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Mr. R. Jason Wiley
Managed Care Rate Setter
Minnesota Department of Human Services
540 Cedar Street
St. Paul, MN 55101-2208

Re: 2009 Benefit, Eligibility, and Reimbursement Changes – Version 3

Dear Jason:

This letter discusses my estimates of the impact of certain benefit, eligibility, and reimbursement changes in Minnesota's public program on the MCOs' cost levels in 2009. The letter provides background on these changes and describes the data and methods I used to calculate adjustment factors for each.

The purpose of this analysis is to assist the Minnesota Department of Human Services (DHS) with setting payment rates for contracting health plans for these programs. The results may not be appropriate for other purposes.

The results contained in this letter are intended only for use by DHS and CMS, the federal agency that must approve the capitation rates used for the PMAP, Minnesota Senior Care (MSC), Minnesota Senior Health Options (MSHO) and MinnesotaCare (MNCare) programs. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This letter should be reviewed only in its entirety. It assumes the reader is familiar with Minnesota's Medicaid programs and managed care rating principles.

The results in this letter are technical in nature and are dependent upon specific assumptions and methods. No party should rely upon these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Differences between estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is almost certain that actual experience will

not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience is different than expected. Accordingly, DHS should continue to carefully monitor actual experience and make adjustments as necessary.

In performing this analysis, I have relied on data and other information provided to me by DHS. I have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of my analysis may likewise be inaccurate or incomplete.

I have performed a limited review of the data used directly in my analysis for reasonableness and consistency, and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of this assignment.

Inclusion of Model Benefit Set for Mental Health Services

Effective January 1, 2008, a model benefit set for mental health services was partially implemented for all public programs. Additional services to be covered in 2009 include mental health targeted case management services (MH-TCM), effective July 1, and the treatment portion of per diem costs for Rule 5 children's residential mental health treatment (Rule 5), effective January 1.

To calculate benefit adjustment factors for the coverage of MH-TCM services, I estimated the cost of the benefit based on information provided by DHS. I used fee-for-service (FFS) data for managed care enrollees to estimate average cost in 2007. Based on information provided by DHS, I assumed that utilization in 2009 will be 7% higher than in 2007 due to an expanded definition of serious and persistent mental illness, and an additional 5% higher for PMAP (under 65) families with children rate cells due to the transition from county management.

MH-TCM was not covered in 2007 for the PGAMC and MNCare Adults programs, so I used an alternative approach to estimate the costs for this group. I used two sources:

- DHS's Fiscal Note: DHS estimated the cost of adding these benefits for PGAMC and MNCare Adults in a fiscal note developed during the budgeting process. The fiscal note included the expected utilization of these services by PGAMC and MNCare Adults relative to utilization by the PMAP (including MSC) population. DHS assumed utilization of about 190% and about 55% of PMAP utilization levels for PGAMC and MNCare Adults, respectively. In addition, DHS assumed a 50% increase in utilization for these programs. I also included the 7% utilization increase mentioned above.

- 2007 Experience: I added the value of services in the 2007 FFS data, described above, for PGAMC and MNCare enrollees who retroactively established MA disability eligibility. There was no provision for these costs in the fiscal note. The cost of these benefits in 2007 was $2.15 for PGAMC and $0.02 for MNCare Adults. Again, the enrollees generating these costs subsequently transferred to MA coverage.

Projected average cost in 2007 dollars, including a provision for administrative costs, ranged from $0.41 to $12.75 PMPM, depending on the rate cell. I divided these figures by two to recognize that coverage is effective July 1, 2009. I then divided projected costs by the age/gender-adjusted average 2007 claim cost for each applicable rate cell and added one to arrive at the benefit adjustment factors shown in Table 1.

Table 1: Adjustment Factors for MH-TCM Services

Program	Affected Rate Cells	Adjustment Factor
PMAP	Ages 2+ Female	1.0062
	Ages 2+ Male	1.0137
	Pregnant Women	1.0005
Seniors	Institutionalized	1.0009
	Non-Institutionalized Female	1.0031
	Non-Institutionalized Male	1.0036
PGAMC	All	1.0068
MNCare	Ages 2+, Preg. Women	1.0049
	Adults	1.0038

To calculate benefit adjustment factors for the coverage of Rule 5 services, I estimated the cost of the benefit based on information provided by DHS. I used fee-for-service (FFS) data for managed care enrollees to estimate average cost in 2007. For PMAP, I used 2007 average costs. For MNCare, I used 2006 and 2007 average costs due to low utilization and concerns about credibility.

