Aged and Disabled Report

State of Indiana

Family and Social Services Administration

Prepared for:
Paul Bowling
Chief Financial Officer

Prepared by:
Rob Damler
FSA, MAAA
Principal and Consulting Actuary

Paul Houchens
FSA, MAAA
Principal and Consulting Actuary

111 Monument Circle
Suite 601
Indianapolis, IN 46024-5126
USA

Tel +1 317 639-1000
Fax +1 317 639-1001

milliman.com

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Table of Contents

EXECUTIVE SUMMARY **3**

BASELINE INFORMATION **7**

Current ABD Enrollment and Expenditures 7

ABD Population Definition and Enrollment 7
ABD Population SFY 2012 Expenditures 8

RECONCILIATION OF ABD ENROLLMENT AND EXPENDITURES **9**

PROJECTED ENROLLMENT GROWTH OF THE ABD POPULATION **12**

INDIANA SPECIFIC ISSUES **13**

Shifting Care from Institutional Settings to the Community 13
QAF/HAF Match 13
MRO Match 13

FINANCIAL PROJECTIONS/ESTIMATED COST SAVINGS **14**

Avoidable Costs 14
Estimated Claims Cost Savings by Type of Managed Care 15
Discussion of Results 16

Care Select and Community, and M.E.D Works Populations 16
Waiver Populations 16
Institutional Populations 17
Under 21 Populations 17

Home and Community Based Services Management Program 18
Administrative Costs of Managed Care 19

DATA, ASSUMPTIONS, AND METHODOLOGY **21**

Data 21
Populations 21
Allocation of Non-Claims Expenditures 22

LIMITATIONS **23**

APPENDIX A: ESTIMATED AGGREGATE NET SAVINGS BY POPULATION UNDER A FULL RISK-BASED PROGRAM EXCLUDING MRO SERVICES

EXECUTIVE SUMMARY

The Indiana legislature directed the Family and Social Services Administration (FSSA) to study the feasibility of providing Medicaid services to the Aged Blind and Disabled (ABD) population through managed care. FSSA is charged with providing a final written report before December 15, 2013 to include the legislative requests outlined in HB 1328, section 28. Milliman was retained to perform the actuarial analysis for this report.

The actuarial analysis included:

- Summarizing historical ABD enrollment and claims.
- Identifying potentially avoidable claims.
- Creating actuarial cost models for the Indiana ABD populations.

Each component of the analysis was used to create estimated claim savings from the implementation of a managed care program. Administrative costs of a managed care program were also estimated. Table 1a illustrates the best estimate of the expected net savings after administrative costs from the implementation of a managed care program for each individual ABD population.

Savings estimates illustrated are best estimates and include a degree of uncertainty. Actual results are expected to deviate from those illustrated in this report. Any reader of this report should consider the following when reviewing the results shown in this report:

- Savings values are shown on an annual basis.
- Savings estimates illustrated are estimated after short term establishment of the managed care program, which may take three to five years. Managed care savings may further increase even after this time period.
- Contracted entities were assumed to be subject to the ACA health insurer fee, which was estimated at 2.5% of the capitation rate. To the extent that that the state contracts with non-profit plans exempt from the fee, the state would realize additional savings in relation to the fee-for-service program. Per federal regulation §57.2(h)(2)(ix), long-term care, nursing home care, home health care, and community-based care were excluded from the estimated 2.5% fee.
- A certain percentage of spend down individuals were assumed to transition to the community population due to the conversion of the State to a 1634 status. Further details are outlined in the body of the report.
- Additional savings may be achieved by the state from current administrative contracts that may be replaced under the various managed care scenarios.

Table 1a

STATE OF INDIANA
Family and Social Services Administration

Aged, Blind, and Disabled Analysis
Estimated Aggregate Net Savings by Population
SFY 2011 and 2012 Estimated Aggregate Annual Expenditures
Under a Full Risk-Based Program and Including MRO Services

