Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Medicaid Managed Care Capitation Rates

Holding Managed Care Rates at Calendar Year 2016 Level

Second Engrossed Substitute House Bill 2376, Laws of 2016, Section 213 (1)(b)

October 1, 2016

Medicaid Managed Care Capitation Rates

Holding Managed Care Rates at Calendar Year 2016 Level

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Executive Summary

The Health Care Authority (HCA) is submitting this report as directed by the 2016 enacted Supplemental Operating budget (proviso) per Second Engrossed Substitute House Bill 2376 (2ESHB 2376), Section 213(1)(b), Laws of 2016 which specifically informs the managed care rate development process for calendar year 2017 through the following proviso directives:

- Hold calendar and fiscal year 2017 Medicaid managed care capitation rates flat at calendar year 2016 levels;
- Engage with stakeholders to identify a range of strategies to achieve flat rates through work group engagement;
- Obtain actuarial analysis, support, and recommendations;
- Give a progress update by August 1, 2016 on these discussions and the progress made to the Joint Select Committee on Health Care; and
- Provide a report to the legislature by October 1, 2016 about the trend and the implications and impacts to clients.

In order to accomplish the work directed by the proviso, HCA convened two meetings in partnership with the Association of Washington Healthcare Plans (AWHP) featuring the participation of managed care plans, Health Care Authority, the Office of the State Actuary (OSA), Office of Financial Management and legislative staff. There was much discussion of the current rates, historical trends for various Medicaid populations served and strategies to mitigate future increase in rates, both short and long-term. After an exercise to prioritize a broader range of ideas for mitigating trend based on feasibility, client impact, stakeholder support, and potential rate impact, three targeted strategies were selected for further exploration and analysis: 1) potentially preventable readmissions, 2) facility fee reduction/elimination paired with a primary care rate increase, and 3) changes to how mental health drugs are managed. A work group led by HCA staff was formed for each focus area. In addition to original participants, providers and health systems were invited to participate in the focused work group discussions.

Summary of Work Group Discussions

	Impact to Clients	Impact to Providers	Recommendations
Potentially Preventable Readmissions (PPR)	Incentivizes care management, discharge planning and coordination linked to improved quality outcomes	Policy change could simplify/clarify incentives to avoid readmissions for providers.	Continue to utilize contracts to assure best use of concurrent review process and create incentives for systems improvements.
Facility Fee Reduction/ Elimination	Concerns regarding how facility fee reduction would impact client access to care at clinics that are receiving the facility fee currently.	Concern for financial impact on hospital-based facilities. Primary care providers would receive increased payment for serving Medicaid clients.	Pursue strategies for collecting the necessary data to inform a data driven decision.
Mental Health Drug Costs	Policy change could limit access to certain drugs for clients. Increased plan flexibility may encourage more effective care coordination and management of medications.	Concern that strategies could create provider confusion if standard formulary and prior authorization processes were abandoned.	Identify opportunities and best practices for prescribing and authorizing mental health drugs.

While work groups raised some next steps in each of the areas reviewed, there was no broad consensus established. Recommendations focus on the further work necessary to more fully develop potential solutions in each of the three areas.

HCA engaged the independent actuarial firm, Milliman, to participate in the work group and assess the work group strategies concurrent to the development of calendar year 2017 managed care rates. OSA also obtained an independent actuarial review.

In accordance with the budget proviso, on July 27, 2016, HCA staff presented to the Joint Select Committee on the progress of the work group meetings and an update on the status of the three strategies and work groups.

The preliminary calendar year 2017 Apple Health base rates compared to last year's base rates result in a -1.0%[1] composite percentage change based on a weighted average PMPM, with a total general fund state impact of $2.9 million[2].

Given the due date of this report and the timing of the calendar year 2017 rate setting process, final rates and analysis cannot be provided. HCA will continue to communicate and keep the Legislature and stakeholders involved as rates are finalized.

[1] Base rates include projected pass-through payments including the Safety Net Assessment Fund (SNAF) and Provider Access Payment (PAP). Base rates do not include Federally Qualified Health Centers (FQHC) and Rural Health Clinic (RHC) enhancement payments.

[2] This estimate includes the medical and non-medical load and makes no assumptions for enrollment growth, assumes no premium tax impact and no change from 2015 to 2016 to the FMAP for AHAC.

Overview

The Health Care Authority (HCA) is submitting this report as directed by the 2016 enacted Supplemental Operating budget (proviso) per Second Engrossed Substitute House Bill 2376 (2ESHB 2376), Section 213(1)(b), Laws of 2016 as stated below:

2013(1)(b) $121,599,000 of the general fund—state appropriation for fiscal year 2017 is provided solely for holding medicaid managed care capitation rates flat at calendar year 2016 levels in state fiscal year and calendar year 2017. To achieve this target, the authority shall engage with a group composed of the office of financial management, the medicaid forecast work group, and the managed care plans on a range of strategies developed both by the authority and the group. The authority shall obtain actuarial analysis, support, and recommendations during this process, and the state actuary shall obtain independent actuarial analysis. By August 1, 2016, the authority shall present the progress made on the initiative to the joint select committee on health care, identifying any possible changes in statute needed to achieve the goal and the possible impacts on clients. The authority shall complete the plan and report to the appropriate committees of the legislature by October 1, 2016.

2016 Rate Drivers

In 2016 the weighted average PMPM Apple Health rates increased nearly 7%[3]. This level of increase was not anticipated and was above the forecasted assumption of 2%. As a result, the Legislature requested more detailed information about why this increase occurred and how to mitigate increases in the future.

Prescription drugs were a significant contributor to the Apple Health PMPM increase from 2015 to 2016. Increasing costs due to specialty pharmacy was not unique to Washington; the impact of specialty pharmacy on state Medicaid spending was experienced across the nation. *"The 2015 Drug Trend Report Medicaid"* report published by Express Scripts Lab showed that, nationally, the traditional drug trend is forecasted to rise by an average of 5.7% while the specialty drug trend is expected to increase steadily by an average of 13.6% over the next three years. This report identifies 7,000 potential drugs in development, with most aimed at treating the high-use categories of oncology, neurologic disorders and infectious diseases which are drivers to the forecasted pharmacy trend.

Historic PMPM Trend

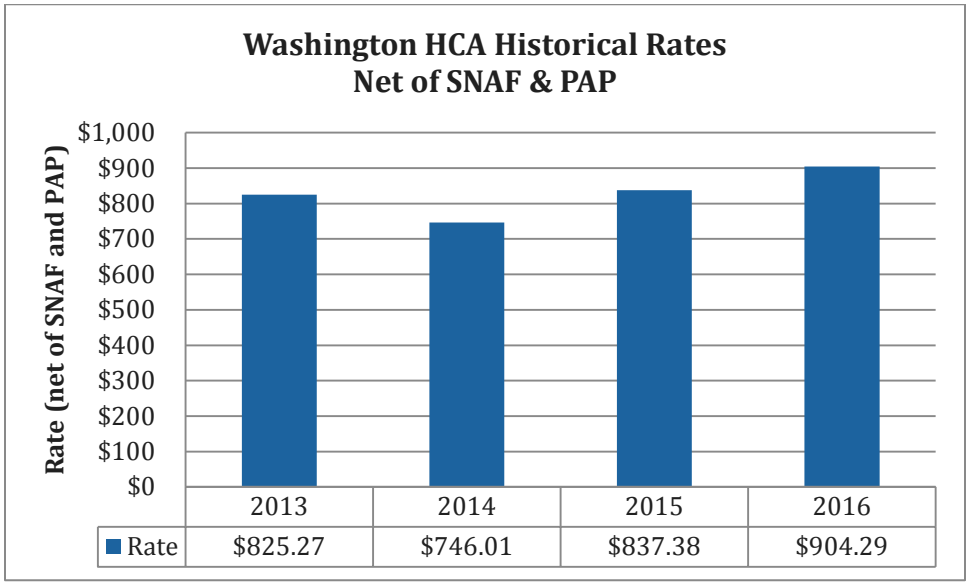
The composition of each rate group, including factors such as age and severity of illness, drives each Apple Health rate group's overall costs. Implementation of the ACA in 2010 led to dramatic changes in the composition of the family, expansion and SCHIP groups. The composition of the blind/disabled and COPES groups remained consistent during this time. Thus, these groups provide

[3] By rate cohort, the calendar year 2016 rates compared to 2015 rates represent an aggregate increase of 3.3% for the Family population, an increase of 19.9% for the SCHIP population, an increase of 13.0% for the AHBD population, an increase of 22.6% for the COPES population, and an increase of 2.8% for the AHAC program.

the best picture of actual cost trend since 2010. That is, the cost trend in these groups is more likely to reflect actual changes in costs rather than changes in the composition of the group.

To provide context to the historic PMPM trends specific to Washington State, Figure 1 shows the annual projected rate trend for the blind/disabled and COPES rate groups from July 2012 to December of 2016. The average annual trend during this time period was approximately 2.9%. These trends exclude pass-through costs [Safety Net Assessment Fund (SNAF) and Provider Access Payments (PAP)].

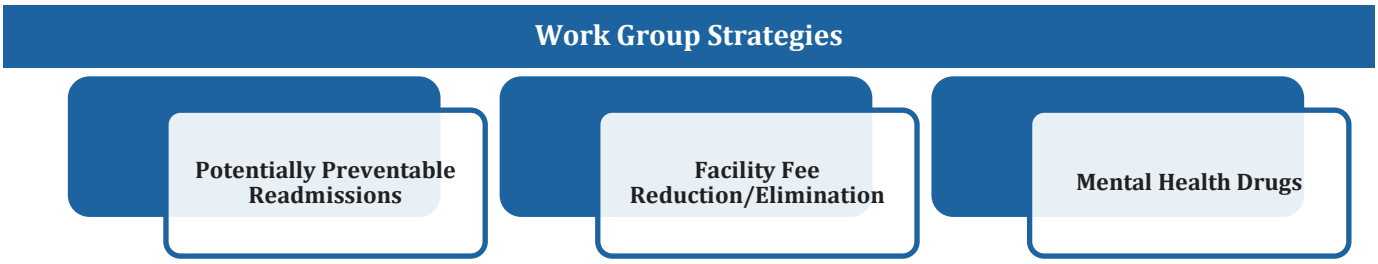
Figure 1: Historical Rates in the Blind / Disabled and COPES Rate Groups



Work Groups and Strategies

In order to accomplish the work directed by the proviso, HCA convened two meetings in partnership with the Association of Washington Healthcare Plans (AWHP) featuring the participation of managed care plans, HCA, the Office of the State Actuary (OSA), Office of Financial Management (OFM) and legislative staff. There was much discussion of the current rates, historical trends for various Medicaid populations served and strategies to mitigate future increase in rates, both short and long-term. After an exercise to prioritize a broader range of ideas for mitigating trend based on feasibility, client impact, stakeholder support, and potential rate impact, three targeted strategies were selected for further exploration and analysis: 1) potentially preventable readmissions, 2) facility fee reduction/elimination paired with a primary care rate increase, and 3) changes to how mental health drugs are managed. A work group led by HCA staff was formed for each focus area. In addition to original participants, providers and health systems were invited to participate in the focused work group discussions.

This section provides an overview of the discussions around each of these strategies including recommendations from each work group, impacts to clients and providers, and fiscal impacts.



