare programs that provide members with needed services, ensure provider costs are being met and maintain a viable program going forward. Quality data comprises 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

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 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

Although national standards seem straightforward, it's important to remember that the standards cover all forms of health insurance, including commercial, Medicare and Medicaid. It's important for the state to use the flexibility provided within the national standards to align the data with programmatic needs; for example, although "Paid Amount" is optional for 837 formatted files, it's intended to be optional due to subcontracted, bundled or global payments. Such encounters should also include additional indicators to show they have other payment arrangements.

## ENCOUNTER SYSTEM EDITS

Ensuring 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 the 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 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 with 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 and specifying the timeframe needed to update the edit logic and what actions the health plan should take. Notification shouldn't be limited to a few plans but provided to all health plans that submit encounters.

Clean, accurate and complete data is the cornerstone of good data analytics. Spending time and effort early on to ensure data is functional and 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 that will bring that unicorn to you. Mercer can help your organization with all of the elements listed above.

Mercer conducts detailed reviews of states' medication therapy management and/or other medicationcompliance programs. These reviews identify the savings opportunity that can result from increased patient monitoring and greater medicationadherence rates. We help ready our clients for what's next: the next policy, the next budget, the next administration, the next opportunity.

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## MERCER GOVERNMENT HUMAN SERVICES CONSULTING



# Design Of Medicaid Managed Care Oversight Models For States

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Over the past two decades, there has been a proliferation of Medicaid managed care programs emerging across the country. States, traditionally providing Medicaid benefits through a fee-for-service system, are now shifting to managed care with the goals of decreasing costs while improving beneficiary outcomes. The Centers for Medicare and Medicaid Services reports that almost 50 million people receive benefits through some form of managed care, on either a voluntary or a mandatory basis.

Today, states show greater interest in operating Medicaid managed long-term services and support programs, as well as using managed care as a strategy to contain costs for individuals with other complex needs, such as children and adults with serious mental illness. These populations (for example, individuals with serious mental illness, chronic substance use disorders, intellectual/developmental disabilities [ID/DD], and aging adults) are now being targeted through the use of fully integrated or specialty plans. Medicaid managed care programs will almost certainly continue to grow in coming years, adding millions of newly eligible beneficiaries while also focusing more on the aged, the disabled, and the chronically ill. Additionally, state behavioral health and ID/DD agencies are increasingly responsible for oversight of managed care entities but often initially lack the necessary Medicaid and/or managed care expertise.

Mercer has an opportunity to offer a valuable service to states expanding their managed care programs through consultation focused on leadership, oversight, and monitoring of managed care contractors. Rather than the specific managed care model states employ, it is often contractual requirements, fiscal incentives, oversight, and leadership that have the most significant impact on how effectively and efficiently a managed care plan will meet the needs of the population. States must master key areas such as utilization and clinical management, provider-network management, quality assurance, rates and claims, customer service, and appeals and grievances in their oversight role.

#### HOW MERCER CAN HELP

The menu of services and products Mercer could market to states include:

#### Structural and Organizational Analysis and Enhancement

- Provide analysis of current roles of state agencies and personnel and recommend options to best operate and oversee Medicaid managed care operations. Facilitate development of a relevant, meaningful, and efficient monitoring team
- Develop a flexible organizational structure/model that supports effective communication and contractoversight
- Identify state agency departments/functional units and personnel that will be actively involved with contractoversight responsibilities, and clarify roles, intra-and interagency collaboration, and coordination needs
- Identify and/or offer initial and ongoing training and technical assistance to ensure that state and other personnel responsible for oversight have the necessary knowledge, skills, and abilities

#### **Optimal Impact of Contracts, Policies, and Standards**

- Review and offer revised language for existing contracts (and applicable policies) with managed care organizations (MCOs) to ensure that appropriate contract requirements and standards across key operational aspects (for example, clinical and quality management, access to care, network sufficiency, financial sustainability, reporting) are in place to effectively monitor and hold contractors accountable
- Identify and implement appropriate contractual remedies that allow for a tiered response to substandard contractor performance that includes technical assistance, training, performance-improvement activities, corrective-action plans, notice-to-cure provisions, and sanctions
- Analyze, identify, and consolidate the most relevant goals and indicators that will support an ongoing evaluation of performance under the program and managed care contractors
- Identify how to incorporate less prescriptive approaches to contract management to facilitate innovation and flexibility while preserving overall goals

#### **Development of Reports and Effective Oversight Tools**

- Identify a set of required reports and data to be included in managed care contracts that promotes the analysis and assessment of targeted system-level performance and summary-level information across contractors, when necessary
- Identify performance goals, reporting specifications, and reporting frequencies to monitor contractor performance (satisfaction, service- utilization trends, access to care, etc.)
- Explore the use of contractual performance guarantees that can serve to incentivize contractors regarding effective fiscal, operational, and clinical management of the program
- Develop and publish a system-level report card that facilitates state agency leadership assessment of contractor performance across established performance indicators, and permits statewide and contractor comparisons of performance, and serves as an early warning sign to trigger additional oversight and follow-up
- Design and/or assist with implementation of targeted performance reviews to evaluate whether meaningful outcomes for recipients and family members (education, employment, reduced incarceration, success in school) are being consistently achieved





## OUR EXPERTISE

With health care experience throughout the country, Mercer welcomes the opportunity to assist states with strategies to design and implement managed care oversight models. Our experience with state Medicaid clients includes the following:

- Reviewing the MCO's compliance with the state contract.
- Assessing whether the state's quality management strategy (QMS) is relevant and has a robust reporting and monitoring process
- Writing the state's QMS
- Proposing and developing the state's MCO oversight structure
- Creating the reporting templates for MCO monitoring
- Ensuring that the QMS data are integrated into the state's oversight process and flows to the right state committee for evaluation and action
- Helping the state evaluate the MCO's performance.
- Evaluating whether the state's solution is working and meeting the QMS and waiver outcomes
- Constructing data cubes to easily identify and remove costs to understand potential savings when evaluating for continuation of optional services
- Developing and maintaining a financial dashboard of the MCO's performance that operates as an early warning system
- Developing and maintaining a quality dashboard of the MCO's performance that operates as an early warning system on identified standards of care
- Developing performance standards that foster physical heath and behavioral health integration

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## MERCER GOVERNMENT HUMAN SERVICES CONSULTING

# **Leveraging Medicaid**

Strategies For Efficient Use Of Funds

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As states face declining tax revenues and the changing health care environment, the efficient use of state funds is more critical than ever. Leveraging Medicaid through state plan design and the strategic use of waivers can help finance critical services. States cannot afford to ignore strategies that leverage Medicaid and "braid" state funds and block grants to provide cost-effective services with proven outcomes.

Mercer has a deep knowledge bank, with winning strategies, creative ideas, tested innovations and industry-recognized

guidelines. This is our foundation, but our people bring everything to life, sharing their experience and knowledge to improve every outcome.

Fact based approaches bolstered by industry leading experience, pricing and analytics. Each approach to every project is backed by rigorous analysis and industry leading experience.



## HOW MERCER CAN HELP

Mercer's team offers state health and human services leaders opportunities for improved leveraging of state funds, increased accountability, and sound strategies that accomplish service and financial goals by:

- Comparing a state's current Medicaid program to options for leveraging additional funds
- Braiding other state-only and block-grant funding sources to leverage
  Medicaid funds
- Proposing research-based and best practice alternatives to restrictive high-cost services and those with known poor outcomes
- Identifying standards that must be included in the state plan as distinct from the details necessary for state regulations and provider manuals.
- Defining the services and utilization goals and costs that become the basis for rate setting and determining the fiscal impact of state plan or waiver changes
- Setting Centers for Medicare and Medicaid Services (CMS) approvable feefor-service and actuarially sound capitated rates

## ACHIEVING RESULTS

- Inclusion of more than \$50 million in cost-effective service alternatives in a state plan to reduce the risk of a CMS audit while having a cost-neutral impact on the state's budget.
- A rewrite of hospital, other licensed practitioner, rehabilitation and early periodic screening, diagnosis, and treatment state plans to protect the state from further CMS disallowances.
- A review of the state plan and home- and community-based services definitions of targeted case management to ensure compliance with changing federal requirements.

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MERCER GOVERNMENT HUMAN SERVICES CONSULTING

# Mental Health Parity and Addiction Equity Act

With the publication of the final Medicaid Mental Health Parity and Addiction Equity Act (MHPAEA) rule, many states are looking at what steps to take to implement the new federal requirements. States have come to Mercer with questions and challenges, such as:

- How do I apply the final Medicaid parity rule if I carve-out mental health and substance use disorder benefits from the managed care organization (MCO)?
- What is an non-quantitative treatment limit (NQTL) and which ones do I have to test?
- How do I document my parity analysis?
- Will it take more than 18 months to assess compliance with the mental health parity rule?
- How have commercial vendors complied with parity requirements?
- Have other states begun work implementing the final parity rules?
- The MCOs have raised concerns regarding the Medicaid parity rule. What guidance should we give them?
- What do we need to do now that the Medicaid parity rule is final?

