Session 118, MLTSS/Medicaid/Duals Overview & Advanced Analytics

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Session 118: MLTSS/Medicaid/Duals Overview & Advanced Analytics

Agenda

- **Medicaid and MLTSS Overview**
  - History of Medicaid
  - Medicaid Today
  - MLTSS Prevalence
- **MLTSS Analytical Challenges for Health Plans**
  - Dual Rating Structures
  - Risk Adjustment
  - State Budgets
  - Premium Rate Adequacy
- **Case Study**
  - Identify Drivers of Dual SNP Member Disenrollment

History of Medicaid

- Authorized by Title XIX of the Social Security Act, Medicaid was signed into law in 1965 alongside Medicare
- Designed to provide health coverage for low-income members
- The Center for Medicaid and CHIP Services (CMCS) serves as the focal point for operations related to Medicaid
- Medicaid Services are provided through combined efforts of State and CMCS
- Federal sets core requirement on eligibility and benefits, States have the flexibility to define and administer the type of benefits
- Each state has the flexibility to administer the program, resulting in variations in Medicaid coverage across the country

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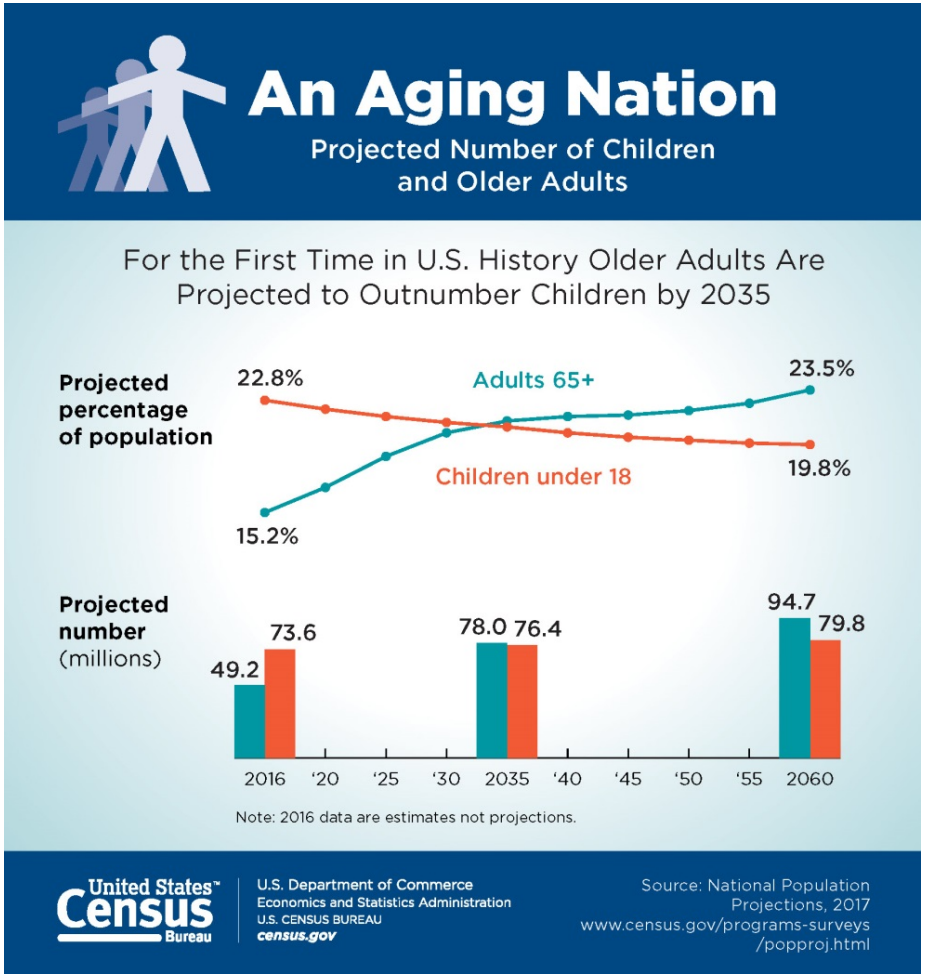
Medicaid Today