Projected average cost in 2007 dollars, including a provision for administrative costs, totaled $0.87 PMPM for PMAP ages 2-20 rate cells, and $0.19 PMPM for MNCare ages 2-20 rate cells. I divided projected costs by the age/gender-adjusted average 2007 claim cost for each applicable rate cell and added one to arrive at the benefit adjustment factors shown in Table 2.

Table 2: Adjustment Factors for Rule 5 Services

Program	Affected Rate Cells	Adjustment Factor
PMAP	Ages 2-20	1.0054
MNCare	Ages 2-20	1.0012

Intensive Mental Health Outpatient Treatment

Intensive mental health outpatient treatment for individuals with borderline personality disorder will be covered for PMAP, PGAMC, and MNCare. According to information received from DHS, utilization of these services by seniors is immaterial. DHS is assuming an effective date of January 1, 2009 for this coverage. I relied on the fiscal note provided by DHS to develop benefit adjustment factors for this coverage. I relied on an assumption provided by DHS that 2/3 of the costs in the fiscal note for GAMC are associated with managed care enrollees. The fiscal note assumes a 20% utilization increase in each of the first two years of coverage. Projected cost in 2007 dollars, including a provision for administrative costs, ranged from $0.01 to $0.08 PMPM, depending on the program. I divided projected costs by the 2007 average claim cost and added one to arrive at the factors shown in Table 3. Note that no adjustment is necessary for MNCare due to low utilization.

Table 3: Adjustment Factors for Intensive MH OP Treatment

Program	Adjustment Factor
PMAP	1.0001
PGAMC	1.0001
MNCare	1.0000

Reinterpretation of 23.7% Rate Increase for Certain Critical Access Providers

Regarding the 23.7% rate increase implemented January 1, 2008 for certain critical access providers, there has been a reinterpretation of the services and providers to which the increase applies. I relied on the fiscal note regarding this reinterpretation, provided by DHS. Based on this information, the reinterpretation is not significant enough to change the adjustment factors developed last year.

Copay Changes

To conform to federal requirements, monthly copays on prescription drugs and non-emergency visits to the emergency room are limited to 5% of family income for individuals at or below 100% of the federal poverty guidelines. I understand the limit applies to PMAP (including seniors) but not PGAMC or MNCare. Also, children and pregnant women are exempt from copays. I received data from DHS regarding the number of non-pregnant adult MA enrollees (including fee-for-service enrollees) that would be subject to a copay maximum for each month from August 2007 through July 2008. Based on this data, 0.70% of MA enrollee-months would be subject to a copay maximum for the year ending July 2008.

I understand that you expect plans generally use a prudent layperson standard to identify non-emergency visits to the emergency room. As a result, such visits are very rare in the data. Assuming that copays for non-emergency visits to the emergency room are immaterial, the maximum copay that might be waived is $7 per enrollee per month for non-seniors. I am assuming this maximum also applies to seniors for Medicaid-covered drugs. If I receive contrary information from DHS, I will modify this assumption. Multiplying this maximum drug copay per month of $7 by the percentage above gives a benefit cost of $0.05 per enrollee per month. I divided this $0.05 by age-gender adjusted 2007 claim costs and added one to arrive at the benefit adjustment factors shown in Table 4.

I have made a number of simplifying assumptions in developing these factors. As mentioned above, I assume that copays for non-emergency visits to the ER are immaterial, and that seniors are subject to the $7 maximum copay for drugs. In addition, I assume that all enrollees will have drug copays of the full maximum of $7 per month, that all affected enrollees will have the entire copay waived, and that a managed care enrollee is typical with respect to income among the population represented in the data received from DHS, which includes FFS as well as managed care enrollees.

Table 4: Adjustment Factors for Income-Based Copay Limits

Program	Affected Rate Cells	Adjustment Factor
PMAP	Non-Pregnant Adults	1.0001
Seniors	All	1.0001

For PMAP non-pregnant adults (including seniors), the eyeglasses copay and the non-preventive visits copay will be removed. When these copays were priced in 2003, the estimated impact on the affected rate cells was 0.02% for eyeglasses and 1.11% for non-preventive visits, as shown in Table 5. According to state law, fee-for-service reimbursement rates may not be increased due to the elimination of these copays. Likewise, payments to managed care plans may not be increased,

presumably because MCOs are expected to follow suit by not adjusting provider reimbursement rates to compensate for this removal of copays. *For this reason, my rate analysis as described in this letter and my letters on trend and surplus adjustments assume that the MCOs will not increase reimbursement to providers to compensate for the reduction in copays, and these factors have not been applied.*