## MOVING TOWARD COMPARABLE COVERAGE

Parity ensures that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are generally no more restrictive than medical/surgical benefits. The Centers for Medicare & Medicaid Services (CMS) issued a final rule that applies parity requirements to Medicaid MCOs, the Children's Health Insurance Program (CHIP), and Medicaid alternative benefit plans (ABPs). The final rule is effective May 31, 2016. States have 18 months from the publication date of March 30, 2016, to comply with final rule requirements. The final rule can be viewed at https://www. gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf.

## PARITY TESTING

The final Medicaid parity rule generally aligns with the commercial parity rules, which were finalized in 2013, creating consistency between the Medicaid and commercial markets. This allows states to draw on the commercial market's experience in implementing parity. Like employee benefits plans, MCOs and state Medicaid agencies must ensure that financial requirements (such as cost sharing) and treatment limitations (both quantitative, such as day limits, and non-quantitative, such as utilization review strategies) comply with the final rule. State Medicaid agencies must ensure that MCO enrollees receiving MH/SUD services from other delivery systems, such as fee-for-services and prepaid inpatient health plans, are in compliance with parity. The final Medicaid rule also addresses aggregate lifetime and annual dollar limits, prescription formularies, and tiering of prescription drug benefits, and disclosure requirements.

Parity requirements apply on a classification-byclassification basis. The final Medicaid rule requires all medical, surgical, mental health and substance use disorder (MH/SUD) Medicaid benefits for MCO enrollees, including long-term care benefits, to be classified into one of the four classifications: inpatient, outpatient (with the option to have a sub-classification for office visits), emergency care, and prescription drugs (with an option to have multitiered prescription drug benefits based on reasonable factors without regard to whether the drug is generally prescribed for medical/surgical or MH/SUD benefits). CMS clarified that any limits applied to out-of-network services must be comparable, but not necessarily identical, for medical/surgical and MH/SUD benefits. Standards for classification assignment must be reasonable and applied in the same manner when assigning medical/surgical and MH/ SUD benefits to classifications. MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided. States will want to classify services in a manner that does not inadvertently negatively impact the parity analysis (for example, classification of medical/ surgical services without limits could inadvertently affect the ability of the state to apply limits in MH/SUD).

Service classifications are tested to ensure that MH/SUD services are not more restrictive than the medical/surgical counterpart. For each service classification, states are required to test each of the following for parity:

- Financial requirements (for example, copay, coinsurance, provider reimbursement)
- Quantitative treatment limits (for example, service visit limits)
- Non-quantitative treatment limits (for example, prior authorization, utilization review, network inclusion standards and standards for accessing out-of-network providers)

The financial and quantitative assessment requires a multistep formula based on the total dollars expected to be paid for medical/surgical benefits in a year for each benefit classification. To be compliant, the MCO covering both medical/surgical and MH/SUD benefits, or the state, if some MH/SUD services for MCO enrollees are provided outside of the MCO contract, must analyze and determine that the types of MH/SUD limitations apply to substantially all (twothirds) medical/surgical services in the classification. If so, the MCO or state must further attest that any MH/SUD limits are not more restrictive than the predominant (half) limit applied to medical/surgical services.

NQTLs require an assessment of whether the processes, strategies, evidentiary standards, or other factors used to apply those limits are applied in a comparable manner to, and no more stringently to MH/SUD than, the nonquantitative treatment limits applied to medical/surgical services in the classification.

Overall, MCOs and states will have to draw on program, clinical, financial, and data system expertise to comply with the final Medicaid parity rule. Failure to supply the appropriate documentation may result in CMS not approving federal reimbursement for MCO contracts.

#### MERCER CAN HELP

The parity requirements are difficult to apply. We can help with the full array of issues such as:

- Training related to understanding the requirements and how to conduct analyses required under the final Medicaid rule
- Assisting the state to develop a plan to assess compliance with mental health parity rule (for example, project management, stakeholder discussion)
- Conducting the initial parity analyses or conducting parity analysis across multiple delivery systems (MCOs, PHIPs, PAHPs, FFS)
- Preparing the parity analysis and compliance submission for CMS (due to CMS in conjunction with contract amendments and state plan amendments no later than October 2, 2017)
- Assisting the state with conducting the parity analysis across delivery systems or assessing MCO compliance with required parity analysis (for example, assess parity application, data collection, service classification)
- Performing financial and quantitative treatment limit tests
- Analyzing NQTLs
- Advising states and MCOs on the design of new quality management approaches and strategies to replace those that are not parity compliant
- Determining how contracts, state plans, waivers, and rates will need to be modified
- Developing MCO instructions or contract revisions,
- Drafting or reviewing public documentation for the state website, demonstrating compliance with final rule

- Assessing the impact of changes necessary to comply with parity requirements on capitation payments and budgets
- Assisting with MH/SUD state plan benefit design changes, including modifying cost-sharing provisions in the state plan and the addition of MH/SUD benefits not previously covered. States may need assistance deciding whether to amend state plans or modify capitated contracts
- Drafting state plan Amendments
- Modifying capitated rates to include additional MH/SUD services necessary to comply with the final Medicaid rule
- Setting rates for new FFS services required for compliance with the final rule

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#### **Application to Medicaid MCO Enrollees**

The final Medicaid rule applies to beneficiaries enrolled in Medicaid MCOs, including any other delivery system — for example, feefor-service (FFS) or prepaid inpatient health plans (PIHPs) — that provides services to MCO enrollees. This rule does not apply parity requirements to non-ABP or non-CHIP Medicaid beneficiaries not enrolled in an MCO. However, CMS encourages states to provide state plan benefits to these beneficiaries in a way that comports with the parity requirements.

Below are highlights from the final Medicaid rule as applied to Medicaid MCO enrollees:

- All Medicaid services provided to MCO enrollees must be delivered in a parity-compliant manner
- The rule clarifies the state Medicaid agency determines parity compliance for all MCO contracts to ensure parity for MCO enrollees across the applicable delivery systems
- The inclusion of long-term care services is a significant change from the proposed Medicaid rule, which had excluded these services from the definition of MH and SUD benefits
- States are not required to include all state plan MH/SUD services in MCO contracts
- States are given the option of including MH/SUD services necessary for compliance with parity either in an amendment to the state plan or through the provision of capitated MH/SUD benefits
- States that choose not to change their state plans are authorized to include the cost of services necessary for compliance beyond the state plan in the development of actuarially sound rates. States may also choose risk mitigation for over and under payments
- CMS modified the definition of actuarial soundness to include parity required services in capitation rates, regardless of the cost effectiveness of those services (as is required for "in lieu of" services). The preamble to the final rule emphasizes that CMS does not expect MCOs to incur a net increase in costs because of compliance with parity
- In states where an MCO has sole responsibility for providing Medicaid services to Medicaid enrollees, the MCO is responsible for conducting the parity analysis. In states where any delivery system other than the MCO is offering services to MCO enrollees, the state is responsible for conducting the parity analysis

#### Application to CHIP

All CHIP programs, regardless of delivery system, must comply with the final rule. If a CHIP state plan provides full coverage of early and periodic screening, diagnosis, and treatment (EPSDT), the state will be deemed to comply with parity requirements for the specific CHIP populations covered for EPSDT. Full coverage of EPSDT will be determined only if 1) the state ensures provision of all medically necessary optional Medicaid services, whether or not the state plan includes the services, and does not exclude benefits on the basis of condition; and 2) publishes information that these medically necessary services are available. CMS referred readers to the July 7, 2014, and September 24, 2014, Medicaid guidance regarding whether applied behavior analysis is covered under the EPSDT benefit for children with autism.

#### Application to Medicaid ABPs/Medicaid Expansion Populations

ABP benefits provided through MCOs must comply with the final Medicaid rule's MCO requirements. ABP benefits provided outside of an MCO (for example, through FFS) must comply with the final Medicaid rule's financial requirements and treatment limitations provisions. ABPs offering EPSDT will be deemed in compliance for children under age 21 years with that coverage.



MERCER GOVERNMENT HUMAN SERVICES CONSULTING

# Health Care Policy Consulting

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.



State and local governments face numerous challenges as they provide innovative, cost-effective, high-quality health care, particularly within a rapidly changing regulatory health care environment. States are responding to the changes brought by the Patient Protection and Affordable Care Act (ACA), but are also leading the way in program innovation.

Mercer Government Human Services Consulting provides expert consulting assistance and creativity to help state clients design and implement innovative, efficient, and comprehensive solutions.

Mercer team members bring vast policy and operational experience, including leadership at the state and federal levels, and understand the barriers and opportunities faced by those involved in systemic change. Mercer has extensive experience in the design, implementation, and operation of many state Medicaid and integrated programs, including those related to behavioral health, pharmacy, clinical, and long-term services and supports. We have helped states successfully build programs within managed care and other service delivery models and have assisted them in their efforts to plan strategically and gain input from key stakeholders. With a cadre of former federal and state officials, Mercer brings unparalleled knowledge of rules and policy-making from the national level, providing invaluable content and context for our clients.