- Medicaid covers 1 in 5 Americans
- 28% increase in enrollment from Pre-ACA
- Medicaid spending is $581.9 billion in 2017, or 17% of total National Health Expenditure (projected to double over the next 10 years)
- State Medicaid agencies are the primary payers for over 60% of nursing home residents in United States
- MLTSS spending accounts for over 25% of Medicaid Spending in most states
- Challenge: Aging Nation resulting in doubling of Medicaid spending



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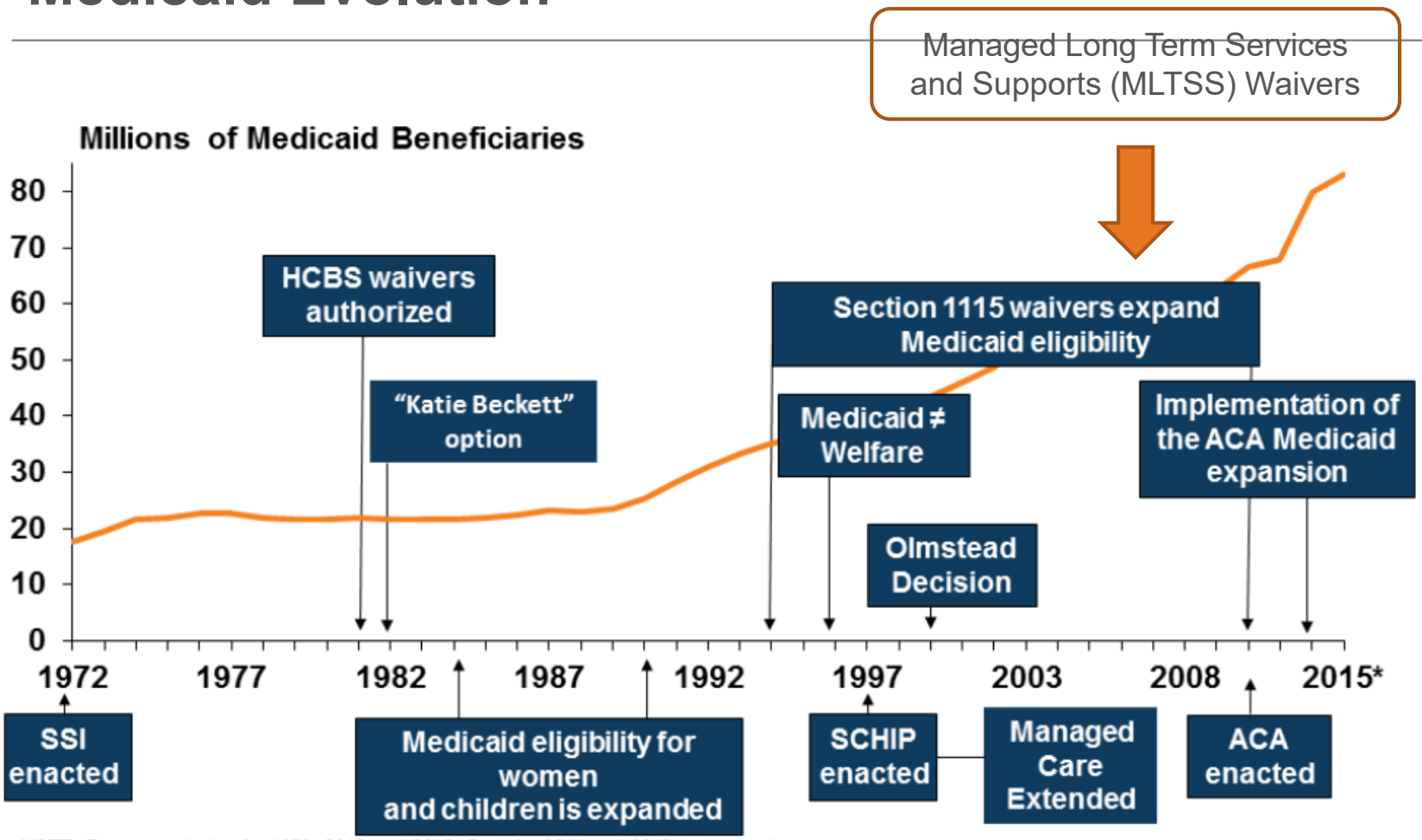
Medicaid Evolution



NOTE: Data are missing for 1999, 2012 and 2013. Data for 2014 and 2015 are projections.
SOURCES: 1972-1998: Unduplicated, ever-enrolled counts as reported in the 2000 House Ways and Means Committee Green Book http://www.gpo.gov/fdsys/search/pagedetails.action?granuleId=&packageId=GPO-CPRT-106WPRT61710.
2000-2011: KCMU and Urban Institute estimates based on unduplicated, ever-enrolled data from FFY 2000-2011 MSIS.
2014-2015: Unduplicated, ever-enrolled counts as reported in the March 2015 CBO baseline.