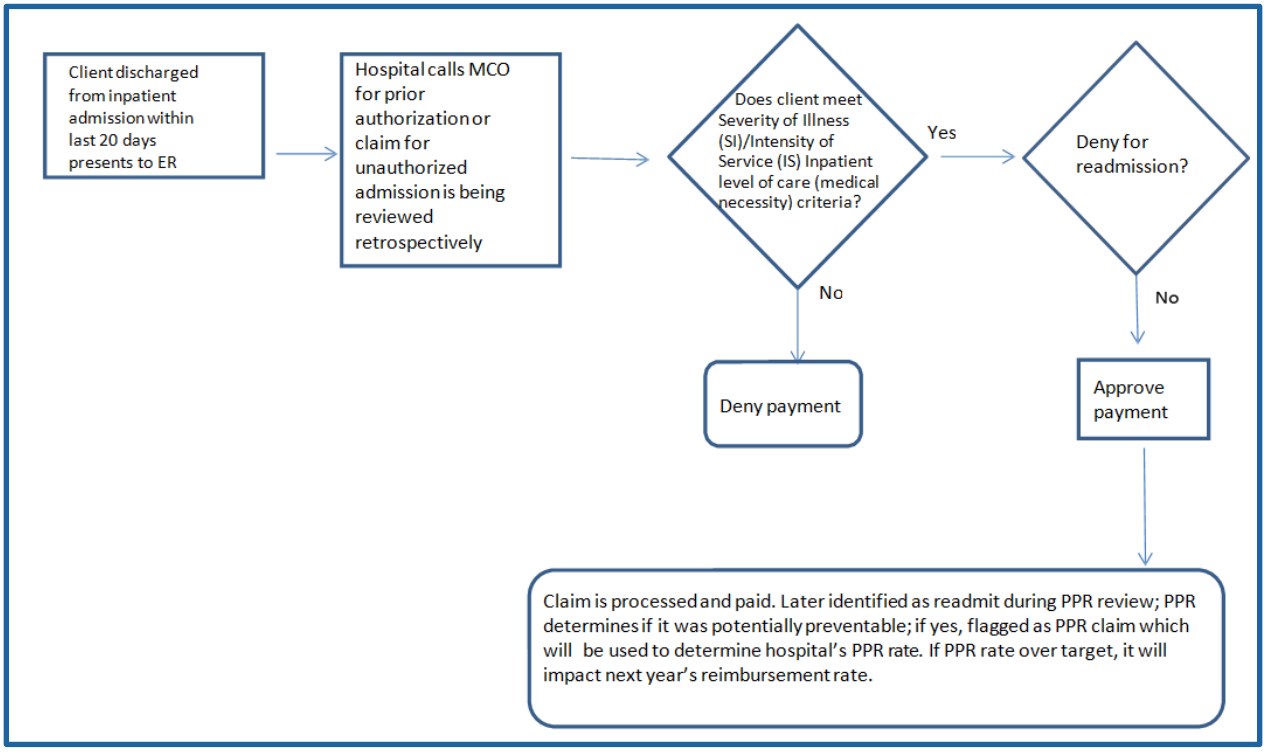
Potentially Preventable Readmission Policy

Potentially Preventable Policy Overview

HCA implemented a population-based approach to reducing avoidable hospital readmissions in January 2016. Prior to this time, HCA's readmissions policy focused on individual review of hospital readmissions occurring at seven and fourteen days post-discharge. This policy allowed MCOs to deny payment for readmissions that, while medically necessary, might have been avoided by better care and discharge planning at the time of discharge from the preceding admission. The previous fee-for-service (FFS) policy operated by HCA for non-managed care clients required registered nurses (RNs) at hospitals and HCA to conduct manual detailed review of individual cases to determine whether a specific readmission was clinically related to the initial admission. MCO plans adopted the FFS readmissions policy and conducted similar processes to monitor preventable readmissions. Because of its flexible nature, this legacy readmission policy was applied and measured differently across the MCO plans and HCA (in its FFS program); identifying the value of the claims denied under the legacy policy, where data was available, required significant effort.

HCA's current readmissions policy uses a standardized, clinically-based methodology developed by 3M to track and measure potentially preventable readmissions (PPRs) and to establish target statewide benchmarks to assess hospital readmission performance. Hospitals that have a risk-adjusted readmission rate exceeding the statewide target, which was set at 85% of the actual risk-adjusted 2014 statewide readmission rate, receive a reduction in their reimbursement rates; this provides an ongoing incentive to reduce future preventable readmissions. Rate reductions applied for CY 2016 were designed to be "budget neutral" relative to estimated aggregate value of the denied payments under the legacy readmission policy. Figure 2 documents the current PPR process.

Figure 2: Current Potentially Preventable Readmissions Policy Process



HCA's current readmissions policy is intended to promote quality improvement by providing population and individual level data back to hospitals regarding readmissions, using a consistent, standard measurement applied to all providers and MCO plans. With this data, hospitals can identify patterns and implement preemptive strategies that lead to systemic improvements aimed at reducing future preventable readmissions before they occur (as opposed to payment disputes over individual claims).

Potentially Preventable Readmission Policy Work Group

The Potentially Preventable Readmission Policy (PPR) subgroup was convened to discuss the current policy's connection to better health outcomes and its financial impact. This work group meeting, facilitated by HCA included representatives from the Washington State Hospital Association (WSHA), the five managed care plans (MCOs), and Navigant Consulting.

The work group discussion began with an overview of the legacy PPR policy and the current PPR policy that was implemented on January 1, 2016. The MCOs expressed concerns that the calendar year 2017 Apple Health contract language does not allow them to utilize concurrent review to identify patients who are being readmitted within a 30 day timeframe and organize appropriate care management strategies for such patients. While HCA's current policy replaced the legacy policy described, it was not the agency's intent to discourage or prohibit MCOs from engaging hospitals in detailed review of readmissions that an MCO might identify through concurrent review as potentially avoidable. MCOs are encouraged to engage hospitals in such dialogue as a means of identifying the care management needs of specific patients and jointly developing improvement

strategies to reduce PPR rates. Moreover, under the new policy, MCOs retain the ability to withhold payment for re-admissions that do not meet medical necessity criteria for admission. As the plans have noted, the new policy has shared risk between providers and payers (including both the MCOs and HCA) – giving the payers the financial incentive to improve health outcomes.

HCA took the action item to clarify the calendar year 2017 AH contract language to ensure MCOs can utilize concurrent review to not only identify patients being re-admitted but use suitable care management strategies.

Recommendations

The PPR work group did not reach any consensus recommendations for changes, however next steps were identified. HCA will clarify calendar year 2017 AH contract language to assure that MCOs utilize concurrent review to identify patients who are being re-admitted within a 30-day timeframe and deploy appropriate care management strategies for such patients.

HCA will also continue to utilize the current population-based approach to create incentives for system improvements aimed at reducing preventable readmission rates. The statewide target rate will be set at 85% of the SFY 2016 risk-adjusted readmission rate. HCA views this as an attainable but aggressive target. In order to optimally leverage this approach, HCA will share hospital-specific readmissions data with health plans, and convene hospitals and MCOs on a quarterly basis to review data and identify opportunities for improvement.

Facility Fee Reduction / Elimination

Medicare and Medicaid Payment Policies for Outpatient Services at Off-Campus Hospital Clinics Overview

Under current Medicare and Washington Medicaid payment policies for outpatient services at off-campus hospital clinics[4], two payments are made for the same service—a facility payment and a professional service payment. Currently, this reimbursement approach is the same for site-based and off-campus clinics. The combined facility and professional service payment is generally higher than the payment for the same service in a physician's office. CMS has also taken this issue up for Medicare, noting in recent proposed rules, "the rapid growth of vertical hospital consolidation and hospital acquisition of physician practices" as a result of current policies that reimburse at higher rates for off-campus clinic services than physician office services.[5]

Under CMS' new Medicare Outpatient prospective Payment System (OPPS) "Site- Neutral" Payment Policy, effective January 1, 2017, outpatient services provided at offsite hospital-based clinics established on or after November 2, 2015 will be paid under either the physician fee schedule or the Ambulatory Surgical Center (ASC) payment system (instead of the OPPS). Off-campus clinics

[4] Off-campus clinics are defined under Medicare's policy as "provider-based hospital departments" that are more than 250 yards from the hospital.

[5] CMS/ Federal Register / Vol. 81, No. 135 / Thursday, July 14, 2016 / Proposed Rules / Page 45688

established before November 2, 2015 are "excepted" and grandfathered into the existing Medicare OPPS payment method.

Medicare's new policy excludes dedicated emergency departments (even if they are off-campus) and provider-based rural health clinics. CMS has provided guidance on what changes a clinic can make and still retain its excepted status; for example relocation of an excepted clinic would make it "non-excepted" and no longer eligible for OPPS reimbursement.

As a practical matter for policy implementation, CMS has said its current payment systems for hospital clinics are only capable of processing payments under the OPPS and that mechanisms are not currently available for payment under alternative systems. As a temporary solution, for CY 2017, non-excepted clinics will not submit facility claims. Instead, physicians in these clinics will submit a professional service claim and be paid the "non-facility" rate under the Medicare physician fee schedule, which includes payment for the ''practice expense'' resources involved in furnishing services. (The "facility" rates, for which physicians are currently paid for these services, are lower and do not include practice expenses.)

CMS believes this temporary one-year solution is consistent with billing practices prior to the spread of off-campus clinics, because many of the physician practices were acquired by hospitals and subsequently became provider-based. Hospitals will have to make payment arrangements with physician practices in order to receive their share of reimbursement. CMS is soliciting comments on changes needed to allow off-campus clinics to bill for these services, including the establishment of a new provider/supplier type, with the goal of having a new mechanism in place by CY 2018.

When considering options for implementation of a new site-neutral policy, Washington State would not be required by CMS to follow Medicare's policy on the timing and grandfathering of clinic sites. Rather, each state has the flexibility to decide to use other parameters for Medicaid, so long as the changes are consistent with the federal requirements related to access, quality, and efficiency. If a new payment methodology were to be put in place, HCA would need to:

- Update multiple sections of Chapter 182-550 WAC,
- Submit an amendment to the agency's Medicaid State Plan,
- Notify hospital providers of the change,
- Update the agency's Medicaid Provider Guide, and
- Update the agency's Medicaid claims payment system, ProviderOne.

The reduction/elimination of the facility fee can be implemented with minor, configurable changes to ProviderOne, the Medicaid payment system that handles fee-for-service claims.

Facility Fee Reduction/Elimination Work Group

The Facility Fee Reduction/Elimination subgroup was convened to discuss the potential benefits and impacts if the State eliminated the current hospital facility fee for outpatient clinics and used those funds to support a primary care provider rate increase with the overall goal of increasing access and, ultimately, achieving cost savings.

This work group included broad stakeholder participation, with representatives from the managed care organizations (MCOs), Washington State Medical Association (WSMA) and the Washington State Hospital Association (WSHA), along with HCA's executive leadership.

The work group discussed the potentially positive impacts and concerns associated with the reduction or elimination of the hospital facility fee for outpatient clinics, as well as the impact on primary care rates. The group agreed that elimination of the facility fee would be insufficient to fully restore the primary care provider rate reduction. With the implementation of the Affordable Care Act (ACA), the federal government addressed the documented disparity in Medicaid reimbursement by increasing primary care rates to encourage providers to care for Medicaid patients. The rates were increased to equal the Medicare rate for specified procedure codes. The federal government funded 100% of the increase in reimbursement in calendar year 2013 and 2014. Effective January 1, 2015, this rate increase was no longer funded by the federal government and the requirement expired.