This level of expertise is bolstered significantly through the additional resources Mercer brings to the table, including individuals with expertise in actuarial, clinical, behavioral health, pharmacy, and information planning.

We combine high-level strategic consulting with practical solutions to help states transform and manage their Medicaid and Children's Health Insurance Programs.



Our capabilities and experience include:

- Strategic planning (program design and federal authorities).
- Medicaid program comprehensive design and redesign, including waiver development.
- Negotiation strategy with state and federal agencies.
- Procurement assistance.
- Policy and procedure development.
- Medicaid managed care and actuarial analysis.
- Behavioral health program redesign.
- Home- and community-based services program design.
- Payment reform models, including Accountable Care.
- Organizations and shared savings.
- Programs and demonstrations to serve dual eligibles.
- Emerging models for long-term services and supports.
- State operations, including developing workflows, informational notices to providers, reporting templates, and program evaluations.
- Reviews of state and health plan readiness with new program implementation.
- ACA options and implementation (health care reform strategy).

Mercer has specialized expertise in policy guidance on Medicaid-specific issues such as:

- Federal funding mechanisms.
- Health care reform provisions.
- Health insurance exchange planning.
- Managed care contracting.
- Behavioral health.
- Long-term services and support (community and institutional).
- Pharmacy.
- Regulatory issues.
- Federally Qualified Health Centers
- Medicaid eligibility.
- Provider tax issues.
- Independent assessments.
- Stakeholder meetings and focus groups.
- Family planning.

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MERCER GOVERNMENT HUMAN SERVICES CONSULTING



# Health-Based Risk Adjustment

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

## APPLYING TECHNOLOGY TO GAIN BETTER OUTCOMES

Health-based risk adjusters are statistical models that correlate disease burden with underlying population costs. These models are an improved method for evaluating risk. In fact, research studies sponsored by the Society of Actuaries and other organizations have found that healthbased risk adjustment models perform significantly better than traditional demographic approaches alone.

## PROACTIVELY ADDRESSING THE ISSUE OF "FAIR" PAYMENTS

Adverse selection can be a large concern within any payment arrangement. Payment structures should be designed to reward providers appropriately. Conversely, providers should be discouraged from targeting healthier members through "cherry picking" practices. While remaining revenue neutral to the state, risk adjustment effectively differentiates enrolled risk by the actual illness burden of each entity's service population.

## BROAD IMPLEMENTATION OF RISK MODELS

Risk adjustment was first implemented in the 1990s by a few state Medicaid programs. Since then, many other states and government-based programs have adopted health-based risk adjustment models, including:

- More than 20 state Medicaid programs
- Medicare Part C (Medicare Advantage)
- Affordable Care Act individual and small group exchanges

## ARE RISK ADJUSTMENT MODELS ONLY USED TO ADJUST CAPITATED PAYMENT RATES?

Risk adjustment models can be used for a variety of purposes. Understanding the health risk of the general population allows actuaries and policymakers to better evaluate programs by:

- Identifying population disease prevalence
- Targeting high-risk members for disease and case management
- Benchmarking provider financial performance
- Evaluating changes in population risk within observed trends over time
- Estimating the risk of newly eligible or expansion populations
- Assessing clinical efficiencies and predictive modeling

## CATALYST FOR ENCOUNTER DATA IMPROVEMENT

Since risk adjustment requires detailed administrative claims data, reporting entities have a large financial incentive to produce accurate and timely information. Many of our clients that have implemented risk adjustment payment systems have seen significant data improvements.

## MERCER IS DEDICATED TO IMPLEMENTING THE BEST APPROACH

Involved from the beginning, Mercer has built a robust team of highly skilled individuals to assist clients with developing risk adjustment payment methodologies. Our approach is to walk step by step through each policy decision to make certain our clients use the right method for each unique environment.



## SITUATION

Through legislative authority, a state was required to expand Medicaid managed care to populations traditionally covered through the state's fee-for-service (FFS) program. The state planned the expansion as a county-by-county phase-in over several months.



## CHALLENGE

Since the expansion population was not in managed care, no formal financial/ cost information was being collected and summarized. Further, the impact on capitation rates was difficult to forecast due to: a) differences in contracting and network affiliations between FFS and managed care, b) challenges with the financial information reported on FFS claims, and c) ramp-up of managed care enrollment through the state fiscal year.



Mercer worked with the state to develop risk scores for both programs to evaluate the expected costs for each group. The state used the risk score information to adjust existing managed care rates to account for the underlying risk of the incoming FFS group. It then applied monthly risk adjustment to ensure health plans • were receiving appropriate payments as the phase-in occurred. We help ready our clients for what's next: the next policy, the next budget, the next administration, the next opportunity.

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Ø RESULTS

- This state was able to fully transition FFS members into managed care within the desired timeframe.
- Health plans reported consistent financial performance before and after the transition.
- The state further expanded risk adjustment for payments statewide to all populations covered under managed care.
- Using risk scores to evaluate the health plans' cost effectiveness, the state negotiated rate adjustments that lowered the overall cost of the program.
- The more risk adjustment was applied for payments, the better the health-plan-reported encounter data became.



## MERCER GOVERNMENT HUMAN SERVICES CONSULTING



# Oversight Of Managed Care Compliance And Program Integrity Best Practices

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

Medicaid expenditures amounted to \$553.8 billion in 2015, representing an increase of 11.6% from 2014, and are projected to increase at an average annual rate of 5.7% over the next 10 years. With the anticipated continued growth in Medicaid expenditures and reliance on managed care delivery systems come new challenges in containing costs and new opportunities for fraud, waste and abuse to occur. Partnerships between managed care organizations (MCOs) and state and federal agencies yielded over \$2.4 billion in fraud recoveries for Medicare and Medicaid in 2015. However, opportunities remain at the state and MCO level to prevent, detect and remediate fraud, waste and abuse at the provider and beneficiary levels.

The Centers for Medicare and Medicaid Services (CMS) published the Medicaid Program Integrity Manual in 2011 and issued revised regulations on MCO Program Integrity oversight in the 2016 Medicaid and CHIP Final Rule. In this environment, states are directly responsible for monitoring the operations of MCOs, and MCOs are required by federal mandate to have effective fraud, waste and abuse detection and prevention programs and to take a more active role in identifying overpayments to providers.

## OUR EXPERTISE

Mercer's program integrity oversight team includes a team of lawyers, CPAs and certified coders. Our team has policysetting expertise at the state and federal levels, experience with data validation techniques, and in identification of program-integrity best practices.

We help ready our clients for what's next: the next policy, the next budget, the next administration, the next opportunity.

Mercer Government Human Services Consulting (Mercer) can help identify best practices in terms of Medicaid MCO compliance and program integrity operations. We have:

- Established review criteria to benchmark MCO program-integrity activities
- Created MCO report cards to establish a method to compare MCO
- Identified promising practices in MCO program integrity activities

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MERCER GOVERNMENT HUMAN SERVICES CONSULTING

# Medicaid/Chip Parity Compliance — Insights From The Field

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

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's 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's 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's 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.

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

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



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:

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

Our experience has shown that 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's also important for the state to have a good working relationship with its managed care vendors.

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# Cures Act: Electronic Visit Verification and Beyond

## CURES ACT

With the passage of the 21st Century Cures Act (Cures Act) CMS established two clocks for compliance with electronic visit verification (EVV) requirements. The first clock set for January 1, 2019, impacts personal care services and the second clock, set for January 1, 2023 impacts home health services. States face escalating financial penalties of up to 1% of FFP for these services for failure to meet each compliance timeframe.

Well-designed EVV systems can efficiently and accurately track the provision of in-home services provided to individuals receiving Medicaid funded personal care and home health services providing states the opportunity to improve program integrity and long term financial sustainability. In fact, the Congressional Budget Office scoring of the Cures legislation attributed EVV system implementation with savings of \$290M between Fiscal Years 2017 – 2026.

## EVV AND BEYOND

EVV systems offer states a unique opportunity to harness valuable data and information that can promote health and welfare, improve outcomes of care, and promote greater client and provider satisfaction. Effective EVV systems align with the requirements of the Cures Act and include electronic verification of the basic elements of time and attendance and information necessary for auditing the delivery of service, reducing the likelihood of fraud and waste.

Long term value of EVV systems can be found in expanded uses beyond tracking and monitoring service delivery to features — including notification of changes in a person's condition, conducting surveys of a person's service experience, and improved provider efficiency and satisfaction through activities like expedited payroll processing and claims management. For some states, EVV offers an even greater opportunity to link EVV systems to the broader health information exchange and technology ecosystem, allowing states to successfully harness data and turn data points into actionable information. For example, a state may want to consider how their EVV system will interface with other components of its Medicaid HIT system such as interfacing EVV missed visit data with claims or encounter data.

# Real Challenges and Real Solutions

We understand that each state may be in a different place on the EVV implementation continuum and we recognize the various challenges and barriers that implementation of the Cures Act presents. We have developed strong tools, based on our experience working with states to implement these systems, and have designed our approach to meet you where you are at and to help you achieve your goals; whether you are just beginning the journey or you are getting ready for implementation.