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Medicaid MLTSS Definitions

- Managed Long-Term Services and Supports (MLTSS):
  - Arrangements between state Medicaid programs and providers
  - Providers receive **capitated payments** for long-term care services and supports (LTSS)
  - Service are provided to individuals requiring **Nursing Home Level of Care**
- State Goals for MLTSS Programs
  - Improved participant outcomes and quality of care
  - Increased access to HCBS
  - Improved care coordination
  - Improved efficiency
  - Increased consumer choice

Medicaid MLTSS Program Forms

- Medicaid MLTSS Stand Alone Program

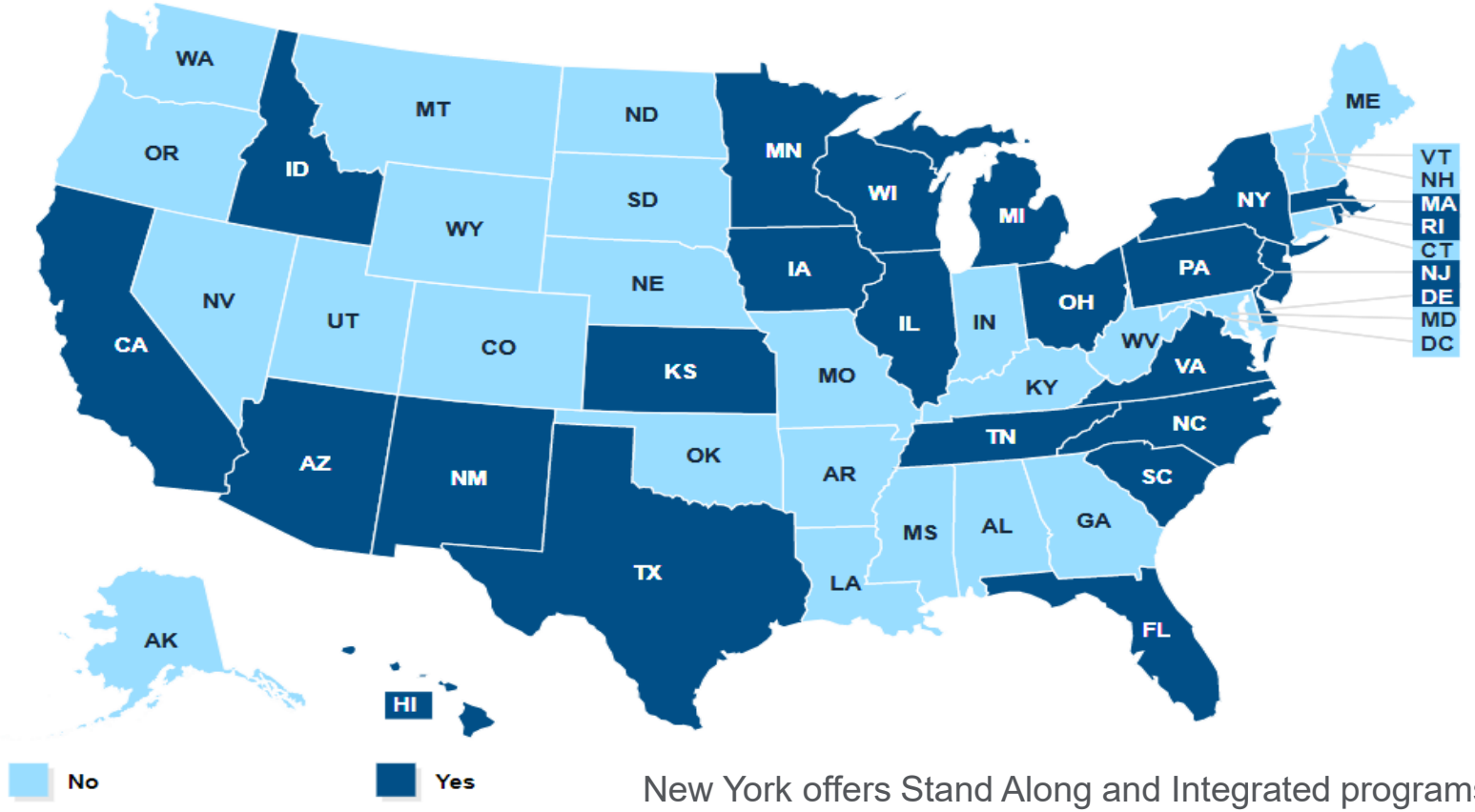
- Partnership with CMS to integrate with Medicare and Medicaid (including LTSS) benefits:
  - Included within Medicaid Managed Care capitation rates
  - Capitated Financial Alignment Demonstration (dual demonstration)
  - Medicare Advantage Fully Integrated Dual Special Needs Plans (FIDE SNP)
  - Program for All-Inclusive Care for the Elderly (PACE)