Population	Estimated Enrollment	Annual Claim Expenditures	Best Estimate Net Savings	Best Estimate % Net Savings
Community Non-Dual Care Select	24,200	$ 506,600,000	$ 10,400,000	2.1%
Community Non-Dual	22,900	481,100,000	27,200,000	5.7%
Community Dual	52,300	158,900,000	(10,700,000)	(6.7%)
M.E.D. Works Non-Dual	1,300	28,000,000	700,000	2.5%
M.E.D. Works Dual	1,700	6,500,000	(600,000)	(9.2%)
Aged & Disabled Waiver Non-Dual	1,000	68,400,000	1,700,000	2.5%
Aged & Disabled Waiver Dual	6,000	181,600,000	(9,800,000)	(5.4%)
Family Supports Non-Dual	1,300	18,000,000	(600,000)	(3.3%)
Family Supports Dual	2,200	21,700,000	(1,300,000)	(6.0%)
CIH Waiver Non-Dual	1,600	131,100,000	(6,400,000)	(4.9%)
CIH Waiver Dual	4,900	320,000,000	(19,100,000)	(6.0%)
Other Institutional Non-Dual	1,200	115,300,000	(1,500,000)	(1.3%)
Other Institutional Dual	4,400	261,700,000	(16,400,000)	(6.3%)
Nursing Home Non-Dual	1,800	176,300,000	9,600,000	5.4%
Nursing Home Dual	24,500	1,049,700,000	(58,700,000)	(5.6%)
Under 21 Non-Dual	19,700	361,300,000	(16,200,000)	(4.5%)
Under 21 Dual	200	4,600,000	(300,000)	(6.5%)
Over 21 Community Non-Dual	47,100	987,700,000	37,600,000	3.8%
All Other Non-Dual	27,900	898,400,000	(12,700,000)	(1.4%)
Total Dual	96,200	2,004,700,000	(116,900,000)	(5.8%)
Total (State and Federal)	171,200	$ 3,890,800,000	$ (92,000,000)	(2.4%)
State Expenditures Only				
Over 21 Community Non-Dual	47,100	330,700,000	12,600,000	3.8%
All Other Non-Dual	27,900	300,800,000	(4,300,000)	(1.4%)
Total Dual	96,200	671,200,000	(39,100,000)	(5.8%)
Total (State Dollar)	171,200	$ 1,302,700,000	$ (30,800,000)	(2.4%)

Notes

1. State share values were estimated using the standard FFY 2015 FMAP of 66.52%. To the extent that certain expenditures may be paid out of the Medicaid Administration account, they will not be eligible for the standard FMAP.
2. State share savings includes total savings to all applicable funds: this includes the Medicaid Assistance account, the hospital assessment fee fund and the DMHA appropriation for MRO services.
3. Values are illustrated on an annual basis and have been rounded.
4. Other key assumptions and methodology notes are outlined in the body of the report.

Table 1a illustrates that the estimated net savings varies significantly by population. The Care Select, community non-dual, M.E.D. Works non-dual, Aged and Disabled Waiver non-dual, and nursing home non-dual populations have an estimated net savings ranging from 1.5% up to 5.6%. The remaining populations have an estimated negative net savings. Each population should be reviewed individually when determining whether or not to implement a managed care program.

The non-dual populations have higher estimates of net percent savings than the dual populations, because the claim costs savings for the dual populations would be shared with Medicare, and the fixed administrative costs are spread over a higher per member cost for non-dual populations. The administrative cost includes estimated administrative costs of the managed care plan and a 2.5% fee for the Patient Protection and Affordable Care Act (ACA) health insurer fee. The ACA health insurer fee was applied to capitation rates excluding long-term care, nursing home care, home health care, and community-based care, which were excluded per federal regulation §57.2(h)(2)(ix).

Table 1a includes the cost of MRO services, and no claim savings were assumed to apply to MRO services. Appendix A illustrates the effect of excluding MRO services in the total annual claim expenditures and savings estimates. The net savings in Appendix A are greater than those illustrated in Table 1a, because the ACA health insurer fee and administrative costs applicable to the MRO services were removed.

Table 1a assumes the claim savings and administrative expense assumptions associated with a full risk-based managed care program. The assumptions used throughout the body of the report are consistent with those used in Table 1a. Table 1b uses estimated claim savings and administrative cost assumptions for a delivery system that is not risk-based, such as a managed fee-for-service system. MRO services are included, and no claim savings were assumed on MRO services.