#### Are you asking these questions?

- 1. How are we going to make the January 1, 2019 target date?
- 2. What options do I have to ensure compliance?
- 3. Why do we need to gather member or provider input?
- 4. How do I select an EVV vendor?
- 5. How do I ensure the system is ready for implementation?

If you are working to answer one or more of these questions, we have real solutions to help because our consulting team consists of individuals that are skilled in project management, Medicaid subject matter experts and individuals that have worked at both the Federal and state levels crafting policy and contracting for EVV systems. We have used our experience to develop our tools and strategic approach that allow us to meet you where you are and develop a pathway forward regardless of where you may be on the EVV implementation continuum.

For states with concerns around the fiscal implications of implementing an information technology heavy solution, Mercer can assist states through the Advance Planning Document (APD) approval process for Medicaid Information Technology (IT) projects which may enable a state to draw down a 90% federal funding match for the cost of designing, developing and installing a system and a 75% match to operate and maintain a system.

## For states just starting the process, Mercer has developed an EVV Toolkit that includes:

- "Mercer's EVV Questions for States" that helps states develop their EVV strategy and identifies possible policy changes needed to support implementation
- Communication plans that include processes for stakeholder engagement and feedback
- An environmental scan of the current state of the EVV landscape
- Strategies for APD development/approval
- Identified best practices and implementation plans that can be customized for a state.

For states further along in their process Mercer can provide:

- End-to-end procurement assistance
- Implementation and project planning
- Readiness assessments

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## MERCER GOVERNMENT HUMAN SERVICES CONSULTING

# Pharmacy Management Consulting

## SLOWING THE PACE OF SPENDING AND ACCELERATING QUALITY AND EFFICIENCY

The nation's current economic situation. combined with the passage and implementation of the Affordable Care Act (ACA), has had an unprecedented impact on state Medicaid programs. Policymakers are facing both challenges and opportunities as they strive to achieve cost containment while ensuring members' access to benefits and maintaining quality of care. While federal law generally requires that all state Medicaid programs offer certain basic benefits, each state program determines the extent to which it will cover optional benefits, including outpatient prescription drugs.

Medicaid's prescription drug benefit is complex. The benefit plan must comply with state and federal regulations, ensure adequate reimbursement to providers, and manage unique member populations with complex disease states while retaining affordable access to services and optimal quality of care. Recent provisions within federal health care reform legislation will influence the net cost of drugs, expand eligibility, and increase utilization and state expenditures. These changes impose even greater emphasis on cost containment and optimization of prescription drug use in the delivery of all Medicaid health care benefits.

## OUR PHARMACY PRACTICE with states to evaluate, design, and

The Managed Pharmacy practice of Mercer Government Human Services Consulting (Mercer) focuses on pharmacy issues pertinent to publicly funded programs across the country. We have more than 27 consulting team members, including 9 pharmacists, 5 former state Medicaid pharmacy directors, and 2 certified pharmacy technicians. Our team members have expertise in areas of pharmacy program consulting, actuarial forecasting, fee-for-service and encounter-data programming and analytics, public health care consulting, clinical quality/ metrics, project management, and administrative support. The diversity and depth of Mercer's pharmacy team set us apart from other firms.

## HOW WE SLOW THE PACE OF SPENDING

#### **Drug Reimbursement**

Budgetary pressures and increasing debate about pharmacy reimbursement methodologies proposed in health care reform legislation are pushing states to review their options. Mercer works implement various reimbursement tools. including State Maximum Allowable Cost programs, Average Actual Acquisition Cost programs, and professional dispensing fees determined by provider surveys. From the discovery stage to the final implementation and maintenance stage, Mercer works side by side with our clients to build a drug reimbursement policy that meets the state's unique goals.

#### Pharmacy Trend Evaluations

Mercer works with states to project pharmacy unit costs and utilization trends for contracted managed care and fee-for-service programs. Using clients' claims data and information in the drug pipeline, data on drugs pending patent loss and over-the-counter status, clinical practice guidelines, and population demographics, Mercer's professionals project future pharmacy unit costs and utilization rates. These projections support the rate-setting methodology and help states identify additional clinical management and cost-savings opportunities.

## HOW WE ACCELERATE QUALITY AND EFFICIENCY

#### **Pharmacy Program Diagnostic**

Determining where to focus resources and efforts is often an important first step for governmental clients. Mercer can provide a pharmacy program diagnostic review to identify opportunities for financial and clinical enhancements. By isolating key cost and utilization drivers of prescription drug trends, Mercer can help agencies and plan sponsors design programs and management alternatives. Agencies can opt to have Mercer conduct an annual diagnostic review or to provide perpetual program oversight and strategic direction through its pharmacy directorship program.

#### **Pharmacy Directorship Program**

Mercer assigns a licensed pharmacist and a supporting consultant team, experienced with governmental clients, to assist agency leadership with maximizing pharmacy program effectiveness within the confines of budget, public policy, and perception. Client-specific quarterly dashboards are one of the tools used for the pharmacy directorship program to identify early trends, spot vendorcompliance issues, and identify clinical utilization program opportunities to accelerate the quality and efficiency of the prescription drug program.

#### Program Re-engineering

Reform, driven by Medicaid waivers and policy changes, requires action steps that are time-sensitive, intricate in nature, and must be executed with limited resources. Mercer collaborates with states to design and implement necessary reform that is in compliance with state and federal regulations. For example, Mercer has worked with state agencies to retool and build efficiencies with physician-administered drug programs, including routine reviews of reimbursement rates and review of submitted billing units for products administered and billed through physicians' offices. Monthly updates for new biological and specialty products approved by the FDA, including clinical summaries and product-cost information, are used by states to proactively determine coverage criteria and reimbursement for the state's potential new-drug spend drivers.

#### **Audits and Onsite Reviews**

States require validation that managed care vendor-reported financial data are accurate and consistent with contractual requirements and that pharmacy programs used by a state are managed as efficiently as possible. Mercer conducts audits and onsite reviews of managed care vendors (such as managed care organizations or health maintenance organizations), validating performance in key areas, such as utilization management, provider profiling, coordination of health management programs, and pharmacy reimbursement methodologies. Process improvements are designed by Mercer and provided to states for appropriate action.

Public plan sponsors choose Mercer because of our demonstrated thought leadership in pharmacy consulting coupled with our proven ability to provide measurable, practical solutions, including:

- Pharmacy policy development.
- Program assessment and savings

projections.

- Specialty drug management.
- Outpatient and physicianadministered drug reimbursement strategy.
- Generic utilization and promotional programs, including State Maximum Allowable Cost program design and implementation.
- Average actual acquisition cost development and implementation.
- 340B policy and program management.
- Collaborative purchasing.
- Pharmacy trend evaluation.
- Health plan efficiency evaluations.
- Pharmacy benefit manager/ administrator vendor selection.
- Audits and onsite reviews.
- State plan amendment (SPA) updates.

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# **Pharmacy Reimbursement**

Many states are looking at steps needed to implement the new outpatient pharmacy rule. These include changes to outpatient pharmacy reimbursement, the drug rebate program, price calculations and drug coverage. States have come to Mercer with questions and challenges, such as:

"What data do we need to present to the Centers for Medicare and Medicaid Services (CMS) to support our reimbursement methodologies?"

"How do we design a cost of dispensing (COD) survey that meets the professional dispensing fee requirements?"

"What options exist for developing average acquisition cost (AAC) pricing?"

"Do we have to use the National Average Drug Acquisition Cost (NADAC), or may we develop our own AAC rates? How do we set specialty reimbursement?"

"We have not included Federal Upper Limits (FULs) in our reimbursement methodology for years. What do we need to do to effectively ensure that we meet the new FUL requirements?"

"What options exist for a compliant 340B specific reimbursement model?"

"What Medicaid Management Information System (MMIS) changes will be needed for compliance? Do any of those changes need an Advanced Planning Document (APD) or qualify for enhanced funding?"

## MOVING TO NEW REIMBURSEMENT METHODOLOGIES

The new rule requires state Medicaid fee-for-service (FFS) programs to adopt AAC pricing and professional dispensing fees that provide total reimbursement to pharmacies sufficient to ensure adequate access for beneficiaries. States will need to evaluate current FFS pharmacy reimbursement methodologies for outpatient drugs and implement changes based on an AAC-based reimbursement model, which includes the following:

 States need to determine whether ingredient cost reimbursement will be based on a state-specific AAC, NADAC, AMP, or other published compendia. States that implement NADAC will need to develop an AACbased reimbursement methodology for any product without a published NADAC

- States must determine the basis of their FFS professional dispensing fee. States may consider options including a flat rate, tiered rates by provider or claims volume, and the potential accommodation for payment of specialized services
- States must include 340B reimbursement policies in their State Plan Amendments (SPAs).