In a 2016 Supplemental Budget request, HCA requested $132 million in total funds: $39 million in GF-S and $93 million in General Fund–Federal Medicaid Title XIX to continue the increased primary care reimbursement rates. HCA's Hospital-Based Clinic Services Report to the Legislature, dated December 1, 2014, identified approximately $16 million in total projected savings (GF-S and GF-F). This is only an estimate, since HCA did not have a reliable way to identify and differentiate hospital-based and off-campus clinics. Since this analysis, the Enhanced Ambulatory Patient Groups (EAPG), an outpatient prospective payment system (OPPS), has changed; these changes make it even more difficult to develop accurate estimates for projected savings. Effective January 1, 2015, CMS provided a billing modifier to identify off-site hospital-based clinics to utilize when submitting outpatient claims. In analysis of this data, the volume of hospital-based clinics was significantly less than expected. HCA is in the process of developing a methodology to effectively identify the fiscal impact of the facility fee for off-campus clinics, to include identifying an alternative source of data to accurately identify hospital-based clinics.

The primary concern raised by the work group was the potential reduction in clients' access to clinic- based providers including specialists, if facilities decide to take less Medicaid clients into their practices. The group agreed that additional data relating to the current use of the facility fee by hospitals was needed to understand the full impact and implications to any facility fee elimination, especially as it relates to patient access.

Recommendations

The work group did not make a recommendation as to whether or not the facility fee should be reduced or eliminated, however action items were identified. Action items were largely data-related and included clarifying specifics around the current use of the facility fee by the hospitals and identifying the number of hospital primary care physicians (PCPs) in hospital based clinics (and the percentage of these practitioners that accept Medicaid). This information is necessary to analyze the full impact to clients' access to care and the financial impact on outpatient clinics of the reduction or elimination of the hospital facility fee. The work group recommends further exploration and stakeholder engagement on this strategy.

While not a recommendation of the work group, the reduction or elimination of the facility fee without a corresponding provider rate increase would generate savings impacting the calendar year 2017 managed care rates.

Reducing Mental Health Drug Costs

Spending on Mental Health Dugs

Managed Care Top Ten Drugs

Figure 3 shows the top ten mental health drugs for Medicaid managed care, in terms of spending, ranked by total amount paid from January 2016 to June 2016. The list is mainly comprised of antipsychotics, ADHD, and anticonvulsant medications. It should be noted that the anticonvulsants can be used for other conditions besides mental health and the numbers presented reflect total claims, not only those attributable to mental health diagnoses.

Managed care plans' contracts limit some potential changes in drugs used for mental health treatment. For example, changes cannot be made to antipsychotic or antidepressant medications that an enrollee has been previously prescribed, regardless of the drug's status on the Contractor's formulary. In addition, plans are required to utilize the state's Preferred Drug List (PDL) for antipsychotic drugs and are limited on what prior authorization criteria can be applied. The plans are also required to follow the age & dose limits for certain mental health drugs when prescribed to members less than 18 years of age. This requirement is unique to mental health drugs in Medicaid and reflects a clinical judgment made at the time these drugs were moved from FFS administration to the managed care plan's responsibility in 2012 to assure continuity of care and standard access to these drugs.

Figure 3: Top 10 Mental Health Drugs

LABEL NAME	CLASS	Paid	Claims	Cost Per Claim
ARIPIPRAZOLE[6]	ANTIPSYCHOTICS/ANTIMANIC AGENTS	$16,598,148	28,191	$588.77
METHYLPHENIDATE HCL ER	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$8,146,541	41,415	$196.71
INVEGA SUSTENNA	ANTIPSYCHOTICS/ANTIMANIC AGENTS	$7,143,593	3,946	$1,810.34
AMPHETAMINE/DEXTROAMPHETAMINE	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$6,775,035	82,245	$82.38
LATUDA	ANTIPSYCHOTICS/ANTIMANIC AGENTS	$5,890,878	6,029	$977.09
LYRICA	ANTICONVULSANTS	$5,601,320	14,045	$398.81
STRATTERA	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$4,279,743	11,090	$385.91
VYVANSE	ADHD/ANTI-NARCOLEPSY/ANTI-OBESITY/ANOREXIANTS	$3,167,063	12,814	$247.16
NEURONTIN	ANTICONVULSANTS	$2,983,610	139,562	$21.38
DULOXETINE HCL	ANTIDEPRESSANTS	$2,358,538	36,586	$64.47

[6] Figure 3 lists the total amount paid for aripiprazole tablets only, and does not include alternative dosage forms, such as injectable solution, injectable suspension, and oral dispersible tablets. If this table included the costs of all forms of aripiprazole, the total amount paid would be much higher.

Mental Health Drug Costs Work Group

HCA convened a work group comprised of medical and pharmacy directors from the State's five Medicaid MCO plans on August 12, 2016 to identify and discuss opportunities to reduce mental health drug costs by assuring more clinically appropriate utilization of this class of medications. The group reviewed the last two years of HCA's mental health drug expenditures and utilization for Point of Sale (POS) drugs and physician administered (PA) drugs, and HCA's current PA criteria.

The group agreed that modest savings in mental health drug costs may be achievable by revising HCA's current PA criteria which plans are required to follow. In addition, the group agreed that any changes to formulary and PA criteria would be standardized across FFS and the MCOs in order to assure seamless access to appropriate mental health drugs for this vulnerable population.

In the short term, it may be possible to implement expedited authorization (EA) for certain medications (e.g. aripiprazole, which is the single most costly medication) prior to the end of CY 2016. More substantive modifications to formularies and PA criteria will require additional research into prescribing patterns (e.g. primary care versus specialty care prescribing patterns); identification of best practices across the plans; and engaging with the mental health provider and consumer community. The group anticipated that changes resulting from this more comprehensive effort would not be ready for implementation before July of 2017. At this time, there is no data or experience to use as a basis for estimating potential savings. The work group discussed piloting changes to the PA criteria on a select group of highly utilized high cost drugs to produce data and experience to better understand the fiscal and clinical impacts. With established data and experience, analysis can be performed to estimate potential savings if the PA criteria were to expand and apply to a broader array of mental health drugs.

Recommendations

The work group identified the opportunity to implement, prior to the end of 2016, expedited authorization for certain costly medications, such as aripiprazole. As a next step, HCA's Chief Pharmacy Officer will convene the MCO pharmacy directors to identify such expedited authorization opportunities, and where appropriate design and implement them effective January 1, 2017.

HCA will further explore and research prescribing patterns among different types of providers and identify best practices across the managed care plans. Additionally, the HCA will engage and stakeholder this work with the mental health provider and advocacy community. These more substantive modifications identified by the work group are not likely to be ready for implementation before July of 2017.

Conclusion

The three strategies discussed with broad stakeholder engagement around holding managed care rates at calendar year 2016 level included: 1) potentially preventable readmissions, 2) facility fee

reduction/elimination paired with a primary care rate increase, and 3) changes to how mental health drugs are managed. As an outcome to the Potentially Preventable Readmissions (PPR) work group, HCA and MCOs will continue to utilize contracts to assure the best use of concurrent review and create incentives for system improvements. The work group examining the facility fee reduction and primary care rate increase is pursuing strategies for collecting the necessary data to estimate the full fiscal impact of any change as well as implications for providers and clients. The mental health drugs work group is identifying opportunities and best practices for prescribing and authorizing mental health drugs with early changes proposed for late 2016. These work groups provided valuable insight into plan, agency and provider perspectives on how to successfully manage cost trends in Medicaid. Work will continue on all three fronts to more fully evaluate any opportunities for changes that would support the shared goals of quality care for Medicaid enrollees and successfully controlling cost trends across the managed care program.

Actuarial Analysis

The Office of the State Actuary (OSA) obtained an independent actuarial review from Willis Towers Watson and HCA obtained its analysis from Milliman. Consultants at both actuarial firms reviewed the draft report and considered the ideas and recommendations of the trend mitigation work groups, provided feedback as to the feasibility and potential impact on trend of the recommendations and whether additional ideas might merit consideration.

Milliman stated, "The purpose of our review was to consider the strategies and recommendations of the trend mitigation work groups and provide feedback as to the appropriateness of the recommendations and their impact to the 2017 calendar year rates. We participated in the work group discussions and agree with the assessment of the work groups that these initiatives are unlikely to have a substantial impact on the trend in program premium rates in calendar year 2017 due to implementation timeliness, stakeholder acceptance, or lag in savings realized. Further actuarial analysis is needed to calculate the impact of each strategy or future strategies to prospective rates."

Willis Towers Watson (WTW) reviewed the work group ideas and recommendations and provided feedback. WTW agreed the Potentially Preventable Readmissions policy is unlikely to have a substantial impact on the trend in the short term, but is an important process improvement with a primary value to ensure quality care for clients. Additionally, the reduction/elimination of the facility fee is an appropriate area of focus on payment reform given the evolution of the market place. They suggest that analysis be performed to identify the potential rate/trend impact. Lastly, for the reducing mental health drug costs strategy, while this is an important and significant area of cost, WTW agrees with the workgroup that additional research and analysis would be beneficial in the area of pharmaceuticals, beyond the treatment for mental health conditions.

To that end, WTW recommends that MCO pharmacy contracts be reviewed to ensure pricing in the contracts is market-competitive and ensure that purchasing economies of scale are being realized by the Medicaid program overall.

WTW suggests further work be done to identify initiatives which may have a more significant and longer-term cost mitigation impact on the program. At a high level, WTW believes such initiatives

may emerge from the areas of further MCO/provider risk-sharing and enhanced pharmacy contracting.

Calendar Year 2017 Rates

HCA retained Milliman with oversight from OFM to develop the MCO capitation rates. Milliman's role is to certify that the calendar year 2017 capitation rates produced are actuarially sound as defined by CMS regulations and current actuarial standards of practice.

Apple Health rates are built by program and include the following:

- Apple Health Family (Family)
- State Children's Health Insurance Program (SCHIP)
- Apple Health Newly Eligible (AHAC)
- Apple Health blind and disabled (AHBD) including:
    - AHBD
    - Community Options Program Entry System (COPES)
    - Developmental Disabilities Administration (DDA)

Specifics regarding the rate setting methodology and adjustments are described in the complete Draft Calendar Year 2017 Capitation Rate Development for Apple Health Programs report prepared by Milliman (See Appendix A).

The preliminary calendar year 2017 Apple Health base rates compared to last year's base rates result in a -1.0%[7] composite percentage change, based on a weighted average PMPM, with a total HCA fiscal impact of $2.9 million[8]. Table 1 shows the percentage change by rate cohort, when comparing the draft 2017 base rates to the 2016 base rates: AH-FAM, .05%; SCHIP, 2.9%; AHBD, 0.5%; COPES, 17.2%; DDA -34.3%; and AHAC, -2.6%. It is important to note that the federal match is 88% for SCHIP, 50% for AH-FAM, AHBD, COPES and DDA, and 97.5% for AHAC.

The rate increase for the AHBD and COPES rate group and decrease to the DDA cohort is a result of establishing a rate cohort for DDA clients, which includes COPES and New Freedom (NF) waivers as well as other DDA clients. As a result, healthier members moved to the DDA rate cohort, which drove the corresponding DDA rate down, leaving the COPES cohort with a sicker population. The composite blind/disabled impact, which calculates a weighted average of the PMPM for the three blind/disabled cohorts, results in a 0.1% change to the 2016 rates.

[7] Base rates include projected pass-through payments including the Safety Net Assessment Fund (SNAF) and Provider Access Payment (PAP). Base rates do not include Federally Qualified Health Centers (FQHC) and Rural Health Clinic (RHC) enhancement payments.

[8] Base rates include projected pass-through payments including the Safety Net Assessment Fund (SNAF) and Provider Access Payment (PAP). Base rates do not include Federally Qualified Health Centers (FQHC) and Rural Health Clinic (RHC) enhancement payments.