Table 1b STATE OF INDIANA Family and Social Services Administration Aged, Blind, and Disabled Analysis Estimated Aggregate Net Savings by Population SFY 2011 and 2012 Estimated Aggregate Annual Expenditures Under a Managed FFS Program and Including MRO Services				
	Estimated	Annual Claim	Best Estimate	
Population	Enrollment	Expenditures	Net Savings	% Net Savings
Community Non-Dual Care Select	24,200	$ 506,600,000	$ 6,000,000	1.2%
Community Non-Dual	22,900	481,100,000	18,000,000	3.7%
Community Dual	52,300	158,900,000	(17,500,000)	(11.0%)
M.E.D. Works Non-Dual	1,300	28,000,000	800,000	2.9%
M.E.D. Works Dual	1,700	6,500,000	(600,000)	(9.2%)
Aged & Disabled Waiver Non-Dual	1,000	68,400,000	1,800,000	2.6%
Aged & Disabled Waiver Dual	6,000	181,600,000	(1,700,000)	(0.9%)
Family Supports Non-Dual	1,300	18,000,000	(200,000)	(1.1%)
Family Supports Dual	2,200	21,700,000	(800,000)	(3.7%)
CIH Waiver Non-Dual	1,600	131,100,000	200,000	0.2%
CIH Waiver Dual	4,900	320,000,000	(1,800,000)	(0.6%)
Other Institutional Non-Dual	1,200	115,300,000	1,000,000	0.9%
Other Institutional Dual	4,400	261,700,000	(1,500,000)	(0.6%)
Nursing Home Non-Dual	1,800	176,300,000	6,200,000	3.5%
Nursing Home Dual	24,500	1,049,700,000	(7,900,000)	(0.8%)
Under 21 Non-Dual	19,700	361,300,000	(4,300,000)	(1.2%)
Under 21 Dual	200	4,600,000	(100,000)	(2.2%)
Over 21 Community Non-Dual	47,100	987,700,000	24,000,000	2.4%
All Other Non-Dual	27,900	898,400,000	5,500,000	0.6%
Total Dual	96,200	2,004,700,000	(31,900,000)	(1.6%)
Total (State and Federal)	171,200	$ 3,890,800,000	$ (2,400,000)	(0.1%)
State Expenditures Only				
Over 21 Community Non-Dual	47,100	330,700,000	8,000,000	2.4%
All Other Non-Dual	27,900	300,800,000	1,800,000	0.6%
Total Dual	96,200	671,200,000	(10,700,000)	(1.6%)
Total (State Dollar)	171,200	$ 1,302,700,000	$ (900,000)	(0.1%)

Notes

1. State share values were estimated using the standard FFY 2015 FMAP of 66.52%. To the extent that certain expenditures may be paid out of the Medicaid Administration account, they will not be eligible for the standard FMAP.
2. State share savings includes total savings to all applicable funds: this includes the Medicaid Assistance account, the hospital assessment fee fund and the DMHA appropriation for MRO services.
3. Values are illustrated on an annual basis and have been rounded.
4. Other key assumptions and methodology notes are outlined in the body of the report.

A delivery system that is not risk-based is not subject to the ACA health insurer fee. Administrative costs were assumed consistent with the ESP program, which pays a flat $33.05 PMPM fee for primary care management of its beneficiaries. Estimated claim savings assumptions were reduced from those supporting Table 1a, because managed care programs that are not risk based generally result in less claim savings than risk-based managed care programs. The Care Select population is already in a managed fee-for-service delivery system, but a review of the claims data indicated that additional savings may be possible.

BASELINE INFORMATION

CURRENT ABD ENROLLMENT AND EXPENDITURES

ABD Population Definition and Enrollment

FSSA requested the initial report include a broad definition of the ABD population. This section of the report includes the following:

- All Medicaid enrollees in Aged, Blind, or Disabled aid categories.
- All Medicaid enrollees with a level of care. These individuals meet criteria for institutionalization or enrollment on a Home and Community Based Services (HCBS) waiver.
- All Care Select Enrollees
- All Healthy Indiana Plan Enhance Services Plan (ESP) enrollees

Individuals who have Medicare eligibility as well as Medicaid eligibility, either full dual or partial status, have been included for purposes of this section of the report. This population is characterized by population and dual status in Table 2.