## CHANGES TO DRUG REBATE REQUIREMENTS

The rule finalizes several changes to the drug rebate program that were implemented in 2010, such as increased rebate percentages and related savings offsets, along with collection of rebates from Medicaid managed care organizations (MCOs).



Changes made in the final rule will most likely have significant impacts to MMIS and drug rebate processing systems. These include:

- A separate calculation for unit rebate amounts for drugs that are line extensions; however, CMS did not finalize the regulatory definition of a line extension drug
- Inclusion of territories into the definition of states to allow participation in the CMS rebate program a year after implementation
- Final calculation requirements for alternative rebates for line extension drugs

States must ensure that:

- Drug claims requiring coverage by Medicare Part D plans are excluded from the drug rebate invoicing process
- Drug claims (for example, epoetin) that are part of bundled end-stage renal disease payments are excluded from invoicing
- Processes are in place to separately identify MCO and FFS claims in the drug rebate invoicing process
- MMIS claims processing systems have the ability to invoice MCO utilization based on date of service rather than the MCO date of payment. Mercer recommends that states make this evaluation as soon as possible to allow time to make the necessary system changes to accommodate the date of service requirement

## PRICE CALCULATION, REIMBURSEMENT, AND DRUG COVERAGE IMPACTS

The final Medicaid Covered Outpatient rule made changes to certain price calculations and drug coverage rules, including:

- If the FUL is in the state's current payment logic, states must ensure that their pharmacy claims processing systems are capable of receiving the new monthly FUL pricing updates beginning May
   1, 2016, in accordance with their current SPA. This includes the capability to update the FULs on a monthly basis
- States must ensure that their pharmacy programs meet the FUL aggregate requirements established by CMS for drugs with and without an FUL
- States should evaluate coverage policies for investigational drugs and update their state plans with coverage determinations
- States should be aware of several key definition changes — including retail community pharmacy, covered outpatient drugs, and over-the-counter drugs — which affect rebates, reimbursement, and coverage
- A CMS process to create an exception to raise FULs in situations where they fall below the NADAC

## COVERAGE AND PROGRAM REQUIREMENTS

Finally, the rule further clarified the following aspects of coverage of outpatient drugs and requirements for both FFS and MCO programs in addition to the statutory language:

- Modifies requirements for retail community pharmacy
- Outlines reporting requirements for states and manufacturers
- Allows states to have optional coverage of investigational drugs and other drugs not subject to rebates
- Includes a definition of over-thecounter drugs to clarify existing pharmacy benefit exclusions and early and periodic screening, diagnosis, and treatment (EPSDT) benefit inclusions

Whether you need help with a single issue, such as technical assistance in developing a COD survey, writing the compliance SPA, or developing your ingredient cost reimbursement strategy, Mercer can help.



## MERCER CAN HELP

Whether you need help with a single issue, such as technical assistance in developing a COD survey, writing the compliance SPA, or developing your ingredient cost reimbursement strategy, Mercer is your best choice for help with:

- Evaluation of the new rule impact, including creating strategies, timelines, and work plans for implementation of the rule
- Development of progressive policies addressing both cost containment and access
- Engagement of stakeholders
- Development of and conducting provider training/orientation to new surveys or reimbursement methodologies
- Reimbursement methodology revisions
- Evaluation, modeling, and implementation of COD surveys and AAC reimbursement methodologies
- Evaluation and implementation of 340B reimbursement alternatives
- Assistance with the development and submittal of required SPAs
- Assessment and management of the MCO impact, including developing actuarially sound rates and MCO contract oversight
- Evaluation of MMIS impact analysis and system enhancement needs
- Evaluation and ongoing program monitoring, including conducting FUL aggregate testing, quarterly monitoring, and managing continuous improvement; provider accountability; and program performance, such as audits and vendor oversight

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# **Pharmacy Program Efficiency**

## **Case Study**

Typically, pharmaceuticals represent more than 17% of health care costs and have been trending upwards at a rate of 1% to 4% annually. To assist our state fee-for-service (FFS) Medicaid clients in becoming more efficient purchasers of pharmaceuticals, we need to accomplish two tasks. First, we must determine the level of program efficiency the state desires to purchase. And second, we must identify the service areas in which opportunities exist.

As with other modes of treatment, medications can be overused or misprescribed, resulting in unnecessary costs. The Managed Pharmacy Practice of Mercer has developed a range of support services and tools to assist state clients with identifying clinical enhancement opportunities that are also cost-effective. Mercer's methodologies can be incorporated to optimize both capitated and FFS programs.

Our expertise and experience include:

- Identifying inappropriate prescribing and dispensing patterns by employing a series of industry-standard utilization-management edits
- Evaluating the aggressiveness of the maximum allowable cost list used in claims reimbursement
- Reviewing pharmacy and medical claims data at the recipient level to determine if medications with high potential for abuse or misuse have a clinically appropriate matching diagnosis

- Identifying physician-administered specialty injectables processed with a J code that could have been processed through the pharmacy benefit with a National Drug Code, garnering a manufacturer rebate.
- Analyzing high-dollar drug-related Healthcare Common Procedure Coding System (HCPCS) codes administered in the physician's office that commonly have incorrect billing units
- Analyzing claims for Medicare/ Medicaid dual-eligible recipients to determine if payment was made by the appropriate carrier
- Evaluating hepatitis-C historical utilization, coverage criteria, and cost information to identify opportunities for more efficient management

State clients wishing to enhance their managed care organization (MCO) rate setting and reimburse for an efficient pharmacy program have used Mercer's analytics to adjust their capitation rates. Results are dependent on the specific analysis, as well as on the recipients and category of aid covered under the Medicaid program.

The results range from \$0.10 to \$1.35 per member per month (PMPM) for any one analysis. States that have implemented multiple initiatives have cumulative annual savings ranging from \$1.00 to \$3.50 PMPM, which varies based on recipients covered in the program.

Mercer's broad data/analytical and actuarial capabilities, together with our clinical depth and breadth, enable us to identify potential pharmaceutical misuse, overuse, and inappropriate prescribing patterns. Mercer assists our state clients in distinguishing between efficient and inefficient MCO practices, resulting in a higher-quality program for the same or a lower price.

# **Case Study**

## ENHANCING MCO CAPITATION RATE SETTING

## SITUATION

Faced with rising medical trends and a shrinking state budget, the state engaged Mercer to identify and quantify inappropriate use of medications within their capitated MCO pharmacy programs.



## CHALLENGE

Both the state, as the ultimate purchaser, and the MCOs needed confidence in the credibility of a pharmacy-specific rate-adjustment process that identified program inefficiencies. The development of an actuarially sound algorithm and analytical tool that would produce defendable results required the integration of clinical, pharmaceutical, and actuarial expertise.



## ACTION

Mercer's pharmacy practice, in collaboration with physicians and nurses, developed a set of utilizationmanagement edits that were incorporated into a clinical rules-based algorithm. The algorithm reviewed one year's pharmacy encounter claims, identifying any claims that met the criteria established for the edits. Within the algorithm, each potentially inappropriate claim was counted only once and assigned to the appropriate edit based on priority rank.

Mercer worked with the client's medical and pharmacy staff to develop adjustment factors that ensured identified claims were in fact inappropriately prescribed and were correctly identified as inefficient. These adjustment factors were assigned to each edit category, customized for Medicaid utilization patterns and based upon:

- Clinical literature.
- Clinical practice guidelines.
- Claims entry and submission errors.
- Eligibility data issues.
- Common prescribing patterns.
- Off-label prescribing practices.
- Medication titration issues.
- Failure of previous therapy.
- Professional judgment.

Finally, cost offsets were estimated for each edit based on potential migration to other clinical therapies, as well as potential impact on rebates earned. Ø RESULTS

The project resulted in savings of \$9 million in Year 1, \$10 million in Year 2, and \$14 million in Year 3. Average PMPM impact in Year 3, across six capitated MCOs, was \$1.23 with an MCO-specific range of \$0.45-\$2.25 PMPM. The greatest opportunities were in the Supplemental Security Income (without Medicare) and Temporary Assistance for Needy Families populations. Mercer optimized this tool in the actuarial rate-setting process for three consecutive years to develop a pharmacy efficiency-rate adjustment according to the level of value the state desired to purchase.

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# Pharmacy State Maximum Allowable Cost Program

With budgetary issues facing most states, cost-saving strategies are a priority for managing health care expenditures. Pharmaceuticals are one of the primary cost drivers in health care today. An effective cost-saving strategy is developing and maintaining a State Maximum Allowable Cost (SMAC) list for generic medications. A SMAC program can quickly produce significant cost savings and maximize the return on investment.

## MERCER'S SMAC PROGRAM

#### **Our Breadth and Depth**

Mercer has successfully implemented and currently updates and maintains SMAC lists for five Medicaid programs. Mercer's SMAC program is built on sound, criteria-based pricing logic and is staffed by highly qualified professionals with extensive experience in SMAC program implementation and maintenance.

Mercer collaborates with clients to develop state-specific SMAC lists that meet the financial and clinical goals of their Medicaid programs. Our SMAC lists contain approximately 800 to 2,000 price points. We also provide SMAC pricing for specific groups of drugs, such as over-the-counter (OTC) medications, prenatal vitamins, and specialty products.