Table 1: Impact of CY 2017 Proposed Base Rates

Washington Health Care Authority Impact of CY 2017 Proposed Rates								
Description	**Family**	**SCHIP**	**AHBD**	**COPES**	**DDA**	**Composite BD**	**AHAC**	**Apple Health Composite**
Base Year Existing Managed Care Membership								
Base Member Months (1)	8,842,442	354,981	888,531	38,645	37,734	964,910	5,750,924	15,913,257
Proposed Capitation Rates (2)	$183.15	$130.23	$1,000.34	$2,473.81	$920.54	$1,056.23	$363.47	$300.07
CY 2016 Comparable Rate (3)	$182.27	$126.57	$995.15	$2,110.74	$1,400.42	$1,055.68	$373.23	$303.00
Impact of Rate Adjustment - Including Only Base Year Enrollment								
PMPM Rate Impact	$0.88	$3.66	$5.19	$363.07	($479.88)	$0.55	($9.76)	($2.92)
Percentage Impact	0.5%	2.9%	0.5%	17.2%	-34.3%	0.1%	-2.6%	-1.0%
Total State/Federal Impact	$7,794,865	$1,300,707	$4,611,344	$14,030,846	($18,107,772)	$534,417	($56,151,941)	($46,521,952)
Assumed FMAP	50.0%	88.0%	50.0%	50.0%	50.0%	50.0%	97.5%	
Total HCA Impact	$3,897,432	$156,085	$2,305,672	$7,015,423	($9,053,886)	$267,209	($1,403,799)	$2,916,927

(1) Base member months are from April 2015 - March 2016.

(2) Proposed rates include DCR and LBW costs and are weighted based on demographics in (1).

(3) January 2016 rates applied based on demographics in (1). FFS projected costs include trend and SNAF/PAP (Also included for all managed rates)

(4) Does not account for FIMC experience or projected rates.

There are several contributing factors relating to the rate changes; a major driver is overall lower utilization. Experience showed an upward trend for professional services, which is assumed to contribute to the downward trend in hospital costs and utilization. The decrease in hospital costs and utilization was observed particularly for the blind/disabled population. Further, while the pharmacy unit costs are still increasing, they are not increasing at calendar year 2016 levels. Overall, pharmacy utilization is flat.

One possible contributor to lower costs is the Health Home program, which started on July 1, 2013 in all counties except King and Snohomish counties. This program integrates care within existing care systems for certain high-risk, high-cost adults and children, including dual eligibles. While a full analysis of the impact of this program on managed care rates has not been completed by HCA, some MCOs have seen a reduction in inpatient utilization and ER use in their high risk populations. The agency is expanding the program to King and Snohomish in January, 2017. Additionally, other care management investments and strategies implemented by the MCOs in 2014 appear to be impacting utilization and costs, and this is especially true for the blind/disabled and COPES/DDA cohorts. Additional analysis of the contributing factors is being performed as the rates are being finalized.

HCA has implemented a continuous monitoring approach for managed care costs and performance. The intent of these monitoring activities and reports is to inform the annual rate setting process and provide an early indication of prospective rate changes. Monthly reports produced by HCA are shared with the Governor's Office, OFM and legislative staff. The reports are structured to monitor enrollment, expenditures and utilization metrics by both plan and population for the following categories of service:

- Pharmacy
- Hospital Inpatient

- Hospital Outpatient
- Urgent Care
- Emergency Room
- Primary Care Providers

In the near future, HCA plans to communicate and provide blinded reports to the MCOs to facilitate conversations around enrollment, cost and utilization. Targeted conversations informed by these monitoring reports will enable HCA and MCOs to develop actionable strategies to mitigate the financial impacts of identified early warnings.

Furthermore, as the state moves towards integrated regional purchasing the monitoring reports will drill down to regional utilization and cost metrics. The intent is to keep the monitoring aligned with the actuarial rate-setting process to ensure accurate early detection and communication of managed care rate drivers.

Next Steps

The preliminary rates produced by Milliman are subject to plan feedback and review by HCA, OFM, OSA, legislative fiscal staff, CMS, and external review by Milliman prior to being final. The preliminary rates have been reviewed and discussed with the Forecast Work Group[9] and reviewed with the managed care plans. HCA plans to submit the rates to CMS for final approval in early November 2016.

Given the due date of this report and the timing of the calendar year 2017 rate setting process, final rates and analysis cannot be provided. HCA will continue to communicate and keep the Legislature and stakeholders involved as rates are finalized. With 1.5 million Washingtonians in Apple Health managed care, even the smallest variation in utilization or costs can result in a fiscal impact. As a result, HCA will continue to actively monitor enrollment, expenditures and utilization metrics by plan, population and category of service to provide early warnings of prospective rate changes and their impact. HCA will communicate these findings monthly to the Forecast Work Group, the Governor's office, OFM, and legislative fiscal staff.

[9] The Forecast Work Group consists of representation from OFM, HCA, Legislative fiscal staff and Milliman.

Appendix A: Draft Calendar Year 2017 Apple Health Rates

State of Washington
Health Care Authority
Calendar Year 2017
Capitation Rate Development for
Apple Health Programs
DRAFT

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Appendices (included as attached Excel documents)

A: Apple Health - Rate Tables and Region-County Crosswalk
Includes Base Rates, Age/Gender Factors, Regional Factors and Kick Payment amounts.

Impact of proposed rates.

B: Apple Health Family and SCHIP Base Year Cost Models by Age/Gender Band.

C: Apple Health Blind and Disabled Base Year Cost Models by Age/Gender Band.
Includes AHBD, COPES and DDA cost models

D: Apple Health Adult Coverage Base Year Cost Models by Age/Gender Band.

E: Hemophilia NDC Exclusion List

F: DCR Rate Development

G: Regional and Age Gender Factor Development

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I. EXECUTIVE SUMMARY

This report documents the development of Managed Care Organization (MCO) capitation rates for the Washington Apple Health programs for calendar year 2017.

The Washington Health Care Authority (HCA) retained Milliman to develop the MCO capitation rates. We developed the capitation rates using the methodology described in this report. Our role is to certify that the calendar year 2017 capitation rates produced by the rating methodology are actuarially sound as defined by CMS regulations and current actuarial standards of practice.

Note that this report does not present rates for Clark or Skamania counties. Those counties receive Fully Integrated Managed Care (FIMC) rates effective April 1, 2016. FIMC rates will be presented separately.

Segment II of this report details the rate development for the Apple Health Family, SCHIP, Developmental Disabilities Administration (DDA) members, which include Community Options Program Entry System and New Freedom (COPES/NF) waivers as well as other DDA clients, other Apple Health Blind and Disabled (AHBD), and Apple Health Adult Coverage (AHAC) populations.

SUMMARY OF RESULTS

The impact of proposed rates is presented in Table I-1 shown below. A more detailed development of the impact is included in Appendix A-2

Table I-1
Washington Health Care Authority
Impact of CY 2017 Proposed Rates

Description	Family	SCHIP	AHBD	COPES	DDA	Composite BD	AHAC	Apple Health Composite
Composite Proposed	$184.15	$131.18	$990.07	$2,384.24	$894.84	$1,042.99	$375.42	$303.13
Composite Prior	$183.12	$127.53	$985.23	$2,047.45	$1,350.23	$1,043.41	$383.88	$306.03
PMPM Rate Impact	$1.03	$3.64	$4.84	$336.79	($455.40)	($0.42)	($8.46)	($2.90)
Percentage Impact	0.6%	2.9%	0.5%	16.4%	-33.7%	0.0%	-2.2%	-0.9%
Total State/Federal Impact	$9,626,694	$1,347,766	$4,493,280	$14,013,089	($18,134,333)	($422,912)	($51,101,991)	($48,615,121)
Assumed FMAP	50.0%	88.0%	50.0%	50.0%	50.0%	50.0%	97.5%	
Total HCA Impact	$4,813,347	$161,732	$2,246,640	$7,006,545	($9,067,167)	($211,456)	($1,277,550)	$3,883,547

. The proposed rates do not include FQHC/RHC payment enhancements.

The following are noted changes for the year:

- Rates for all programs are based on the base year experience for the incurred period April 1, 2015 – March 31, 2016.
- The risk mitigation program for the AHAC population is no longer in place for CY 2017. The plan experience will be subject to the gain-share provision, but there will not be a separate retroactive AHAC adjustment.
- Several new populations have been added to the managed care rates including:
    - Members in blind/disabled populations not previously covered by managed care (these include various DDA waivers). Additional transition to managed care was the result of

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recipient aid category (RAC) code updates. Note that most have been previously enrolled in managed care, but have not been separated as a unique rate cohort.
- Members enrolled in Medicaid during their initial one to two month period, which was previously covered under fee-for-service (FFS).
- Members for which HCA is a secondary insurer (referred to as "TPL" members).
- Members 65 years old and older with appropriate RAC codes who are not Medicare eligible.

Detailed cost models by program and age/gender band are included as appendices (B-D). Refer to Table of Contents for description of each appendix.

DATA RELIANCE AND IMPORTANT CAVEATS

This analysis is intended for the use of the Washington Health Care Authority in support of Apple Health programs. We understand that this information will be shared with other parties. To the extent that the information contained in this report is provided to third parties, the document should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Similarly, third parties are instructed that they are to place no reliance upon this report prepared for HCA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. It is the responsibility of any MCO to make an independent determination as to the adequacy of the proposed capitation rates for their organization.

Actual costs for the program will vary from our projections for many reasons. Differences between the capitation rates and actual MCO experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate development calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is higher or lower than expected. Experience should continue to be monitored on a regular basis, with modifications to rates or to the program as necessary.

This analysis has relied extensively on data provided by the participating health plans and HCA. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our 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 our assignment.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis in this letter.

The terms of Milliman's contract with the Washington Health Care Authority signed on April 1, 2013 apply to this report and its use.

II. METHODOLOGY AND ASSUMPTIONS

This section includes descriptions of key data sets, methods and assumptions used in the development of 2017 rates for the Apple Health programs.

RATE CELL CHANGES

Effective with the July 2017 rates, the Apple Health Blind and Disabled populations is now divided into three rate cells as defined below.

The following populations are included in the COPES rate population:

COPES

- The Community Options Program Entry System, or COPES for short, is a Washington State Medicaid (Apple Health) program designed to enable individuals who require nursing home level care, to receive that care in their home or community living environment, such as an assisted living residence.

New Freedom

- Area - Currently limited to eligible individuals who reside in ***King and Pierce Counties.***
- Eligibility - Any person who meets functional and financial eligibility criteria to receive in-home services under Washington's Medicaid long-term care waiver programs is eligible to be enrolled in New Freedom (NF).

The following populations are included in the DDA (other Developmental Disability Administration (DDA) waiver members not part of the COPES rate cohort) rate population:

CIIBS

- Children's Intensive In-home Behavioral Support
- Ages 8 through 20 who are assessed at high or severe risk of out-of-home placement due to challenging behaviors

Basic Plus

- For children and adults living in the family home or other community-based settings (such as Adult Family Homes) and whose ability to continue being supported in that setting is at risk without additional services.

Core

- For children and adults at immediate risk of out-of-home placement who have a need that cannot be met by the Basic Plus waiver and who: May need up to 24-hour residential services that include training and education; or May require daily to weekly one-on-one support for physical or health needs.
- All services available under Basic Plus and Supported Living (Residential) Services. CORE waiver services provide more funding for services than Basic Plus, based on assessed need.

All other disabled blind and disabled members are included in the AHBD (Apple Health Blind Disabled) rate population.

The RAC codes that define eligibility for each population are shown below in Table II-1. Table II-2 presents RAC codes for eligible members over 65 years old.

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MEMBERSHIP

Below are descriptions of assumptions related to the underlying membership used in the development of capitation rates.

The membership and corresponding claim experience data used in the development of rates for the Apple Health programs were based on the incurred period between April1, 2015 and March 31, 2016.