Medicaid MLTSS Prevalence

MLTSS Program Focuses on Frail Population

- 2004 – 8 states had at least one implemented MLTSS program
- 2012 – 16 states had implemented 19 programs
- 2017 – 22 states had implemented MLTSS programs, including
  - Programs that make capitated payments to contractor primarily for MLTSS
  - Programs that make capitated payments to contractor for all or most Medicaid Services
  - Fully integrated Medicare – Medicaid programs that include all Medicaid and Medicare services
- Exclusion: Programs focused exclusively on mental health and substance abuse

2017 Medicaid MLTSS Map



New York offers Stand Along and Integrated programs
Massachusetts only offers Integrated program
Texas offers MLTSS through the Star Plus Managed Care program

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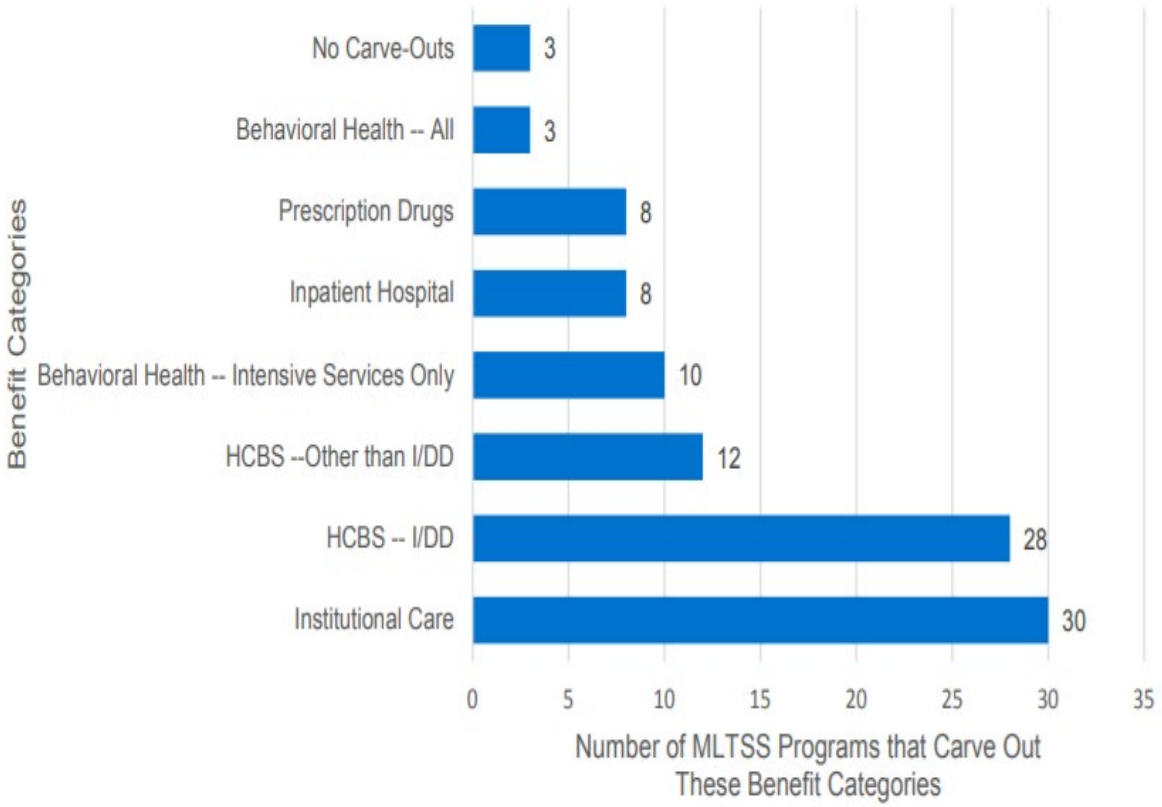
MLTSS Program Benefits and Exclusions