Mercer's SMAC pricing reflects the uniqueness of Medicaid programs and all aspects of product purchasing and reimbursement, including issues related to wholesaler distribution, rural-pharmacy product acquisition, product margin, fee-for-service reimbursement, preferred drug lists, and rebate considerations. We work with states to tailor a SMAC list that achieves their financial and clinical goals while also being mindful of their SMAC program's impact on the pharmacy-provider community.

#### **Proven Return on Investments**

Mercer has been establishing SMAC rates since December 2001. Our clients have achieved an annual return on investment of between 150:1 and 350:1. The range of savings depends on a number of factors, including but not limited to:

- Program size
- Aggressiveness of SMAC pricing factors chosen by the client
- Drug mix
- Inclusion of OTC and/or specialty products

#### **Ongoing Review of SMAC Price Points**

To develop and update our SMAC pricing list, Mercer uses a proprietary database of national drug-wholesaler information. We proactively monitor newly approved generic products for potential SMAC implementation at the earliest opportunity while taking into consideration market dynamics and regulations. This practice helps ensure that pharmacies have ready access to the products at the acquisition cost used to develop the SMAC price points. Mercer performs scheduled reviews of all SMAC price points to ensure that clients are maximizing savings as generic products are introduced into the market and prices drop due to competition. Our pricing methodology includes a review of the entire SMAC list pricing on a regular basis – no less than quarterly.

If pricing concerns develop during off-cycle reviews, Mercer works collaboratively with the state and the provider community to quickly address and resolve any provider concerns regarding SMAC price points. We anticipate and take into consideration the likely reactions of the pharmacy providers and other stakeholders to recommend and develop responses that cultivate the buy-in necessary for program success.

#### Steps Involved in Creating a Mercer SMAC List

Mercer reviews the state's current utilization data and estimates savings based on different SMAC pricing and product-type scenarios.

Mercer meets with the state to discuss SMAC modeling scenarios and a recommended SMAC list.

Mercer and the state determine the communication strategy and meet with interested external parties, such as pharmacy associations, to proactively address concerns, if requested.

Mercer electronically publishes and implements the state's SMAC list.

## A HIGHLY QUALIFIED AND EXPERIENCED TEAM

Mercer has a dedicated team of highly qualified professionals to develop, implement, and maintain its SMAC program. Our SMAC team includes licensed pharmacists, several certified pharmacy technicians, experienced data analysts, and a contract administrator to ensure that Mercer provides the state with the highest level of service. Mercer's team is known for being responsive, efficient, and experienced in working with all components of SMAC programs. For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

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# **Specialty Drug Management**

The term "specialty pharmacy" refers to drugs that are high-cost medications requiring special handling, clinical monitoring, and/or administration by a health care provider. These drugs treat chronic, complex diseases and are often included in a limited distribution network.

Specialty brand drug cost is currently one of the most important factors driving drug trends. The overall annual trend for specialty drugs reported by pharmacy benefit managers for 2013 was 14% to 19.5% and is expected to continue to grow. Recent forecasts predict overall annual specialty trend to be between 16% and 25% for 2014 to 2016.

Specialty pharmaceuticals tend to have extremely high ingredient costs, with average drug costs estimated to be more than \$2,000 per month per patient. A single drug used to help manage some complications of leukemia costs \$6,800 a month. Other specialty drugs cost as much as \$100,000 per year, with the most expensive specialty drugs costing up to \$750,000 per year. As specialty drugs make up increasingly larger portions of state Medicaid pharmacy budgets, states, like employers, must address ways to manage the cost of specialty medications.

The Managed Pharmacy practice of Mercer offers a range of support services to assist state Medicaid programs with the clinical and fiscal management of specialty drugs, including assisting states with clearly defining specialty drugs and their reimbursement. Mercer's approach identifies opportunities for clinical review and monitoring improvements that are also cost-effective.

## SPECIALTY DRUG REIMBURSEMENT

#### **Outpatient Pharmacy Reimbursement (Pharmacy Claims)**

Mercer helps clients save between 0.75% and 1.50% of the current outpatient drug budget by adding specialty drugs to the State's Maximum Allowable Cost list program and/or adding a separate specialty reimbursement that varies by branded specialty drug class and/or product.

#### Physician-Administered Drug Reimbursement (Medical Claims)

Mercer provides routine Healthcare Common Procedure Coding System (HCPCS) provider- reimbursement updates when new products enter the market to maximize savings for new generic products and to appropriately price new products that are billed with HCPCS dump codes.

## SPECIALTY DRUG PIPELINE MONITORING

#### Specialty Pipeline Report (Quarterly)

Mercer monitors specialty drugs moving through the Food and Drug Administration approval process and tracks those that are projected to come to market within the next 12 to 18 months. Clients use the specialty drug pipeline report to assist in projecting the impact of the specialty pipeline on future budgets and clinical programs.

#### **Clinical New Product Reports (Monthly)**

Mercer monitors and reviews new specialty products brought to market, ensuring timely updates to the appropriate reimbursement schedule.

Clients use the new product reports and clinical recommendations to establish timely provider billing guidelines and parameters for new specialty products.

## SPECIALTY DRUG MANAGEMENT

Specialty drug management strategies should be tailored to best meet the clinical, financial, and political requirements of the state's program. Mercer's expertise includes:

- Pharmacy and medical program specialty drug reimbursement savings projections
- Channel management strategies for pharmacy and medical programs to ensure minimal crossover of medications between channels and to align pricing metrics in both channels
- Utilization management (UM) reviews, including prior authorization, step therapy, quantity limits, and other clinically appropriate UM programs available for specialty drugs, such as stringent diagnosis requirements for new high-cost drugs used to treat hepatitis C
- Specialty drug sole-source contracting, including reviews of proposed request for proposals, necessary State Plan Amendment language, and Centers for Medicare and Medicaid Services (CMS) requirements, including requirements for a 1915(b) freedom-of-choice waiver, conducted by Mercer's CMS policy specialists
- 340B pharmacy program financial optimization reviews, including an evaluation of the state's current 340B environment targeted at understanding and prioritizing the opportunities (both operational and financial) available through the maximization of 340B pricing
- Clinical management, including review of specialty medication compliance and coordination with existing clinical disease and case management programs

• Efficiency adjustments for Medicaid programs with capitated managed care organizations, including review of professional claims data to identify reimbursement and clinical-management opportunities for specialty medications. Retrospective analyses to identify instances of duplicate billing for specialty drugs covered in both pharmacy and medical programs

## MEDICATION COMPLIANCE

#### Medication Compliance Rates and Gaps in Therapy

Mercer assists Medicaid programs in measuring current medication-compliance rates and gaps in therapy for recipients. Mercer collaboratively develops program modifications to increase appropriate prescribing and eliminate barriers to participants' compliance.

Mercer conducts detailed reviews of states' medication therapy management and/or other medication-compliance programs. These reviews identify the savings opportunity that can result from increased patient monitoring and greater medication-adherence rates.

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# **State Pharmacy Consulting Options**

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## 340B Directorship/Optimization

Objective: Maximize the State's 340B benefits and identify strategies to optimize savings, streamline administration, and drive efficiencies while maintaining compliance with the regulations and guidelines governing the 340B program.

### DEVELOP 340B REIMBURSEMENT STRATEGY

Assist the State in developing a 340B reimbursement strategy. Identify all avenues for maximizing the number of organizations that achieve 340B designation and develop programs that utilize these providers.

- Make best-practice recommendations related to 340B use provisions/programs, which may include adjudication and/or coverage considerations
- Assist the State in identifying 340B claims
- Develop strategies for physician-administered medications
- Develop strategies for Managed Care Organizations (MCOs)
- Develop strategies for contract pharmacy arrangements

### 340B POLICY STRATEGY AND UPDATES

Assist the State in updating and/or developing written 340B policies, including:

- State statute
- Medicaid State Plan Amendments
- State contracts with MCOs
- MCO provider agreements and manuals
- 1915(b) freedom-of-choice waivers



### 340B COST OF DISPENSING SURVEY

Assist the State in setting an appropriate professional dispensing fee by conducting a comprehensive cost analysis to determine the covered entities'/contract pharmacies' average cost of dispensing a prescription to a State Medicaid program recipient.

### TARGETED CARE MANAGEMENT

Explore savings opportunities for Medicaid recipients with chronic disease states, including:

- Assist the State in identifying sole-source or limited-network options with 340B entities to provide targeted drugs at 340B pricing with the inclusion of case-management fee payment
- Assist the State in steering targeted, high-cost Medicaid recipient groups into care management/disease management programs operated by 340B providers

#### 340B AUDITS

Conduct post-pay reviews of 340B claims to identify overpayment for medications purchased through the 340B program.