Table 2

STATE OF INDIANA
Family and Social Services Administration

Aged, Blind and Disabled Analysis
SFY 2012 Average Monthly Enrollment (June 2013 data)
By Population and Medicare Status

Disabled Universe

POPULATION	Dual	Non-Dual	Partial	Total
Institutionalized				
Nursing Home	26,436	2,183	171	**28,790**
Other Institutionalized	4,411	1,754	2	**6,167**
Waiver				
Aging Waiver	6,045	2,436	7	**8,489**
DDRS Waiver	7,275	5,218	7	**12,499**
DMHA Waiver	-	546	-	**546**
Care Select	438	34,024	0	**34,462**
ESP	39	1,303	-	**1,342**
MA-U	468	17,415	-	**17,883**
M.E.D. Works	1,879	1,733	-	**3,612**
Spend Down	53,954	8,695	-	**62,649**
Other Disabled	34,325	31,260	31,934	**97,519**
Total Disabled	**135,270**	**106,567**	**32,121**	**273,957**

ABD Population SFY 2012 Expenditures

SFY 2012 Medicaid expenditures for ABD enrollees are illustrated by service type in Table 3.

Table 3

STATE OF INDIANA
Family and Social Services Administration

Aged, Blind and Disabled Analysis
SFY 2012 Incurred Expenditures (June 2013 data)
By Service Type

Disabled Universe

SERVICE TYPE		Expenditures
Institutional	$	1,582,336,521
Waiver Services		635,012,185
Hospital Services		1,194,641,902
Non-Hospital Services		291,238,652
Pharmacy		386,233,586
Home Health		214,804,768
Capitation and Fees		68,000,369
Mental Health Services		188,020,309
Dental		38,116,791
Other Claims Expenditures		1,273,465
Total Claims Expenditures	**$**	**4,599,678,547**
HAF for MA-U in Managed Care	$	31,932,709
Pharmacy Rebates (allocated by pharmacy expenditures)		(169,266,165)
ESP Transfer Payments		7,588,424
M.E.D. Works Premiums		(1,794,069)
Medicare Buy-Ins		213,626,754
Clawback Payments		95,143,585
DSH (Incurred)		225,800,000
UPL (Incurred - non-Hospital)		200,305,942
Total Non-Claims Expenditures	**$**	**603,337,179**
Total Disabled SFY 2012 Expenditures	**$**	**5,203,015,726**

Of the $5.2 billion in ABD expenditures, $4.6 billion was summarized from the claims data, and identified as corresponding to an ABD enrollee. The remaining $0.6 billion corresponds to non-claims expenditures.

For some non-claims expenditures, the full cost is illustrated in Table 3 (for example, ESP Transfer payments). For other expenditures, only a portion of the non-claims expenditures was allocated to the ABD population (for example, pharmacy rebates). Allocation methodology is detailed in the methodology section.

RECONCILIATION OF ABD ENROLLMENT AND EXPENDITURES

The previous section illustrated SFY 2012 enrollment and claims expenditures without any adjustments in order to provide a complete profile of the ABD population. The rest of the tables throughout the rest of the report include certain adjustments in order to modify the data to a format that is more amenable for the analysis of the implementation of managed care. Key differences include the following:

- ABD individuals under the age of 21, regardless of initial population, were assigned to the under 21 population. This population was not further stratified.

- Individuals with a partial Medicare status, in the MA-U program, or in the ESP program were excluded because of either an incomplete cost profile, lack of an ability to manage, or enrollment in other risk-based managed care programs.

- The spend down program will be eliminated with the conversion of the State to a 1634 status, but some of the current spend down individuals are expected to transition to the community population. 22% of non-dual spend down individuals were assumed to transition to the non-dual community population in the 2015 enrollment estimate, and 38% of the dual spend down individuals were assumed to transition to the dual community population in the 2015 enrollment estimate. Spend down individuals were excluded from any PMPM estimates because of an incomplete cost profile.

- PMPMs illustrated are a combination of SFY 2011 and 2012 data to create more stable estimates. In order to account for the increase in facility reimbursement rates beginning SFY 2012, the estimated SFY 2012 facility unit costs were used with SFY 2011 utilization data to adjust the SFY 2011 facility expenditures.

- The first three months of Medicaid eligibility and claims for individuals not enrolled in a Care Select population were removed from the data. These months usually include retroactive eligibility and are not manageable. This assumption was not applied to the enrollment used to create Table 6 so that a complete enrollment estimate was made.

- Population groupings are displayed differently. Population group mappings are illustrated on the next page.