Table 5: Value of PMAP (including Seniors) Copays

Program	Affected Rate Cells	Copay	Benefit Cost Factor
PMAP, Seniors	Non-Pregnant Adults	Eyeglasses	1.0002
PMAP, Seniors	Non-Pregnant Adults	Non-Preventive Visits	1.0111

For PGAMC, PMAP non-pregnant adults, and non-institutionalized seniors, the maximum monthly prescription drug copay will be reduced from $12 to $7, effective January 1, 2009. I used data received from DHS to estimate the cost of reducing these maximum monthly copays. DHS provided a distribution of total monthly copays by program for managed care enrollees for calendar year 2007. The distribution grouped enrollee member months into copay bands one dollar wide (e.g. $1.00-$1.99, $2.00-$2.99, $3.00-$3.99).

I made the simplifying assumption that all monthly copay amounts are whole dollar amounts, noting that a copay will always be a whole dollar amount unless the cost of the drug is less than $3 ($1 for generics). Also, I have assumed there will not be any change in prescription drug utilization as a result of these copay changes. I converted the estimated cost of reducing these maximum monthly copays to a PMPM and divided by the age/gender adjusted 2007 claim cost to arrive at the benefit cost factors shown in Table 6. *Again, I understand there will be no explicit rate adjustment due to state law which may prohibit such adjustment, and I am assuming the MCOs will not increase reimbursement to providers to compensate for the reduction in copays.*

Table 6: Value of Reducing Prescription Drug Copay Limits

Program	Affected Rate Cells	Benefit Cost Factor
PMAP	Non-Pregnant Adults	1.0007
PGAMC	All	1.0009
Seniors	Non-Institutionalized	1.0025

Rateable Reductions

DHS is applying "rateable reductions" to reduce payments to the MCOs effective January 1, 2009. These reductions correspond to reductions in the Medicaid fee-for-service fee schedule. My rate analysis, including my letters on trend and surplus analysis, assumes that the MCOs will be able to decrease their payments to providers by the amount of the rateable reductions to make up for the reduction in capitation rates.

Morbidity Impact of PGAMC to MNCare Migration

Significant numbers of GAMC enrollees migrated from PGAMC to MNCare starting in November of 2006. As a result, a new MNCare rate cell, the G(MC) rate cell, was developed for these transitional enrollees.

Rates for this new cell were originally developed in my letter dated October 12, 2005, and were based on rates for the B(M1) rate cell (the G(MC) enrollees have the same benefits as the B(M1) enrollees). In my previous letter regarding benefit and eligibility changes dated November 19, 2007, I developed a morbidity adjustment factor of 0.838 for the G(MC) rates based on emerging 2007 experience.

Now that additional data is available, I have reviewed the claim costs and rates for the G(MC) and B(M1) enrollees. Based on claim cost data from 2007 and the first half of 2008, I have calculated the following adjustment factors.

Table 7: Recommended G(MC) Rate Adjustment Factors

Rate Cell		Recommended Adjustment Factors
F	21-49	1.0339
F	50+	0.8816
M	21-49	0.7346
M	50+	0.7111

These adjustment factors were developed by comparing the 2008 demographic capitation rates for the G(MC) rate cells to the corresponding rates for the B(M1) cells. I then calculated average per

member per month (PMPM) claim costs for each rate cell using the detailed incurred claim data from 2007 and the first half of 2008 submitted by the plans for the area factor review. After adjusting the claim costs for geographic area and benefit changes from 2007 to 2008, I compared the claim costs for each G(MC) rate cell to the corresponding B(M1) rate cell. The detail appears in Table 8 below.

Table 8: Development of G(MC) Rate Adjustment Factors

Rate Cell		2008 Demographic Rates PMPM*			2007 and First Half 2008 Area Adjusted Claim Costs and Enrollment				
		B(M1)	G(MC)	G(MC) / B(M1)	B(M1)		G(MC)		G(MC) / B(M1)
		PMPM	PMPM		PMPM	MM	PMPM	MM	
F	21-49	$386.16	$427.92	1.1081	$455.04	48,010	$521.34	33,051	1.1457
F	50+	$605.42	$672.95	1.1116	$631.72	28,353	$619.05	9,930	0.9799
M	21-49	$281.62	$407.95	1.4486	$388.20	53,080	$413.12	52,610	1.0642
M	50+	$544.76	$776.01	1.4245	$607.77	19,787	$615.66	10,703	1.0130

* Note: Rates were divided by area factors and then combined using first half 2008 membership distribution.