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## MERCER GOVERNMENT HUMAN SERVICES CONSULTING

# Management Of Specialty Drug Trend

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

Specialty drugs are generally considered to be high-cost drugs 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's no surprise that specialty drugs like Spinraza<sup>™</sup>, used to treat spinal muscular atrophy (SMA), costing as much as \$750,000 for the first year, have the potential to considerably increase pharmacy spend for a Medicaid program.

With state definitions of "specialty" varying, a statespecific specialty percentage of overall prescription drug spend can be difficult to project without detailed data analysis. However, Mercer estimates specialty drugs to be approximately one-third 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,<sup>1</sup> orphan drug sales are forecasted to reach around 20% of worldwide prescription drug sales by 2020. Although orphan drugs have a positive lasting effect on patients with rare health conditions as well as 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 increase 14%–18% for calendar years 2016–2017 and 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 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 approved dosages, diagnoses and duration of therapy for specialty drugs through prior authorization, step therapy and quantity limit programs.

New payment models are emerging that 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
- Incorporation of value-based purchasing requirements in managed care organization contracts and contracts with providers

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.

### HOW MERCER CAN HELP

Mercer's team offers state health and human services leaders opportunities for improved leveraging of state funds, increased accountability, and sound strategies that accomplish service and financial goals by:

- Comparing a state's current Medicaid program to options for leveraging additional funds
- Braiding other state-only and blockgrant funding sources to leverage Medicaid funds
- Proposing research-based and best practice alternatives to restrictive high-cost services and those with known poor outcomes
- Identifying standards that must be included in the state plan as distinct from the details necessary for state regulations and provider manuals
- Defining the services and utilization goals and costs that become the basis for rate setting and determining the fiscal impact of state plan or waiver changes
- Setting Centers for Medicare and Medicaid Services (CMS) approvable fee-for-service and actuarially sound capitated rates

### ACHIEVING RESULTS

- Inclusion of more than \$50 million in cost-effective service alternatives in a state plan to reduce the risk of a CMS audit while having a costneutral impact on the state's budget
- A rewrite of hospital, other licensed practitioner, rehabilitation and early periodic screening, diagnosis, and treatment state plans to protect the state from further CMS disallowances
- A review of the state plan and homeand community-based services definitions of targeted case management to ensure compliance with changing federal requirements

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<sup>1</sup> EvaluatePharma. Orphan Drug Report 2017.

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# Cross-Agency Collaboration and Organizational Redesign (CCOR)

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

States face challenges in determining how to allocate limited resources and build synergies across sister agencies, divisions, or business units for quality oversight and monitoring purposes. These challenges drive states to rethink moves in new directions despite budget constraints and staffing limitations. The unique depth and breadth within Mercer can bring the combined knowledge and experience of former CMS officials, ex-state Medicaid operational staff, credentialed actuaries, financial analysts, certified public accountants, clinicians, and data analysts – providing a multidisciplinary team to assist the state in its redesign and interagency collaboration efforts.

Mercer's Government Human Services Consulting group helps governmental agencies design, implement, and reorganize organizational structures to oversee their agency directives and programs within budgetary constraints. Our wealth of experience working with states in designing, implementing, and monitoring governmental programs makes us valuable partners for states needing assistance with organizational changes and cross-agency collaboration.



### HOW MERCER'S GOVERNMENT HUMAN SERVICES CONSULTING TEAM CAN HELP

We combine high-level strategic consulting with practical solutions to help states transform and manage their agencies' organizational structures. Our consultants are actively working in a number of states to bring change to governmental agencies across the nation. Our capabilities and experience include:

- **Providing analysis of current roles** of state agencies and personnel, and recommending options to best operate and oversee agency goals
- Developing a flexible organizational structure/model that supports effective communication and program oversight within and across governmental agencies
- Assessing state agencies' readiness for program implementation, including areas such as information systems readiness, beneficiary protections, quality assurance, and performance improvement

 Analyzing organizational structures to ensure the efficiency and effectiveness of agency program oversight and operations. Identifying state agency departments/ functional units and personnel that will be actively involved with contract oversight responsibilities, and clarifying roles, intra- and interagency collaboration, and coordination needs

- **Providing technical assessments** of agencies policy and regulatory guidance related to federal and state requirements
- Assessing states' program standards and requirements, and agencies' readiness to develop, implement and monitor agency directives

Mercer team members bring vast policy and operational experience, including leadership at the state and federal levels, and understand the barriers and opportunities faced by those involved in systemic change. Mercer has extensive experience in the design, implementation, and operation of many state Medicaid and integrated programs, including those related to behavioral health, pharmacy, clinical, and long-term services and supports.

We have helped states successfully build programs within managed care and other service delivery models, and have assisted them in their efforts to plan strategically and gain input from key stakeholders. With a cadre of former federal and state officials. Mercer brings unparalleled knowledge of rules and policy-making from the national level, and this level of expertise is bolstered significantly by the additional resources Mercer brings to the table, including individuals with expertise in actuarial, clinical, behavioral health, pharmacy, and information planning.

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		PROJECT MANAGEMENT:	Task management and proj Tracking deliverables Providing regular progress Risk identification and mitig	reports		
PROJECT DESIGN	ORGANIZATIONAL ASSESSMENT	COMMUNICATION MANAGEMENT	TECHNICAL SUPPORT	TRANSITION PLANNING	EXECUTION OF TRANSITION	EVALUATION
<ul> <li>Governance structure</li> <li>Model/design development</li> <li>Priorities and objectives</li> <li>Objectives measurement</li> <li>Strategyz</li> <li>Guiding principles</li> <li>Key dates</li> <li>Known risks</li> </ul>	<ul> <li>Document requirements and processes</li> <li>Org structure</li> <li>Personnel</li> <li>Assets/resources</li> <li>Risks/barriers</li> <li>Cultural assessment</li> <li>Change capacity</li> <li>Readiness assessments</li> </ul>	<ul> <li>Internal and external messaging</li> <li>Communication strategy and plan</li> <li>Stakeholder engagement plan</li> <li>Facilitation of advisory/ stakeholder forums</li> <li>Project management communication</li> </ul>	<ul> <li>Full array of national best practices in the areas of:</li> <li>Policy and regulatory guidance</li> <li>Finance/actuarial</li> <li>Clinical</li> <li>Operational</li> <li>Systems</li> <li>Pharmacy</li> </ul>	<ul> <li>Redesign</li> <li>Tasks</li> <li>Timeline/milestones</li> <li>Interdependencies</li> <li>Responsible parties</li> <li>Identifying deliverables</li> <li>Risk assessment/mitigation</li> <li>Contingency plan</li> </ul>	<ul> <li>Project management</li> <li>Staff extenders</li> <li>Technical support</li> <li>Staff training</li> <li>Policy development</li> <li>Rate development</li> <li>Development of MOAs or contracts</li> <li>CMS waivers</li> </ul>	<ul> <li>Development of tools processes to ongoing measurement of objectives</li> <li>Conduct and report of meeting objectives</li> <li>Identify areas for refinement, if necess</li> </ul>



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# Medical Loss Ratio: Not As Bad As It Seems

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multi-disciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

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 on 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. Although formal CMS MLR rules are new to Medicaid, with minor deviations, they're in alignment with the Affordable Care Act private market and Medicare Advantage MLR standards. Additionally, capitation rating processes may already be achieving the applicable 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 toward paying claims (including quality improvement activities). In other words, no more than 15% of after-tax premium can go toward administrative costs (which exclude taxes and 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's what Mercer's seeing evolve from these requirements:

- No later than rating period for contracts starting on or after July 1, 2017 – MLR Standards
- No later than rating period for contracts starting on or after July 1, 2019 – Section 438.4(b)(9): Develop capitation rates so that health plan can reasonably achieve an MLR of at least 85

### WHAT ARE STATES CURRENTLY UP TO?

# 1. Updating managed care organization (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

- A. Requirements of MCOs include:
  - Providing calculation back-up detail
  - Demonstrating consistency (or a comparison) with financial reports
  - Attesting to calculation accuracy
  - Revising MLR if rates are adjusted retroactively
- B. Considerations made by states include:
  - Timing 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, that supports populations that typically require lower administrative expenses on a percentage basis
- 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.)

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

# 3. Considering requiring remittances from MCOs:

and denominator

- Having discretion to exempt newly contracted MCOs from MLR requirements during their first year
- 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

#### 4. Preparing state oversight standards:

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

# 5. 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:

- 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?
- 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 manner, how is the CHIP MLR to be calculated and reported?

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# Affordable Care Act Repeal And Replace Efforts: A Long Way From The Finish Line

After a dramatic journey through the House of Representatives, the American Health Care Act (AHCA) is now in the hands of the Senate. Several groups of senators are working behind the scenes to construct Affordable Care Act (ACA) repeal and replace alternatives with the hope of holding a vote this summer. Although there is an overwhelming sense of uncertainty, especially with respect to proposed changes to the Medicaid program, there are ways states can begin understanding the potential impacts of legislation on their Medicaid programs and predicting how the healthcare reform legislative process might unfold.