These programs include the following subpopulations:

- Apple Health Family (traditional Medicaid). We have excluded Foster Care members, assuming these members have transitioned to the Foster Care program.
- State Children's Health Insurance Program (SCHIP)
- Medicaid expansion referred to as the Apple Health Adult Coverage (AHAC) population.
- Apple Health blind and disabled (BD) including:
    - AHBD
    - COPES
    - DDA

Table II-1 shows the RAC codes associated with the COPES and DDA rate cells. Table II-2 shows over 65 RAC codes.

Table II-1
Washington Health Care Authority
BD Population RAC Codes

RAC Code	BD Population
1146	Copes-New Freedom
1147	Copes-New Freedom
1152	Copes-New Freedom
1153	Copes-New Freedom
1148	Copes-New Freedom
1149	Copes-New Freedom
1174	Copes-New Freedom
1150	Copes-New Freedom
1151	Copes-New Freedom
1175	Copes-New Freedom
1218	DDA
1219	DDA
1220	DDA
1221	DDA
1222	DDA
1223	DDA
1224	DDA
1225	DDA

Table II-2
Washington Health Care Authority
O65 RAC Codes Moving to AHBD

1046	1109	1250
1065	1162	1251
1067	1163	1256
1068	1174	1257
1070	1236	1260
1071	1238	1262
1073	1244	1264
1104	1246	1265
1106	1248	1266
1108	1249	

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CLAIMS COST AND BENEFIT ADJUSTMENTS

General steps in the rate development process are described below. Beyond general steps taken, specific additional adjustments are subsequently identified.

Final capitation payments are based on the following formula:

Capitation Rate = Base Rate x Regional Factor x Age/Gender Factor x Risk Score x (1-Withhold Factor*)
***Withhold Factor is 1%. Rates presented in this report are prior to the application of the withhold adjustment.**

General Rate Development Process

Step 1: Collect Experience Data

Milliman requested, received, and used both financial and encounter data provided directly from participating health plans in the development of rates. Once received, the experience data was tested to determine if there were major problems in the collection or reporting of experience. The data sources were compared to each other as well as to other benchmarks. Significant differences and the potential need for adjustment to account for missing, underreported, duplicated, or other data issues were discussed with the plan as necessary. Any issues with our reconciliation were resolved with each MCO.

Data was provided directly to Milliman by the participating MCOs. In addition, HCA provided eligibility, managed care encounters and FFS claims from their ProviderOne system. We excluded ProviderOne claims not part of the extract provided by MCOs, assuming that additional claims were since voided or reversed.

Data was provided for this rating exercise included incurred claims January 2015 – March 2016, paid through April 2016. In addition, Milliman has claim incurred from July 2012 – December 2014 for Family/SCHIP and disabled populations and incurred claims from January 2014 – December 2014 for AHAC members.

In addition to this data, Milliman also utilized FFS data for several aspects of rate setting.

Step 2: Build Actuarial Cost Models from Experience Data

Milliman used the experience data to develop actuarial cost models for the FFS and encounter claims experience by rating cohort. The actuarial model illustrates the following information: underlying member months, utilization rates per 1,000, cost per unit of service, and PMPM claim costs. The actuarial models were created on a service line level of detail for each of the rate cells. We also made adjustments and performed analyses at the claim detail level as well. This allowed a direct comparison between the mix of services as well as to compare the experience to other benchmark data sources.

Only services covered under the managed care contracts for covered individuals were included in the analysis. For new services or policy changes, we use available state information as well as our proprietary databases, professional experience, and actuarial judgment to develop adjustments to the base data in developing the rates.

Once the base data was established, we adjusted the data to ensure that the rates were fair and appropriate, sufficient but not excessive, and in compliance with all federal regulations. Typical

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adjustments included claims completion, medical trend, program/population adjustments, risk adjustment, and MCO pharmacy rebates. Specifics of these adjustments are described later in this report.

Note that these rates do not include data for Clark or Skamania counties. Effective April 1, 2016, these counties receive Fully Integrated Managed Care (FIMC) rates for members in a medical/behavioral health integrated program. Similarly, we have also excluded foster care experience and enrollment as those members are not part of a separate program also effective April 1, 2016.

Step 3: Compare Encounter Data with Financial Cost Data

Milliman reviewed the financial cost data and experience documentation in relation to the encounter data provided by MCOs. Upon receipt, we reconciled the submitted data to lag triangles by major category of service provided by the MCOs. Once we were comfortable with the high-level reconciliation, we reviewed the financial data provided by plans to crosswalk the encounter data to the submitted financials. This process involved frequent dialogue with some plans to get complete data reconciled to control totals provided.

Step 4: Rate Cell Actuarial Cost Models

After accounting for recognized data anomalies, we built actuarial cost models by rate cell for the experience data. These models, including additional adjustments as described below, were the basis of final rates.

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Specific Adjustments

Standard Rate Adjustments

Completion Factors

Rates for all programs were computed based on data incurred in between April 1, 2015 and March 31, 2016 with claim run-out through April 2016. Completion factors were calculated and applied separately by program, MCO/FFS, major service category and quarter. Claims were summarized in to claim lag triangles based on the incurred and paid months. We used this data to compute outstanding liabilities by month. These estimates were compared with those provided by MCOs for reasonableness. Aggregate completion factors by program and service category are provided below in Table II-3.

Table II-3
Washington Health Care Authority
Completion Factors

Service Line	Family/SCHIP	AHBD/COPES	AHAC
Hospital Facility	1.084	1.087	1.081
Professional/Other	1.027	1.060	1.038
Pharmacy	1.000	1.000	1.000

Trend

The annual trend rates shown in Table II-4 below were applied for 21 months, from the midpoint of the base data period (October 1, 2015) to the midpoint of the rating period (July 1, 2017). Trend rates were developed using multiple years of experience with the Family/SCHIP, BD and AHAC populations, comparisons to other state Medicaid programs, and actuarial judgment.

Trends were selected based on data analysis and actuarial. Our analysis included reviewing linear regressions applied separately for unit cost and utilization trend. We normalized the data to a common age/gender curve across all months to reflect medical experience that are not influenced by demographic changes. Similarly we normalized for fee schedule disruptions. The pharmacy trend development is described below.

We utilized the proprietary Milliman tool GlobalRVUs in our trend analysis. GlobalRVUs are a relative value system that covers the entire range of healthcare services. Relative value units (RVUs) are commonly used with payment schedules to define relative cost between services and enable comparison of cost schedules. Other RVU systems are limited, because they only focus on one type of provider and do not relate services for different types of providers. GlobalRVUs correct this disconnect by providing an RVU system that covers all healthcare services. We converted all hospital and professional services to GlobalRVUs and reviewed the trend in RVUs and unit costs over time. In this way we account for the mix of services properly. We combined inpatient and outpatient experience for our facility trend analysis, which is appropriate following the utilization normalization processed with the GlobalRVUs.

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Table II-4 Washington Health Care Authority Annual Medical Trend Factors			
AHBD/COPES/DDA			
	Util. per 1,000	**Unit Cost**	**PMPM**
Hospital	(1.50%)	2.00%	0.47%
Professional/Other	3.00%	0.75%	3.77%

Family-Adult			
	Util. per 1,000	**Unit Cost**	**PMPM**
Hospital (Non-Maternity)	(1.00%)	(0.50%)	1.50%
Hospital Maternity	0.00%	0.00%	0.00%
Professional/Other	1.00%	0.00%	1.00%

Family/SCHIP Child			
	Util. per 1,000	**Unit Cost**	**PMPM**
Hospital	(0.50%)	3.50%	2.98%
Professional/Other	1.25%	0.25%	1.50%

AHAC			
	Util. per 1,000	**Unit Cost**	**PMPM**
Hospital (Non-Maternity)	(1.25%)	1.00%	0.26%
Hospital Maternity	0.00%	0.00%	0.00%
Professional/Other	2.25%	0.25%	2.51%

Additional comments regarding trend noted below:

- We reviewed experience from July 2012 to March 2016 for non-expansion populations and experience from January 2014 to March 2016 for expansion members.
- Some periods were excluded from the regression analysis because of enrollment or program changes over time that could not be adjusted to avoid significant disruption.
- The time period available for the Expansion population is not yet stable enough to serve as a basis for trend development. We therefore used an average of blind/disabled and Family-Adult trends for this population.
- We have normalized for demographic and known fee schedule changes prior to reviewing trend analysis results.
- Hospital-Maternity trends have been held flat. We did not observe unit cost changes, and changes in the number of deliveries are addressed though the kick payment.
- Trends have been rounded to the nearest quarter percent.

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Pharmacy Trend

Our determination of pharmacy trend shown in Table II-5 relied upon a detailed model that considered several factors driving pharmacy trend. Each of these drivers is described below.

Table II-5
Washington Health Care Authority
Annual Pharmacy Utilization Factors

Service Line	Family	SCHIP	AHBD	COPES	DDA	AHAC
Pharmacy Scripts/1,000	0.00%	0.00%	1.62%	1.62%	1.62%	0.00%
Pharmacy Unit Cost	8.10%	8.48%	9.38%	9.38%	7.14%	7.41%

Unit cost trends presented above incorporate all factors presented below.

Pharmacy Utilization Trends

Utilization trends were based on historical experience by program from January 2014 – March 2016.

Given the volatility and short history in the AHAC population experience, we used the Family Adult trend rates for this population. Similarly, all three AHBD populations received the same trend utilization trend which was based on composite utilization trends for BD members.

Brand Patent Loss

When a brand drug loses patent, the vast majority of utilization shifts from the brand drug to the new generic alternatives. Generic equivalents are in most cases significantly less costly than the corresponding brand.

The following table shows the final adjustments for generic conversions:

Table II-6
Washington Health Care Authority
Brand - Generic Conversion Adjustment

Service Line	Family	SCHIP	AHBD	COPES	DDA	AHAC
Brand/Generic Conversion	(3.18%)	(3.18%)	(2.06%)	(2.06%)	(2.06%)	(3.18%)

The projected generic conversion rate by drug and the estimated generic costs are based on Milliman research used for Medicare Advantage pricing work.

Table II-6 presents those brand drugs conversions which have the greatest impact in calendar year 2017.

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Table II-7 Washington Health Care Authority Share of Impact to Generic Conversion Factor					
Brand Name	**Generic Name**	**Launch Date**	**AHBD**	**Family/ SCHIP**	**Expansion**
EPIPEN 2-PAK	epinephrine (epipen 2-pak)	10/1/2016*	6.31%	26.38%	12.23%
VENTOLIN HFA	albuterol sulfate (ventolin hfa)	12/19/2016*	12.07%	22.52%	16.61%
TAMIFLU	oseltamivir phosphate	8/2/2016	0.67%	11.09%	1.73%
ADVAIR DISKUS	fluticasone propionate/ salmeterol xinafoate	8/1/2016	1.24%	0.58%	1.51%
SUBOXONE	buprenorphine hcl/naloxone hcl (suboxone)	9/25/2016*	2.10%	6.35%	15.15%
BANZEL	rufinamide	5/14/2016	17.22%	3.87%	0.63%
GLEEVEC	imatinib mesylate	2/1/2016	6.35%	3.37%	7.86%
SEROQUEL XR	quetiapine fumarate (seroquel xr)	11/1/2016*	5.45%	1.19%	3.88%
ABILIFY	aripiprazole	4/28/2015	2.01%	0.38%	0.77%
Other			46.59%	24.26%	39.63%
Total			**100.00%**	**100.00%**	**100.00%**

*Estimated launch dates.