- Only 3 MLTSS programs covered all Medicaid covered benefits within managed care capitation rate
- All other programs at least carved out >=1 benefit



Section 1115 MLTSS Waiver

Purpose of Waivers:

- Waiver allows States to use Federal Medicaid and CHIP funds in ways that are not otherwise allowed under Federal rule
- Waivers reflect priorities identified by states and CMS

MLTSS Waiver:

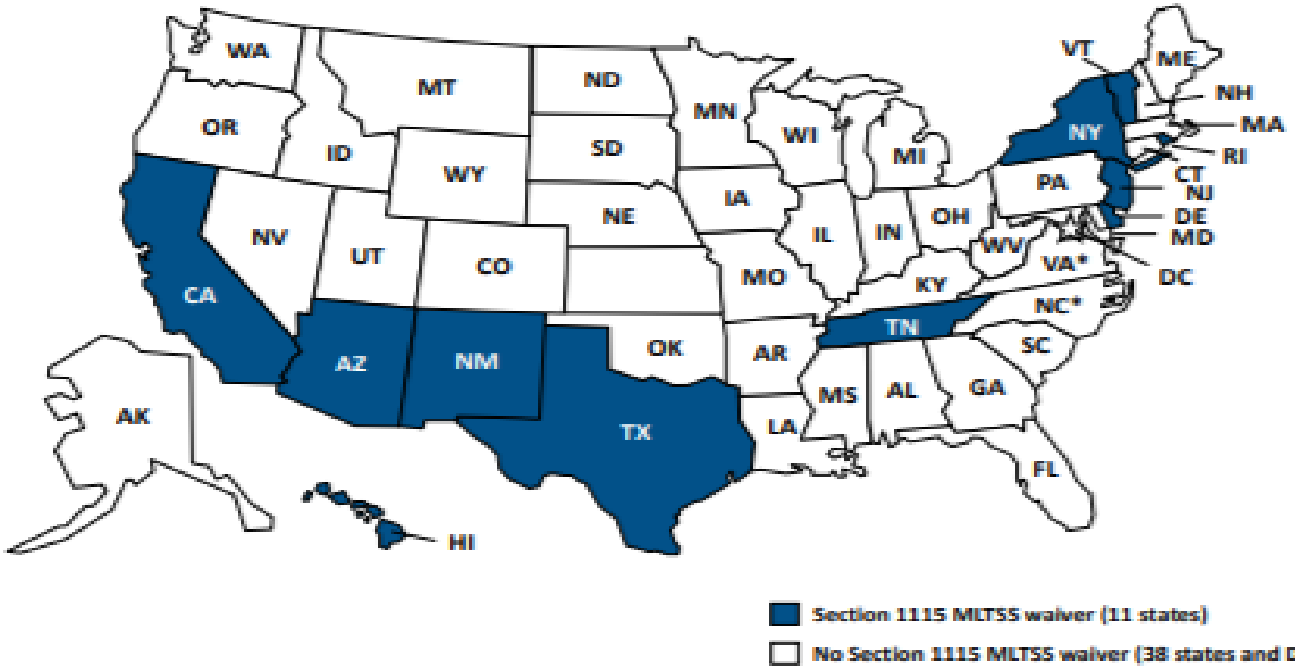
- Medicaid fills a gap by covering long-term services and supports that are largely unavailable through private insurance or Medicare
- Services traditionally have been financed on a fee-for-service basis
- More states are adopting capitated Medicaid MLTSS programs using this waiver

Section 1115 MLTSS Waiver Cont.