### ANTICIPATING AND PLANNING FOR MEDICAID CHANGES

There are elements of the AHCA's Medicaid reforms that are expected to be reflected in any bill that the Senate brings forward for a vote: a phase-down of Medicaid expansion (with timeline being a key outstanding issue) and some form of per capita caps on federal Medicaid spending. We may also see a block grant option, new authority for work requirements, new state flexibilities and targeted funding for opioid addiction treatment to mitigate some of the impact of the end of Medicaid expansion.

The House AHCA bill employs different formulas for calculating per capita spending targets for different populations as well as a different formula for determining the amount of a block grant for a state making that choice. For example, two different inflationary factors are used for different Medicaid populations under the per capita spending target formula, and the block grant formula uses yet a third inflationary factor. The compounding, year-overyear financial ramifications of these various inflationary factors can be dramatic. 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, because each of these elements could change the degree to which per capita caps or block grant financing mechanisms might affect one state or another. Mercer's policy and actuarial consultants are helping our state Medicaid clients assess how they would fare under different legislative scenarios.



Procedurally, the Senate version of AHCA must save the federal government at least as much money as the Congressional Budget Office estimated the House version would save. Several Republican senators have stated that they want to see the AHCA changed to delay or soften the repeal of the Medicaid expansion option under the ACA and the subsidies for individuals, especially for those over age 50, increased. Because both of these policies would increase federal spending, simultaneously securing these Senators' votes and meeting the budget savings targets creates a narrow legislative needle for the Senate to thread. Essentially, the Senate would need to reduce the tax cuts in the AHCA, raise other taxes not addressed in the AHCA or cut other spending to offset these amounts.

Further complicating Congress's path to health reform are the pending expiration of funding for the Children's Health Insurance Program and community health center operating support on September 30. Although reauthorizing spending for each of these programs has strong bipartisan support on its own, it will be difficult for Congress to address those funding issues if ACA repeal and replace proposals remain unresolved.

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. We help ready our clients for what's next: the next policy, the next budget, the next administration, the next opportunity.

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## MERCER GOVERNMENT HUMAN SERVICES CONSULTING



# **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 to accelerate transition of their programs to valuebased payment models. Maximizing Medicaid funds while improving access and quality is 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's important that a VBP plan address the unique program needs, goals and challenges particular to a state's Medicaid program.

In CMS's State Health Official letter of November 22, 2013 (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 include:

- 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 help you identify appropriate quality metrics to measure whether value and quality goals are being met. It's 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 surprisingly 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, 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. Although we advocate for the use of nationally recognized measures, a state should also consider the development of state-specific technical specifications for "homegrown" outcome measures, including lowacuity, non-emergent emergency department utilization, preventable (re-)admissions and gaps in care.



#### **Targets**

Establishing 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's 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're 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 — 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've learned that it's critical to provide clear data translated into meaningful 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 models. Now is the time to prepare for these goals, even while the healthcare environment is fluid and uncertain. We help ready our clients for what's next: the next policy, the next budget, the next administration, the next opportunity.

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# Substance Use Disorders

For over 35 years, we have worked with 45 US states and territories. We bring the right mix of battle-tested experts and multidisciplinary practitioners to the table to shape real-world solutions and face the toughest issues.

States are experiencing an unprecedented demand for substance use disorder (SUD) services and, as a result, are actively seeking new opportunities and innovative approaches to optimize resources. For example, the national opioid epidemic has resulted in aggressive efforts at both the federal and state levels to prevent addiction to prescription opiate pain medications, limit access to heroin and synthetic fentanyl, prevent death from unintentional overdoses and reduce the prevalence of neonatal abstinence syndrome. States want to increase access to treatment for addiction, and legislation is being enacted in many states that limits prescriptions for opioid pain relievers, requires use of prescription drug monitoring programs by physicians and pharmacists, and makes naloxone readily available to first responders and members of the broader community. Although there was a 10.6% reduction in opioid prescribing nationally in 2015,<sup>1</sup> drug

overdose remains the leading cause of accidental death in the US, with 52,404 lethal drug overdoses,<sup>1</sup> including 33,091 (63.1%) that involved an opioid.<sup>2</sup>

Although the opioid epidemic is drawing national attention. Mercer and state systems realize states must continue to respond to the ongoing needs for treatment for other dangerous and disabling substances as well, including alcohol, marijuana, methamphetamine, cocaine, synthetic drugs and tobacco. An estimated 88,000 people die from alcohol-related causes each year, making it the fourth leading preventable cause of death in the United States.<sup>3</sup> Data from 2013 indicate that approximately 46% of the 72,559 deaths due to liver disease among individuals age 12 and older involved alcohol.<sup>4</sup> Collaboration with a broad array of stakeholders, including public health, public safety, criminal justice and others, is vital to impacting cost and quality outcomes associated with SUDs, regardless of the substance involved.

For example, through collaboration, numerous states now enroll Medicaideligible individuals immediately upon release from custody to facilitate rapid engagement in SUD services.

#### <sup>1</sup> American Medical Association. Physicians' Progress to Reverse Nation's Opioid Epidemic, 2016.

- <sup>2</sup> Centers for Disease Control and Prevention.
  "Increases in Drug and Opioid-Involved Overdose Deaths – United States, 2010-2015," Morbidity and Mortality Weekly Report (MMWR), Volume 65 Issue 50-51 (December 30, 2016), pp. 1445-1452.
- <sup>3</sup> National Institute on Alcohol Abuse and Alcoholism. Alcohol Facts and Statistics, February 2017.

<sup>4</sup> Ibid.

States need a cost-effective, comprehensive and responsive healthcare system capable of identifying and treating individuals with SUDs and services that demonstrate positive outcomes. In the absence of such a system, individuals with SUDs can be caught in a negative pattern of repeated admissions for detoxification/withdrawal management, frequent emergency department utilization and unstable employment, housing and family relationships. Individuals experiencing SUDs often develop severe and costly physical health problems, such as cirrhosis, hepatitis and HIV/AIDs, and are at higher risk for preventable accidents when impaired. Mercer can assist states with adoption and implementation of best and promising practices, including but not limited to:

- Screening, brief intervention and referral to treatment models
- American Society of Addiction Medicine (ASAM) criteria
- Medication-assisted treatment
- Motivational interviewing, motivational enhancement therapy, community reinforcement approach/adolescent community reinforcement approach and cognitive behavioral therapy
- Peer recovery support specialists and healthcare navigators
- Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain
- Active monitoring and surveillance of potentially excessive or problematic prescribed opioid use outside of Food and Drug Administration guidelines
- Value-based payment models incorporating opioid-related outcome measures

Mercer understands states must consider cost containment and program sustainability, network development and capacity needs and how to incentivize high-quality performance through effective procurement and contracting. States must consider how they will finance these services and understand the regulatory requirements of funding streams. Requirements related to the Mental Health Parity and Addiction Equity Act final rule, the Home and Community-Based Services final

rule and the Medicaid Managed Care final rule all impact the design and implementation of a state's SUD service system.

Mercer assists states in SUD program design, development of federal state plan amendments and CMS waivers, procurement activities, actuarial rate setting and analysis, managed care contracting, value-based purchasing, staff training and development, and conversion from fee-for-service to a managed care delivery system.



SITUATION

Prior to 2011, the state's Medicaid program did not include SUD treatment services as a covered benefit. State general funds and/or federal block grant dollars were the primary source of funding to pay for SUD services to Medicaid-eligible members. In an effort to contain costs while also expanding access to SUD services for Medicaideligible members, the state decided to add SUD benefits to its Medicaid state plan and incorporate these benefits into its managed care structure. CHALLENGE

The state wanted to expand coverage and capacity for an array of ASAM levels of care and support adoption of medication-assisted treatment. The state wanted to support providers and managed care organizations in this transition by helping them fully understand service definitions, provider qualifications and billing expectations. The state also recognized the need to gather current SUD program and staffing information from providers in order to assist in provider reimbursement and capitation rate development.





ACTION

Mercer worked in collaboration with the state's behavioral health and Medicaid agencies to draft an SUD state plan amendment (SPA) that included ASAM levels of care. The SPA included methods and standards for coverage and reimbursement of these services within the Rehabilitative Services option and supported recovery-oriented treatment. Mercer provided clinical, pharmacy, policy and actuarial support to design an SUD continuum of care consistent with national standards and best practices. We worked with state SUD experts to establish service descriptions. provider qualifications and FFS rates as well as assisting with identifying MMIS programming edits. Mercer supported CMS negotiations, assisted with the drafting of a comprehensive state manual to explain the benefits, drafted contract language for the capitated vendor to manage the benefit and assisted with readiness reviews of the statewide vendor.



RESULTS

Today, the state is able to offer Medicaid-reimbursable SUD services, including medication-assisted treatment and ASAM levels of care consistent with any federal limitations applicable to larger residential settings. In 2016, the state carved out all behavioral health services, including SUD, into the managed care plan contracts. Mercer assisted with drafting the integrated contract, including performance measures, and setting the capitation rates. We are currently assisting the state in pursuing an 1115 waiver authorizing reimbursement for use of institutions for mental disease for residential stays exceeding 15 days.

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