Pharmacy Unit Cost Trends

Pharmacy unit cost trend assumptions are based on a combination of historical Washington Medicaid data analysis, Milliman research on pharmacy utilization and cost trends, and internal Milliman research. The final trends are calculated as the ratio of the average drug costs in the projection period (CY 2017) compared to the average drug costs in the base period and then average annual trend rates are computed.

The cost per script trends are based on a study of historical average wholesale price (AWP) data. We mapped AWPs from Medispan by NDC and analyzed the annual trends over the past several quarters, using a fixed market basket of drugs claims experience for all populations combined. We also used public industry trend reports to validate these unit cost trends. Below is additional discussion of our analysis for brand, generic, and specialty trends.

Table II-8 shows pharmacy unit cost trends without adjustments for the brand/generic conversion or new high cost specialty.

Table II-8 Washington Health Care Authority Pharmacy Unit Cost Trends						
Service Line	**Family**	**SCHIP**	**AHBD**	**COPES**	**DDA**	**AHAC**
Unit Cost Trends	9.09%	9.33%	9.19%	9.38%	8.05%	9.09%

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Additional discussion of our analysis for brand, generic, and specialty trends can be found below.

Brand Cost Trends

We analyzed AWP trends for the brand drugs used by Medicaid populations. Based on a combination of Milliman research, industry trend reports, and the historical AWP trends using Medicaid program data, we assumed a default brand cost trend of 13.5%. We varied trends from this default for several classes though, based on variations in the Medicaid data for classes with typically higher or lower than average trends. Table II-9 shows the classes for which we used a unique trend value:

Table II-9
Washington Health Care Authority
Brand Cost Trends for Specific Therapeutic Classes

Therapeutic Class	Brand Trend
Insulin - Long Acting	10.0%
Phosphate Binder Agents	20.0%
Valproic Acid	8.0%
Enzymes - Topical	5.0%
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	4.0%
Nonsteroidal Anti-inflammatory Agents (NSAIDs)	18.0%
Anaphylaxis Therapy Agents	25.0%
Nasal Steroids	20.0%

Generic Cost Trends

Generic drugs, which historically have had only modest price increases, have experienced more significant price increases in recent quarters due to ingredient shortages, changes to legislation, and consolidation of generic manufacturers resulting in a reduction to competition. However, this pattern has begun to slow, and generic trends are expected by the industry to return to more typical levels over the next few years.

Based on a combination of Milliman research, industry trend reports, and the historical AWP trends using Medicaid program data, we assumed a default generic cost trend of 5%. Similar to brand trends, we varied trends from this default for several classes, based on variations in Medicaid data for classes with typically higher or lower than average trends. Table II-10 shows the classes for which we used a unique trend value:

Table II-10
Washington Health Care Authority
Generic Cost Trends for Specific Therapeutic Classes

Therapeutic Class	Generic Trend
Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)	10.0%
Antifungals - Topical	10.0%
Attention-Deficit/Hyperactivity Disorder (ADHD) Agents	0.0%
Corticosteroids - Topical	7.0%
Acne Products	7.0%
Amphetamines	0.0%

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Specialty Cost Trends

There has been a focus on the high cost of specialty medications and their role as a driver of high pharmacy trends in recent years. The primary driver of increasing pharmacy costs is a change in mix—as utilization of specialty products increases, the average price of all drugs increases, because specialty products cost significantly more than non-specialty products. Although utilization trend is high for specialty drugs, AWP trends for these drugs tend to be lower than for traditional brand drugs.

Based on a combination of Milliman research, industry trend reports, and the historical AWP trends using Medicaid program data, we assumed a default specialty cost trend of 8%. We varied trends from this default for several classes though, based on variations in Medicaid data for classes with typically higher or lower than average trends. Table II-11 shows the classes for which we used a unique trend value:

Table II-11
Washington Health Care Authority
Specialty Cost Trends for Specific Therapeutic Classes

Therapeutic Class	Specialty Trend
Bradykinin B2 Receptor Antagonists	8.0%
Immune Serums	2.0%
Antineoplastic Enzyme Inhibitors	18.0%
Antiretrovirals	8.0%
Soluble Tumor Necrosis Factor Receptor Agents / Anti-TNF-alpha - Monoclonoal Antibodies	18.0%

New Specialty Drugs

In order to account for the cost of new specialty drugs we reviewed claim information to identify potential candidates for specific drugs by population. We reviewed the PMPM costs assumed against drug cost projections to validate that assumptions were within the expected range. The specific products included in our analysis are illustrated in Table II-12.

Table II-12
Washington Health Care Authority
New Specialty Drugs Considered

Drug Name	Relevant Condition
Orkambi	Cystic Fibrosis
Entresto	Heart Failure
Repatha & Praluent	Hyperlipidemia
Daralex, Ninlaro and Empliciti	Multiple Myeloma
Tagrisso, Portrazza, Alecensa	Non-Small Cell Lung Cancer

Our estimated costs were developed based on the prevalence of the conditions treated, projected unit cost, and projected take-up rates. For drugs that had already launched, including Entresto, Orkambi, Praluent, and Repatha, we used experience after the launch date to inform our projection of future claims.

We computed PMPM adjustments for these drug, shown in Table II-13 and incorporated those adjustments into the final pharmacy trend adjustment.

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Table II-13 Washington Health Care Authority Pharmacy New Specialty PMPM						
Service Line	**Family**	**SCHIP**	**AHBD**	**COPES**	**DDA**	**AHAC**
New Specialty PMPM	$0.32	$0.41	$5.64	$11.99	$1.70	$0.32

The result of these pharmacy components are the trends included in Table II-5.

AHAC Adjustments for Impact of Enrollment Duration and Historical Anti-Selection

We expect the AHAC population to differ between the projection period and the base period. These differences would arise from two key sources:

- Changes in spending based on a member's time from initial enrollment (or "duration") - For example, previous rate development assumed there would be some level of pent-up demand, which would result in increased utilization during early durational periods for members who previously had not had healthcare coverage.
- Changes based on the morbidity level of members – Previous rate development assumed that early enrollees in the Medicaid expansion program would require more healthcare services, increasing capitation rates in the initial stages of the program.

To evaluate the impact of duration, we conducted a study reviewing costs during our 12-month experience period for Expansion membership, separated by month since enrollment. Due to credibility concerns, we averaged monthly cost factors into durational quarters. Furthermore, because of the limited data available for membership with enrollment of more than one year, we assumed that costs stabilized after two years. To estimate the impact of duration into our projection period, we assumed

- Members would disenroll at a rate of 1% per month and
- New membership each month would be equivalent to the average monthly new membership in the last seven months of the experience period.

Table II-14 shows the results of this study. In this table, the "Factor" column represents average costs during the quarter, relative to costs observed in the first month of enrollment. Contrary to our expectations when developing initial capitation rates, costs seem to be increasing across the first year of membership, with a slight increase into the second year. The net expected impact of duration is an increase of 1.9% over the historical costs in the experience period.

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Table II-14 Washington Health Care Authority Expansion Relative Costs by Duration				
	Base Period		Projection Period	
Quarter	Factor	MMs	Factor	MMs
1	1.016	494,898	1.016	454,354
2	0.991	508,955	0.991	440,859
3	1.020	507,611	1.020	427,765
4	1.059	525,380	1.059	422,871
5	1.104	704,891	1.104	423,594
6	1.095	1,048,200	1.095	388,756
7	1.091	950,780	1.091	356,195
8	1.125	798,359	1.125	352,323
9	1.125	486,225	1.125	359,774
10			1.125	366,941
11			1.125	408,995
12			1.125	566,912
13			1.125	885,079
14			1.125	783,698
15			1.125	655,521
16			1.125	402,336
Total	**1.077**	**6,025,299**	**1.097**	**7,695,973**
Net Impact			**101.9%**	

To evaluate the impact of anti-selection, we conducted a cohort study by grouping members into month of initial enrollment and calculating their average costs relative to their managed care enrollment month.. Due to credibility concerns, we averaged monthly cost factors into six-month enrollment cohorts. To estimate the impact of the unwinding of anti-selection, in our projection period, we made the same lapse and enrollment assumptions described above.

Table II-15 shows the results of this cohort study. In this table, the "Cohort Factor" column represents average cost for members in the cohort relative to costs observed among members whose first month of enrollment was January 2014. As expected, costs in the first cohort were higher than those in subsequent enrollees. Because high-cost cohorts will be a smaller part of the projection period costs than they were in the experience period, a downward adjustment to experience is necessary to reflect expected future costs. As shown in Table II-13, the adjustment factor is 1.0, or no impact.

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Table II-15 Washington Health Care Authority Expansion Cohort Adjustment for CY17 Rates			
Initial Enrollment	Cohort Factor	Membership	
		Base	Projected
Jan 2014 - Jun 2014	0.849	3,532,756	2,912,676
Jul 2014 - Dec 2014	0.824	831,965	657,753
Jan 2015 - Jun 2015	0.639	1,181,720	864,099
Jul 2015 - Dec 2015	0.782	384,807	586,074
Jan 2016 - Jun 2016	0.795	94,051	877,486
Jul 2016 - Dec 2016	0.795	-	839,106
Jan 2017 - Jun 2017	0.795	-	695,489
Jul 2017 - Dec 2017	0.795	-	263,291
Total			
Membership		6,025,299	7,695,973
Cohort Factor		0.800	0.800
Net Impact			**100.0%**

Note that the claims underlying these adjustments were adjusted for the following impacts:

- Age/gender: We adjusted claims using the age/gender factors implied by our calendar year 2016 rates to account for demographic changes.
- Trend: We trended claims to the midpoint of the projection period (July 1, 2017) in order to account for differences in trend between months. The trends used are the ones shown in Tables II-4 and II-5 described in the trend section of this report.

Combined, the impact of the duration and cohort effects is an increase of 1.9%. This was applied as a percentage increase across all Expansion rate cells.

Non-Medical Load

We have loaded the medical cost by the amounts identified in Table II-16 to account for non-medical costs incurred by MCOs. The administrative load is lower for the marginal early enrollment transitioning months than for all other member months. Members enrolled during the early enrollment period are not new members but are being transitioned to managed care sooner than they were in the historical period. We have assumed that much of the fixed costs associated with the member would be covered under the administrative load in the non-early enrollment member months. Covering these additional months should not increase the fixed costs but would impact the variable costs associated with processing additional claims and typical month to month management of members. We assumed fixed cost represents one-third of the total administrative load (excluding WSHIP and premium tax) and variable costs made up the other two-thirds of the total administrative load (excluding WSHIP and premium tax).

This administrative load adjustment is applied to the early enrollment population to develop rates and these rates are then blended with the remaining membership. There is not a different capitation rate paid in the first one to two months of a member's Medicaid enrollment.

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Table II-16 Washington Health Care Authority Non-Medical Load			
Component	**Family/SCHIP**	**AHBD/COPES/DDA**	**AHAC**
Administration	8.5%	6.5%	10.0%
Surplus Requirements	1.5%	1.5%	1.5%
WSHIP Assessment	$1.07 PMPM	$1.07 PMPM	$1.07 PMPM
Premium Tax	2.0%	2.0%	2.0%
ACA Insurer Tax	0.0%	0.0%	0.0%

Note the following related to the administrative component of the capitation rates:

1. There is a moratorium on the ACA Insurer Tax in CY 2017.
2. The Delivery Case Rate (DCR) and Low Birth Weight (LBW) kick payments have been fully loaded at the same non-medical rate as shown above with two exceptions:
    a. The WSHIP is paid on a PMPM basis in the monthly capitation rate, and
    b. The AHAC DCR payment is loaded with the Family administration amounts to keep the DCR payment consistent.
3. While Certified Public Expenditures (CPE) claims are paid separately, an administrative load of 1% on those claims is included in the final AHBD/COPES/DDA rates. This load is for management of those claims and is not included above.
4. A subset of the final capitation rates are intended to cover PMPM provider reimbursement enhancements (UPL hospital supplement/SNAF and PAP). The administrative loads associated with these costs include only a premium tax component.
5. The composite of non-medical loads will not be the sum of the parts due to the order of application. We have applied a load to costs for administration and surplus requirements and then load that for taxes and assessments. We are therefore not paying an administrative/surplus load on taxes and assessments.