Table 4 STATE OF INDIANA Family and Social Services Administration Aged, Blind and Disabled Analysis Mapping of Populations	
Detailed Population	**Rolled-Up Population**
Under 21	Under 21[1]
Nursing Home	Nursing Facility
Hospice	Other Institutional
ICF/ID	Other Institutional
Aged & Disabled	Aged & Disabled Waiver
Money Follows the Person	Aged & Disabled Waiver
Traumatic Brain Injury	Aged & Disabled Waiver
CIH	CIH Waiver
Family Supports	Family Supports Waiver
Care Select	Care Select
Other Disabled	Community
M.E.D. Works	Community
Spend Down[2]	Community
MA-U	Excluded
ESP	Excluded

Notes

1. Any individual under 21 was included in this population, regardless of the original population.
2. Only a certain percentage of this population was transitioned to Community.

The remainder of the report will use the above stated population definitions and methodology. Table 5 illustrates the effect of the above adjustments.

Table 5 STATE OF INDIANA Family and Social Services Administration Aged, Blind, and Disabled Analysis Adjustments to ABD Expenditures and Enrollment SFY 2011 and 2012 Combined		
	SFY12 Expenditures	Average Monthly Enrollment
Tables 2 and 3	$ 5,203,015,726	273,957
Less Non-Claims Expenditures		
Pharmacy Rebates	(169,266,165)	
M.E.D. Works Premiums	(1,794,069)	
Medicare Buy-Ins	213,626,754	
Clawback Payments	95,143,585	
DSH (Incurred)	225,800,000	
UPL (Incurred - non-Hospital)	200,305,942	
MA-U Capitation and Care Select Fees	68,000,369	
Subtotal	$ 4,571,199,311	273,957
Less Population Exclusions		
Partials	$ 12,884,412	31,888
Spend-Downs	311,479,503	62,620
MA-U	87,328,496	17,878
ESP	15,699,338	1,347
Subtotal	$ 4,143,807,562	160,224
Other Adjustments		
1st 3 Month of Eligibility	170,379,370	6,303
Spend Down to Community	(23,422,919)	(22,305)
SFY12 Total	$ 3,996,851,112	176,226

Table 5 reconciles the difference for SFY 2012 enrollment and expenditures. Differences between totals displayed in Table 5 and other tables throughout the report are attributable to the remainder of the report using combined SFY 2011 and 2012 enrollment and expenditures.

PROJECTED ENROLLMENT GROWTH OF THE ABD POPULATION

FSSA requested a projection of ABD population enrollment growth through SFY 2025. This is illustrated in Table 6.

Table 6

STATE OF INDIANA
Family and Social Services Administration

Aged, Blind and Disabled Analysis
Estimated Average Monthly Enrollment
Population Totals by SFY

Population	2012	2015	2020	2025
Nursing Home	28,600	30,300	33,000	36,700
Other Institutional	5,800	5,900	6,200	6,400
Aged & Disabled Waiver	7,200	11,500	12,400	13,300
CIH Waiver	6,800	7,500	7,600	7,700
Family Supports Waiver	3,800	7,000	7,000	7,000
Care Select	22,800	23,100	23,200	22,900
Community	62,100	87,300	91,200	94,600
M.E.D. Works	3,600	3,600	3,600	3,500
Under 21	19,500	19,600	19,800	20,000
Total	**160,200**	**195,800**	**204,000**	**212,100**

Note: The effect of spend down individuals transitioning to the community population is illustrated beginning in SFY 2015. Spend down individuals are not included in the SFY 2012 enrollment. Additionally, the first three months of enrollment were not excluded from this table.

The above table illustrates the effect that aging baby boomers are projected to have on ABD enrollment. Notably, ABD enrollment in nursing homes is projected to increase more than 25% from SFY 2012 to 2025. When considering transitioning to a managed care program, it is important to understand that changing enrollment patterns may magnify the total expenditure savings or loss. However, the increased enrollment in institutional settings may be dampened to the extent that medical advances, societal change, or other factors cause fewer Indiana residents to need institutional care in the future.

Enrollment estimates were created by projecting SFY 2012 ABD enrollment using population growth estimates from STATS Indiana.[1] The estimates assume that the current proportion of Indiana residents in each age band who are enrolled in the Medicaid programs above will remain constant. Additional adjustments were made for the enrollment policy changes in the Aging & Disabled, CIH, and Family Supports waivers to increase enrollment for those populations beginning in the 2015 enrollment estimate.