11 States by 2015

Figure 1

States with Medicaid Section 1115 Capitated MLTSS Waivers, 2016

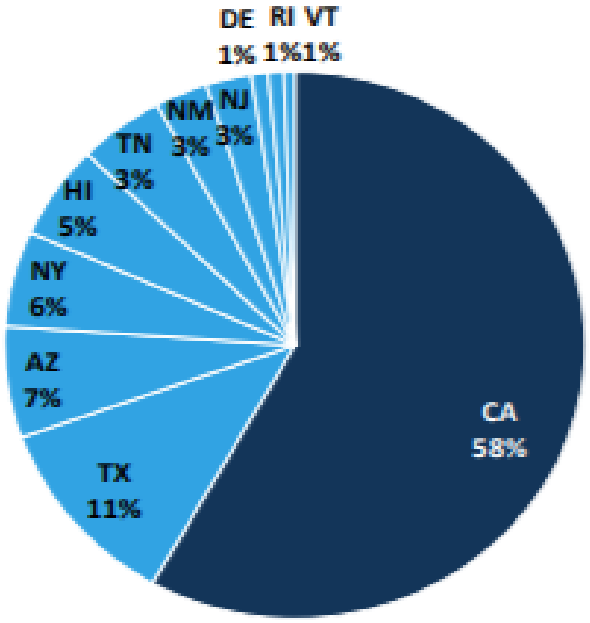


NOTE: Some states are implementing MLTSS through another authority.
SOURCE: KFF analysis of waiver special terms and conditions.

Section 1115 MLTSS Enrollment as of 2015

Figure 2

Medicaid Section 1115 MLTSS Waiver Enrollment By State, 2015



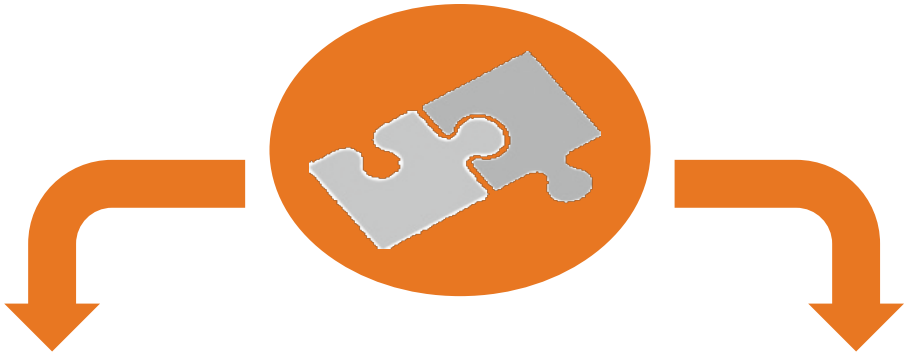
Total Enrollment = 880,000

NOTES: Enrollment totals reflect beneficiaries using LTSS. Totals may not sum due to rounding.
SOURCE: KFF survey of Section 1115 capitated MLTSS waivers (2016).

MLTSS Analytical Challenges for Health Plans

- Dual Rating Structures
  - Challenges associated with information from Federal and State
- Risk Adjustment
  - Each state has its own risk adjustment model
  - Models are non transparent
- State Budgets
  - Budgets are limited resulting in benefit changes year over year
- Premium Rate Adequacy
  - CMS Final Rule impact on rate setting
  - Rate transparency

Dual Rating Structures



CMS
Medicare

State
Medicaid / MLTSS

Data Validation Process

- Ensure appropriate data exchange between plan and federal/state entities
- Validate revenue / risk scores (if applicable)
- Accurate encounter data submissions

MLTSS Risk Adjustment

CLINICAL ASSESSMENT BASED

- Ensuring members are assigned to appropriate rate cells (Nursing Home Certifiable vs. Community)
- Rate cell membership reconciliations
- Member mix impact

MEMBER ASSESSMENTS / DIAGNOSIS BASED

- Risk adjustment model based on subjective member assessment data.
- Budget-Neutrality / zero-sum game
- Provider risk sharing reporting

Additional Challenges

- State budget
  - Carve in/ out benefits
  - Carve in / out populations
- Premium rate adequacy
  - CMS Final Rule
  - Transparency
  - Actuarial soundness

Analytical Considerations

Segment population into homogenous risk cohorts

- i.e. based on different plan of care, trends and care management

Predictive Analytics

- MLTSS data excellent target for predictive analytics
- Can study
  - Drivers of profitability
  - Predict member chronic conditions etc.