Service Adjustments

Hemophilia Drugs

Hemophilia drugs are paid through FFS and are not the responsibility of the MCOs. Appendix E illustrates NDC codes we used to identify hemophilia drugs to exclude from the base data. In addition, the HCPCS codes identified in Table II-17 have also been excluded.

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Table II-17 Washington Health Care Authority Hemophilia HCPCS Carve Out List	
HCPCS	**Short Description**
J7183	Wilate injection
J7185	Xyntha inj
J7186	Antihemophilic viii/vwf comp
J7187	Humate-P, inj
J7189	Factor viia
J7190	Factor viii
J7192	Factor viii recombinant NOS
J7193	Factor IX non-recombinant
J7194	Factor ix complex
J7195	Factor IX recombinant
J7198	Anti-inhibitor
J7199	Hemophilia clot factor noc

Hepatitis-C Drugs

High-cost Hepatitis C drugs (including Harvoni, Olysio, Sovaldi, and Daklinza) were not the responsibility of the MCOs in CY16 or CY17. We have therefore continued to exclude the costs of these drugs from the base experience.

Bright Futures

Three additional developmental and autism screenings were approved and funded for Bright Futures in the final 2015-17 operating budget. This change was effective January 1, 2016. We relied on the model approved by the Washington state legislature to estimate the impact of this change to managed care. This model contains cost and funding levels split out by FFS and managed care programs for both FY 2016 and FY 2017. Because the experience period contains three months during which Bright Futures screenings were funded, we damped the model output by a factor of 0.90. Using this information, we calculated an increase of $0.08 PMPM to the Family/SCHIP rates and an increase of $0.01 for AHBD/COPES/DDA.

Long-Acting Reversible Contraception (LARC)

HCA increased the FFS insertion fee for LARC effective September 1, 2015. We anticipate that providers will expect the higher rate from MCOs as well, and that the MCOs will accommodate the providers.

This change impacts the following CPT codes:

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Table II-18 Washington Health Care Authority LARC CPT Codes	
CPT Code	**Description**
11981	Implant insertion
11983	Implant removal
58300	Insertion of intrauterine device

To estimate the impact, we looked at claims for these codes, and compared data prior to the fee increase with data after the fee increase. We then increased claims incurred prior to that September 1, 2015 by this amount. The additional dollars were added to the rates by population and age-band. The adjustments added to experience months prior to September 1, 2015 are shown below in Table II-19.

Table II-19 Washington Health Care Authority Impacts of LARC Adjustments						
Age/Gender	**AHAC**	**Family**	**SCHIP**	**Copes NF**	**Non-DDA HOBD**	**Other DDA**
Age <1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Ages 1-2	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Ages 3-14	$0.00	$0.01	$0.01	$0.00	$0.00	$0.00
Female 15-18	$0.00	$0.48	$0.49	$3.82	$0.00	$0.00
Male 15-18	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Female - 19 - 34	$0.63	$1.12	$0.00	$0.98	$0.29	$0.24
Male - 19 - 34	$0.00	$0.01	$0.00	$0.00	$0.01	$0.00
Female - 35 - 64	$0.11	$0.28	$0.00	$0.02	$0.04	$0.22
Male - 35 - 64	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Ages65+	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Autism Spectrum Disorder Screenings Services

Effective July 1, 2015 plans were required to provide the following additional Autism Spectrum Disorder services for children under 21 years old:

- One 18 month Developmental Delay / Autism Screening (effective July 1, 2014)
- One 9 month Developmental Delay / Autism Screening
- One 24-30 month Developmental Delay / Autism Screening
- One additional Autism Screening between 18 and 24 months, and
- Applied Behavior Analysis (ABA) services.

This change is reflected in the experience period data with the exception of the months April 1, 2015 through June 30, 2015. We compared the claim levels in these months with the claim levels after July 1, 2015. We then increased claims incurred prior to July 1, 2015 in our experience period. The adjustments added to experience months prior to July 1, 2015 are shown below in Table II-20.

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Table II-20 Washington Health Care Authority Impacts of ASD Adjustments						
Age/Gender	**AHAC**	**Family**	**SCHIP**	**Copes NF**	**Non-DDA HOBD**	**Other DDA**
Age <1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Ages 1-2	$0.00	$0.07	$0.03	$0.00	$0.83	$0.00
Ages 3-14	$0.00	$0.17	$0.51	$65.54	$3.87	$38.33
Female 15-18	$0.00	$0.03	$0.00	$0.00	$0.02	$0.00
Male 15-18	$0.00	$0.03	$0.05	$7.29	$0.36	$6.88
Female - 19 - 34	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Male - 19 - 34	$0.00	$0.00	$0.00	$0.00	$0.07	$0.00
Female - 35 - 64	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Male - 35 - 64	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Ages65+	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Medication Assisted Treatment

Effective July 1, 2015 additional funding was approved for medication assisted treatment (MAT) or maintenance therapy for substance use disorders for Washington State Medicaid members. Additionally, effective October 1, 2015, the state is carving all previously paid FFS MAT claims into the managed care contract. Capitation rates were adjusted to load the costs of these two changes into the managed care experience as follows:

- Data for MAT services was pulled for the entire experience period and divided into three buckets:
  - Claims prior to July 1, 2015 (no additional MAT funding or carve-ins)
  - Claims incurred during 2015 Q3 (additional MAT funding, but no carve-ins)
  - Claims incurred after October 1, 2015 (additional MAT funding and FFS carve-ins)

- For claims prior to July 1, 2015, adjustments were made to gross-up the PMPMs to post-October 1, 2015 levels by program, age and gender. Post-October 1, 2015 levels are defined as the weighted average of MAT claims incurred between October 1, 2015 and March 31, 2016 as reported in MCO encounter data, adjusted for completion.

- For claims incurred during 2015 Q3, different adjustments were made to gross up the PMPMs to post-October 1, 2015 levels.

- The adjustments made to each time period are shown below.

Table II-21a Washington Health Care Authority Impacts of MAT Adjustments to 2015Q2						
Age/Gender	**AHAC**	**Family**	**SCHIP**	**Copes NF**	**Non-DDA HOBD**	**Other DDA**
Age <1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Ages 1-2	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Ages 3-14	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Female 15-18	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Male 15-18	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00
Female - 19 - 34	$0.23	$0.47	$0.00	$0.06	$0.11	$0.00
Male - 19 - 34	$0.41	$0.50	$0.00	$0.00	$0.07	$0.00
Female - 35 - 64	$0.12	$0.28	$0.00	$0.11	$0.08	$0.00
Male - 35 - 64	$0.18	$0.36	$0.00	$0.01	$0.08	$0.00
Ages65+	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

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Table II-21b Washington Health Care Authority Impacts of MAT Adjustments to 2015Q3						
Age/Gender	**AHAC**	**Family**	**SCHIP**	**Copes NF**	**Non-DDA HOBD**	**Other DDA**
Age <1	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Ages 1-2	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Ages 3-14	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Female 15-18	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Male 15-18	$0.00	$0.01	$0.00	$0.00	$0.00	$0.00
Female - 19 - 34	$0.20	$0.45	$0.00	$0.00	$0.05	$0.00
Male - 19 - 34	$0.39	$0.47	$0.00	$0.00	$0.07	$0.00
Female - 35 - 64	$0.12	$0.22	$0.00	$0.11	$0.06	$0.00
Male - 35 - 64	$0.16	$0.30	$0.00	$0.01	$0.00	$0.00
Ages65+	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

Health Home Care Coordination Services

Effective January 2014, the state implemented a health home care coordination model consistent with its program for dual eligible members. The state has targeted the members with the highest risk scores as candidates for this additional management activity. Risk scores are based on an algorithm from the state that is primarily based on a PRISM score (greater than 1.5).

Historically, members in King County were not eligible for this program. King and Snohomish counties will now be included, and we have included PMPM amounts from the rest of the state to account for this change. The CPT codes used to define Health Home cost include: HCPCS G9148 (Medical home level 1), G9149 (Medical Home Level II), and G9150 (Medical Home Level III).

Cost Adjustments

Safety Net Assessment Fund (SNAF)

The SNAF is effectively an increase to funding for inpatient and outpatient payments for select hospitals. The PMPM load for the revised SNAF payment is part of the premium amount that is adjusted by age, gender, area, and risk factors. Allocation of funds is based on aggregate expected hospital costs. Composite rates are shown in Table II-21.

Table II-22 Washington Health Care Authority SNAF PMPM	
Program	**SNAF PMPM**
Family	$ 11.27
SCHIP	$6.61
COPES	$125.65
AHBD	$53.10
DDA	$31.29
AHAC	$21.36

Provider Access Payment

The Provider Access Payment (PAP) program was developed to provide additional funding to critical professional providers. This payment is based on services from the following six clinics:

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- Children's University Medical Group (CUMG)
- Harborview Medical Center (HMC)
- University of Washington Medical Center (UWMC)
- University of Washington Physicians (UWP)
- Valley Medical Center (VMC)
- Northwest Hospital (NWH)

Managed care enrollment was pulled for calendar year 2015. Separate FFS and encounter claims for the clinics were provided by Navigant, repriced at an enhanced fee schedule. We relied on the repricing performed by Navigant as a vendor for HCA. This claims data included the Medicaid fee schedule allowed amount and the CY 2015 average enhanced payments for all services. We assumed no additional trend for Medicaid fee schedules, enhanced payment rates, or utilization changes.

Claims and membership were summarized to establish expected PMPM costs by program and clinic at 100% of Medicaid fee schedule allowed amounts and at enhanced rates. The difference in premiums is the additional premium before any adjustments.

The additional premium was aggregated for all plans and is equal to the amount needed to raise claim payment levels to the enhanced rate from the baseline Medicaid fee schedule. The additional premiums before tax and utilization trend are presented in Table II-22 by program.

Table II-23
Washington Health Care Authority
PAP PMPM Load

Component	PAP PMPM
Family	$2.42
SCHIP	$2.43
COPES	$20.94
AHBD	$13.29
DDA	$8.26
AHAC	$3.94

Pharmacy Rebates

Based on data and information provided by participating health plans, we adjusted total pharmacy costs to net out supplemental rebates negotiated by MCOs in their PBM contracts. This adjustment was based on actual historical MCO supplemental rebates received during calendar year 2015. Rebate assumptions are presented in the table below.

Table II-24
Washington Health Care Authority
Pharmacy Rebate Percentages

Component	Family/SCHIP	AHBD/COPES /DDA	AHAC
Pharmacy Rebates	(3.5%)	(2.1%)	(2.7%)

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EAPG and APR-DRG Adjustments

HCA implemented a new payment system for inpatient hospital services on July 1, 2014. To ensure budget neutrality, an adjustment factor was applied to base APR-DRG rates on a quarterly schedule, based on calculated aggregate paid amounts under the old and new system. While the adjustment is intended to be budget neutral over a 2 year period, it is not budget neutral for the experience period. The adjustments applied to the base period were as follows:

- 8/1/15: -0.85% (3 months)
- 11/1/15: -8.15% (3 months)
- 2/1/16: +8.95% (4 month reversal of prior adjustments)

For example, a factor of 1 / 0.9185 was applied to Inpatient claims incurred 11/1/2015 through 1/31/2016. We assumed that these factors would apply to 85% of claim dollars and other claims would not be subject to these adjustments given outlier status.