[1] Please see http://www.stats.indiana.edu/index.asp for more information on STATS Indiana.

INDIANA SPECIFIC ISSUES

The most expensive segment of the aged and disabled population is those that require long term care or significant personal assistance. The traditional means of caring for these individuals has been in institutions, primarily the following:

- Nursing Home: for those who require assistance with activities of daily living
- ICF/ID: for those with significant developmental disabilities
- State mental hospital: for those with a serious mental illness

SHIFTING CARE FROM INSTITUTIONAL SETTINGS TO THE COMMUNITY

Many states have been successful substituting care in the home for institutionalization. Medicaid can provide long term care support services in the home through a 1915(c) home and community based service (HCBS) waiver. These services allow the individual to stay in the home while the State avoids the cost of nursing home or ICF/ID care. For those with serious mental illnesses, Medicaid Rehabilitation Option (MRO) services can provide day treatment that allows the individual to continue living at home and functioning in the community setting.

CMS is generally very supportive of providing institutional care in the community. However, because this type of care was not a standard offering when Medicaid was enacted in 1965, it is not a mandatory benefit. To provide institutional care in the community, the State must have an approved waiver, and must be able to show that the average cost of providing services in a community setting is less than or equal to the cost of caring for similar individuals in an institutional setting.

Often, providing care in the home is more cost effective than in an institution. This is particularly true if the individual needs light support or has relatives who are willing to help with the care at home. However, if an individual requires round the clock care and has no family support, home care can be much more expensive because of the inability to share caregivers in a private home. Another intermediate option that has shown promise recently in Indiana is the use of Assisted Living. This model does not require a family caregiver, but is more suitable for those with intermediate support needs. Under this model, the resident lives more independently in his or her own apartment, but because the rooms are clustered in common buildings, is able to share caregivers and other services such as meals or transportation.

QAF/HAF MATCH

Current financing mechanisms favor institutional care over community care. Nursing homes currently receive revenue of three types: regular Medicaid reimbursement, enhanced Quality Assessment Fee (QAF) reimbursement, and Upper Payment Limit (UPL) reimbursement. For services provided during SFY 2013, regular Medicaid reimbursement to the nursing homes was $879.2 million, QAF reimbursement was $315.7 million, and UPL was $381.6 million. The federal government funds all three income streams at the standard FMAP (67.16% during FFY 2013), but the State only contributes to the regular Medicaid reimbursement payment. The State share of the QAF and UPL payments is contributed by nursing facility providers. This type of payment arrangement would be difficult to duplicate under risk-based managed care. UPL payments are generally only available under fee-for-service (FFS) arrangements. Provider contributions under quality assessment fee arrangements are limited to 6% of provider net revenue, so the amounts currently being paid in Indiana are already near the maximum allowed.

Since UPL payments are not allowed under risk-based managed care, it would be difficult to maintain the current level of payments to providers without increasing the cost to the State.

MRO MATCH

Medicaid Rehabilitation Option (MRO) is the community alternative to inpatient psychiatric services for those with serious mental illnesses. Expenditures for MRO services were $217.7 million during SFY 2013. State share funding for MRO services is provided through DMHA appropriation state-appropriated funds allocated to the community mental health centers, with additional support from the counties. Since funding was not provided through the Medicaid appropriation, it is unclear what parties would need to approve a transition to managed care contracting.

FINANCIAL PROJECTIONS/ESTIMATED COST SAVINGS

This section provides further detail on the data, assumptions, and methodology used to develop this analysis.

AVOIDABLE COSTS

An algorithm that identifies avoidable cost on was applied to the Indiana Medicaid experience data. The algorithm is based on internal and published clinical research and identifies services that are "potentially avoidable." These are acute services for conditions that potentially could have been avoided via appropriate ambulatory care. The algorithm emphasizes inpatient admissions and ER visits for conditions such as COPD, CHF, pneumonia, and septicemia. Conditions such as cancer or transplant patients are generally not considered avoidable, even though they are high cost conditions.

Potentially avoidable costs are generally represented by inpatient hospital and emergency room service categories (both facility and professional services). Other service categories such as office visits have very limited potential savings, and costs for some of these service categories may actually increase when transitioning from a traditional FFS program to a managed care environment. For instance, in the estimated cost savings analysis, office visit utilization was increased to reflect the shift of avoidable ER visits to office visits under a managed care program. Utilization and costs identified as “non-avoidable” were assumed to not be reduced by the transition from a FFS to managed care program. Cost savings may be generated by reducing avoidable costs through better care management practices.