The adjustment factors in Table 7 above are calculated by dividing the rightmost column in Table 8 (the claim cost relativity G(MC) / B(M1)) by the third column in that table (the current demographic rate relativity). The recommended adjustment factors would bring the demographic rate relativities back in line with the claim cost relativities.

If DHS were to decide to make this adjustment revenue neutral across the entire Limited Hospital population, this could be accomplished by multiplying all rate cells in that population by 1.0476. I calculated this revenue neutrality adjustment using the enrollment for the first half of 2008 provided by the plans. The factor is intended to be applied to both demographic and risk adjusted rates.

I have also reviewed the claim costs for the GAMC population. In this case, an adjustment of 1.2050 was applied to GAMC rates for 2008 to reflect the higher morbidity of members remaining in GAMC as compared to those transitioning to MNCare. In Table 9, I have developed adjustment factors that could be applied to current GAMC rates to reflect the additional claim data now available (specifically, calendar year 2007 and the first half of 2008).

Table 9: Recommended GAMC Rate Adjustment Factors

		Current Demog. Ftrs.	Morbidity Adjustment	Current Relativities	Recommended Relativities	Adjustment Factors
GA	F	1.0000	1.0000	1.0000	1.0000	1.0000
GA	M	0.8585	1.0000	0.8585	0.8585	1.0000
GAMC	F	0.6281	1.2050	0.7568	0.7554	0.9981
GAMC	M	0.5508	1.2050	0.6637	0.6104	0.9196

The first column contains the current demographic factors for PGAMC, normalized so that GA females are 1.0. The second column contains the morbidity adjustment applied last year. The third column is the product of the first two, and gives the current rate relativities. The recommended relativities for GAMC were developed using the rate cell level claim and membership data for 2007 and first half 2008 provided by the plans, adjusted for changes in benefits and for area. The adjustment factors are then the ratio of the recommended relativity to the current relativity for each rate cell. I am recommending no change for GA at this time.

If DHS were to decide to make this adjustment revenue neutral across the entire PGAMC program, this could be accomplished by multiplying all four PGAMC rate cells by 1.0167. I calculated this revenue neutrality adjustment using the enrollment for the first half of 2008 provided by the plans.

Chemical Dependency Room & Board Costs in Freestanding Residential Treatment Centers

Effective January 1, 2009, the MCOs will not be responsible for the room & board (R&B) portion of chemical dependency costs for stays in freestanding residential treatment centers. I received data regarding total costs (including R&B and treatment costs) for these stays, by program, from five of the nine MCOs. Based on fee-for-service data received from DHS, R&B costs amounted to 25.8% of total costs for these stays on average for state fiscal years 2006-2008. I converted the cost data received by the MCOs to a PMPM, multiplied by 25.8%, divided by the 2007 average claim cost for the five MCOs, and subtracted from one to arrive at the benefit adjustment factors shown in Table 10. Only one of the five plans provided data separately for PMAP <65 and MSC/MSC+. I combined the data from this plan with the combined data from the other four plans to arrive at a single adjustment for PMAP <65 and Seniors. By applying this factor to all seniors, I am assuming that total cost for MSHO enrollees is similar to that for PMAP <65 and MSC/MSC+ enrollees.

Table 10: Adjustment Factors for Chemical Dependency R&B Services

Program(s)	Affected Rate Cells	Adjustment Factor
PMAP, Seniors	All	0.9992
PGAMC	All	0.9971
MNCare	All	0.9990

2008 Benefit Changes

The impact of certain benefit changes that took effect July 1, 2008 was spread over the entire year 2008. Table 11 shows the adjustment factors that were applied for such benefit changes and will be applied again to the 2009 rates to account for the additional half-year of cost for providing the benefits throughout 2009.

Table 11: Adjustment Factors for Halfway House and Extended Care Services

Program(s)	Affected Rate Cells	Adjustment Factor
PMAP	Ages 2+	1.0011
Seniors	Non-Institutionalized	1.0011
PGAMC	All	1.0078
MNCare	Ages 2+	1.0017

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Jason, please contact me if you have any questions about this letter. You can reach me at (952) 820-2481 or at leigh.wachenheim@milliman.com.

Sincerely,

Leigh M. Wachenheim, FSA, MAAA
Principal & Consulting Actuary

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