Similarly, HCA implemented a new payment system for outpatient hospital services on July 1, 2014. To ensure budget neutrality, an adjustment factor is applied to base EAPG rates on a quarterly schedule, based on calculated aggregate paid amounts under the old and new system. While the adjustment is intended to be budget neutral over a 2 year period, it is not budget neutral for the experience period. The adjustments applied to the base period were as follows:

- 8/1/15: +8.20% (3 months)

Quality Incentive Payments

We received a list from HCA of providers who qualified for and will receive incentive payments during the period July 1, 2016 to June 30, 2017. We used this list in combination with the list HCA previously sent us of providers who received payments during the base period to determine what provider payments in the base data needed to be adjusted for the rate projection. Providers on the prior list were assumed to have the 1% inpatient incentive payments already present in the base data. If those same providers also appeared on the FY17 list, then we made no adjustment to their claims, but if they no longer appeared on the FY17 list, we multiplied their inpatient claims by a factor of 1 / 1.01 to remove the 1% incentive. Conversely, if a provider was not on the prior list, but did appear on the FY17 list, we adjusted their inpatient claims by a factor of 1.01 to simulate the incentive payments. Overall, this resulted in a decrease of roughly 0.1% in inpatient payments, because fewer providers qualified for the incentives in 2017 than did in the base period.

Other Rate Issues

CPE Hospital Claims Costs

The initial claim data for the CPE hospitals included only the federal portion of the payment amount. In order to forecast complete costs for these hospitals, claims were repriced at FFS levels. All original CPE inpatient claims data were removed and replaced with the repriced claims. A review of aggregate CPE costs versus the portion of the capitation rates not distributed to plans but rather budgeted for these services indicated that costs were in line with budgets. This only applies to the AHBD/COPES/DDA populations.

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Delivery Case Rate (DCR)

To determine the amount of the DCR, we used FY15 AH Family data to identify the average cost of all deliveries. This calculation is presented in Attachment H. The average cost of a delivery was $6,391.57. This amount was loaded with 10% admin and 2% premium tax to arrive at the final kick payment of $7,246.68.

The DCR did not change for the CY 2017 rates relative to the CY 2016 rates. We reviewed more recent data, but determined it did not warrant a change at this time.

Related to the base year data, in each cost model we identify the number of deliveries assumed in that population, based on DCR claims during this period adjusted for lag in reporting, and removed a total number of deliveries x DCR from the total dollars for that rate cell. In this way, total funding is unchanged; it is just a transfer of risk for those plans that incur more deliveries than average for a rating cell.

The DCR payment only applies to the Family, SCHIP, and AHAC populations.

Low Birth Weight Payment (LBW)

Similar to the DCR payment, the LBW payment is a kick payment made to the MCO for low birth weight-baby related expense for those enrolled with the MCO during the month of a qualifying low birth weight event. The LBW payment shall only be paid to the MCO if the MCO has incurred and paid direct costs for a qualifying low birth weight event based on valid encounter data received by HCA. Qualifying events must meet three requirements:

1. The event must qualify for one of the following APR-DRG codes in Table II-22.
2. The qualifying claim must have an MCO paid amount of more than $75,000.
3. The payment applies to members enrolled under the Family/SCHIP programs.

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Table II-25
Washington Health Care Authority

APR DRG	SOI	DRG Description
588	1	NEONATE BWT <1500G W MAJOR PROCEDURE
588	2	NEONATE BWT <1500G W MAJOR PROCEDURE
588	3	NEONATE BWT <1500G W MAJOR PROCEDURE
588	4	NEONATE BWT <1500G W MAJOR PROCEDURE
589	1	NEONATE BWT <500G OR GA <24 WEEKS
589	2	NEONATE BWT <500G OR GA <24 WEEKS
589	3	NEONATE BWT <500G OR GA <24 WEEKS
589	4	NEONATE BWT <500G OR GA <24 WEEKS
591	1	NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE
591	2	NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE
591	3	NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE
591	4	NEONATE BIRTHWT 500-749G W/O MAJOR PROCEDURE
593	1	NEONATE BIRTHWT 750-999G W/O MAJOR PROCEDURE
593	2	NEONATE BIRTHWT 750-999G W/O MAJOR PROCEDURE
593	3	NEONATE BIRTHWT 750-999G W/O MAJOR PROCEDURE
593	4	NEONATE BIRTHWT 750-999G W/O MAJOR PROCEDURE
602	1	NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM
602	2	NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM
602	3	NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM
602	4	NEONATE BWT 1000-1249G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM
603	1	NEONATE BIRTHWT 1000-1249G W OR W/O OTHER SIGNIFICANT CONDITION
603	2	NEONATE BIRTHWT 1000-1249G W OR W/O OTHER SIGNIFICANT CONDITION
603	3	NEONATE BIRTHWT 1000-1249G W OR W/O OTHER SIGNIFICANT CONDITION
603	4	NEONATE BIRTHWT 1000-1249G W OR W/O OTHER SIGNIFICANT CONDITION
607	1	NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM
607	2	NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM
607	3	NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM
607	4	NEONATE BWT 1250-1499G W RESP DIST SYND/OTH MAJ RESP OR MAJ ANOM
608	1	NEONATE BWT 1250-1499G W OR W/O OTHER SIGNIFICANT CONDITION
608	2	NEONATE BWT 1250-1499G W OR W/O OTHER SIGNIFICANT CONDITION
608	3	NEONATE BWT 1250-1499G W OR W/O OTHER SIGNIFICANT CONDITION
608	4	NEONATE BWT 1250-1499G W OR W/O OTHER SIGNIFICANT CONDITION
609	1	NEONATE BWT 1500-2499G W MAJOR PROCEDURE
609	2	NEONATE BWT 1500-2499G W MAJOR PROCEDURE
609	3	NEONATE BWT 1500-2499G W MAJOR PROCEDURE
609	4	NEONATE BWT 1500-2499G W MAJOR PROCEDURE
630	1	NEONATE BIRTHWT >2499G W MAJOR CARDIOVASCULAR PROCEDURE
630	2	NEONATE BIRTHWT >2499G W MAJOR CARDIOVASCULAR PROCEDURE
630	3	NEONATE BIRTHWT >2499G W MAJOR CARDIOVASCULAR PROCEDURE
630	4	NEONATE BIRTHWT >2499G W MAJOR CARDIOVASCULAR PROCEDURE
631	1	NEONATE BIRTHWT >2499G W OTHER MAJOR PROCEDURE
631	2	NEONATE BIRTHWT >2499G W OTHER MAJOR PROCEDURE
631	3	NEONATE BIRTHWT >2499G W OTHER MAJOR PROCEDURE
631	4	NEONATE BIRTHWT >2499G W OTHER MAJOR PROCEDURE

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This payment is not intended to increase or decrease funding but rather to enhance risk adjustment for services generally not captured in our risk adjustment process. While this is an improvement in risk payment transfer, it is not meant to fully compensate for these newborns or adjust for all high cost newborns. Also similar to the DCR, funding not included in this payment remains in the monthly capitation rates. The intended payment is $100,000. With the non-medical load, the final LBW payment is $113,378.68. The LBW payment is not modified by any other rate adjustment factors. We have assumed that 135 such births were included in the base year data based on LBW payments and claim data adjusted for incomplete data.

Age/Gender Factors

Age/gender factors for each population are based on the cost and utilization included in the base data. The costs establishing these relativities are inclusive of all adjustments discussed above.

Regional Map

Regional assignments for CY 2017 rates have been updated from 2016 rate regions. The new regions are presented with the rates in Appendix A. Regions were assigned in order to minimize the variance between age/gender normalized costs and actual costs. Some of the regional re-assignments are material. The county to region mapping is consistent across all AHBD populations, as well as the CPE components for both

FQHC/RHC Enhancement

In an effort to minimize the disruption to the current system for providing enhancement funding to the FQHC/RHCs, the monthly enhancement payments in the form of per member capitation amounts will be made to the MCOs, which will then pay the FQHC/RHCs. Outside of a load for premium tax, the payment to the MCO will be the same as has been paid to the FQHC/RHCs, such that current funding to FQHC/RHCs will be unchanged. There will be a reconciliation process similar to the current process to settle the differences between the enhancement payments and the final costs related to these payments. In addition, there will be a second reconciliation between HCA and MCOs to ensure that plans have been appropriately funded for the enhancement costs.

The amount paid from HCA to the MCO will be equal to the enhancement amount for each FQHC/RHC times the number of members enrolled with that FQHC/RHC (loaded for premium tax). MCOs will then be expected to pass this amount, net of premium tax, to the FQHC/RHC.

We expect that over time, this process may be adjusted as plans are able to pay an encounter rate at the point of service and FQHC/RHCs are comfortable with that process.

At this time, there is no change to the capitation rates as this pass through amount is not included in the base capitation rates.

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NEWLY COVERED POPULATIONS

These rates contain populations not reflected in the base data. This section describes each population and how they were incorporated.

Each population is expected to receive increased management due to the transition from FFS to managed care. The exception is the third party coverage members; we have not assumed savings from trended historical costs for these members. These management factors are shown below:

For claims already covered under mature managed care programs we have not applied further management factors. Management factors applied to FFS claims are presented in Table II-25.

Table II-26
Washington Health Care Authority

FFS Management Assumptions

Category of Service	Utilization Management Factors	
	Early Enrollment	Other FFS Conversions*
Inpatient Hospital	11.0%	20.8%
Emergency Room	11.0%	20.8%
Outpatient Hospital	11.0%	20.8%
Professional	8.0%	15.4%
Pharmacy	5.0%	9.8%
Other	8.0%	15.4%

*No management factors applied to TPL members

The assumptions are based on management factors assumed in other states for similar programs converting from FFS to managed care as well as those assumed in other Washington Medicaid programs. We dampened the adjustments from our research to account for the limited ability of MCOs to manage member costs in a member's first few months.

Note that we did not apply management reductions to the maternity service lines. Facility reductions that directly impact professional service lines were adjusted consistent with the facility adjustment. These services are summarized below.

Cost Model Line	Benefit
P11	Inpatient Surgery - Primary Surgeon
P13	Inpatient Anesthesia
P14	Outpatient Surgery
P16	Outpatient Anesthesia
P55	Radiology IP
P56	Radiology OP - General
P57	Radiology OP - CT/MRI/PET
P61	Pathology/Lab IP/OP

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"Early Enrollment" Membership

CY 2017 capitation rates include costs of members who previously received coverage through FFS Medicaid prior to enrollment in Apple Health. As of April 1, 2016, members will be enrolled immediately in Apple Health instead of transitioning from FFS to Apple Health. Using a list of FFS member IDs from the state, we identified these members in our FFS data and have included their costs in the rate development.

This change impacts all populations.

Third Party Liability Members

Members for whom Apple Health is not the primary insurer have previously been excluded from coverage under managed care. HCA is in the process of allowing more of these members to enroll in managed care plans, and we have included these members and their experience in the development of CY 2017 capitation rates. The state provided a list of FFS member IDs for this population. Using this list, we incorporated the claims and membership for members who use Apple Health as a secondary insurer.

This change impacts all rate cells.

Members Aged 65+

Members who are age 65 or over at the beginning of the month in certain AHBD RAC codes will be enrolled in managed care for the CY 2017 contract period. These members previously received coverage through FFS Medicaid.

III. RISK ADJUSTMENT

Given the lag in base year data and application of rates, we have chosen to update risk scores closer to implementation with emerging experience. Risk scores have not been updated at this time, but we will recalculate scores effective during CY 2017 which will be revenue neutral to the state.

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