Rate Adequacy

- Develop experience reporting by risk cohorts / rate cells
- Ensure components of premium rates are adequate (CMS Final Rule):
  - Risk Adjustment
  - Program changes etc.

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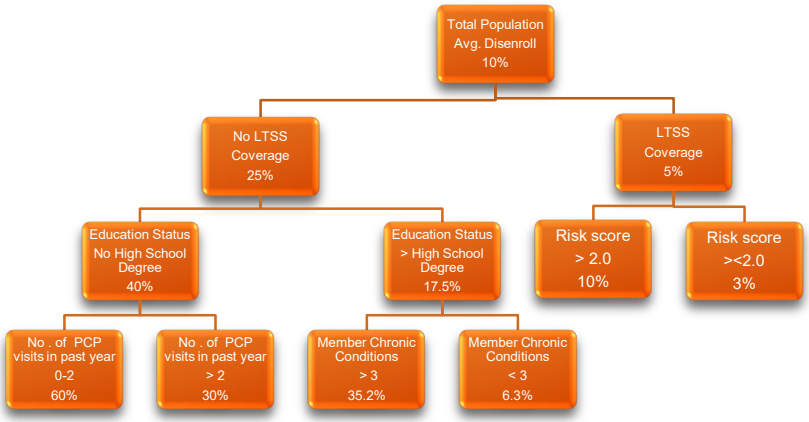
Case Study Discussion

Identify drivers for Dual SNP disenrollment for a national carrier operating in the MLTSS space

Data Mining Process

1. Identify the problem (i.e. high MLR, high disenrollment rates etc.)
2. **Data discovery**: Gather explanatory variables from various sources (demographic, utilization, social determinants etc.)
3. Determine Target/Dependent variable (voluntary disenrollment)
4. Profile data (distribution analysis, correlations)
5. Determine final variables for Model
6. Execute supervised decision tree model
7. Score test data
8. Make recommendations

Supervised Disenrollment Decision Tree (Illustrative Purposes Only)



RESULTS

4.1%

Year-over-year overall improvement in Disenrollments

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Team Bios- Examples

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Steve Prasad is a Director in Optum's Payer Actuarial Consulting team. He has more than 13 years of experience in various Actuarial analytical roles. In his current role as a Senior team member in the Medicaid/MLTSS Practice, he manages all Actuarial aspects of client relationships. Steve's expertise lies in Medicaid/MLTSS, Predictive Analytics, population risk stratification, risk profiling and data mining for the dual eligible marketplace.

Prior to joining Optum, Steve led an effort to build an extensive analytical reporting platform, including the use of advanced analytics, for a large regional health plan.

Steve has both a bachelor's degree in mathematics and an masters degree in Actuarial Science from Boston University.

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Sanjit Puri is a Senior Director in Optum's Payer Actuarial Consulting team. He has more than 15 years of industry experience working with payers, providers, and employers. Sanjit led the teams that completed the desk review of CY2006 – Cy2018 Medicare Advantage (MA) and Part-D plans on behalf of CMS. Most recently Sanjit was responsible in developing FY2018 budget estimates for various plans offered under Private Sector Care (TRICARE) including developing PMPM cost estimates. Sanjit also led the actuarial review of Medicaid Managed Care Capitation rates, the review of PACE program capitation rates and HCBS rate filings on behalf of CMS and has reviewed the ACA filings on behalf of Commonwealth of Virginia, New Jersey Department of Banking and Insurance and the State of Colorado. Sanjit was the chief actuary responsible for the development, completion and signing of the GASB45 reports for Post-Retirement Medical Benefits for the New York School Districts.

Sanjit is an Associate of the Society of Actuaries and a Member of the American Academy of Actuaries. In addition, he is a Physician by background.

Thank you.

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