For the ABD population, pharmacy costs are generally a large component of an individual’s costs. However, managed care savings from pharmacy expenditures may be limited due to Indiana’s Preferred Drug List[2] (PDL) program. Features of the PDL program that result in cost reductions to the State include:

- The PDL program does not require prior authorizations for preferred drugs, but generally requires prior authorizations for non-preferred drugs.
- Brand name drugs with an available generic substitutable generic are non-preferred unless otherwise specified on the PDL.

In accordance with Indiana law, all antianxiety, antidepressant, antipsychotic, and “cross indicated” drugs are considered as being preferred, and therefore, in general would not require prior authorization. These drug classes are not listed in the PDL. To the extent Indiana law was changed, savings may be possible from these drug classes by switching individuals to generic equivalents when medically appropriate.

[2] See https://inm.providerportal.catamaranrx.com/rxclaim/INM/Downloads/Catamaran%20Master%20Preferred%20Drug%20List%20%20Links%20updated%2007112013_2.xls.

ESTIMATED CLAIMS COST SAVINGS BY TYPE OF MANAGED CARE

The potential savings from transitioning the ABD population from a FFS arrangement to a full risk-based program is estimated in this section.

The following table illustrates a best estimate of claims savings from the implementation of managed care initiatives for each ABD population. The degree of healthcare management will influence the amount of savings that is achievable. Estimated savings are based on the methodology outlined in the "Avoidable Costs" section above. Generally, a program with less rigorous management will achieve less savings, while a program with more rigorous management will achieve more savings. Implementing a full risk-based program does not guarantee estimated savings will be achieved.

These estimates are for fully functioning managed care programs. Transitioning to a managed care environment may take multiple years. Therefore, the managed care savings may not fully materialize immediately.

Population expenses for SFY 2011 through SFY 2012 period by service category are illustrated in Table 7 on a per member per month (PMPM) basis, along with a best estimate of ***claim savings*** for the same time period if a managed care program were in place. Inpatient and emergency room categories of service reflect both facility and professional expenses.

Table 7

STATE OF INDIANA
Family and Social Services Administration

Aged, Blind, and Disabled Analysis
Claims Cost and Estimated Savings PMPM by Population
SFY 2011 and 2012 Combined

Population	IP	ER	Other OP	Other Prof	Rx	LTSS	Other	Total	Estimated $ Savings	Estimated % Savings
Care Select	$ 600	$ 89	$ 348	$ 126	$ 438	$ 45	$ 98	$ 1,745	$ 191	11%
Community Non-Dual	803	83	390	132	240	39	63	1,751	255	15%
Community Dual	45	7	103	17	5	29	47	253	13	5%
M.E.D. Works Non-Dual	575	58	461	162	473	28	39	1,796	203	11%
M.E.D. Works Dual	18	5	169	66	5	29	26	319	7	2%
Aged & Disabled Waiver Non-Dual	1,117	81	920	118	629	1,380	1,455	5,699	480	8%
Aged & Disabled Waiver Dual	61	6	155	14	5	1,394	886	2,522	24	1%
Family Supports Non-Dual	86	16	60	31	144	700	118	1,156	43	4%
Family Supports Dual	5	2	51	9	4	688	63	823	2	0%
CIH Waiver Non-Dual	216	37	206	61	489	5,517	302	6,828	103	2%
CIH Waiver Dual	15	3	54	15	8	5,170	177	5,441	5	0%
Other Institutional Non-Dual	646	39	213	87	554	5,949	516	8,004	259	3%
Other Institutional Dual	25	3	1,065	9	12	3,825	19	4,957	14	0%
Nursing Home Non-Dual	2,275	68	355	132	703	4,464	162	8,160	863	11%
Nursing Home Dual	43	2	14	4	12	3,479	16	3,570	17	0%
Under 21 Non-Dual	198	23	336	65	263	501	141	1,528	48	3%
Under 21 Dual	50	11	204	24	93	1,437	118	1,937	14	1%

The majority of estimated savings for each population is a result of a decrease in inpatient expenditures. Additionally, savings is expected to be achieved through the redirection of emergency room visits. The rest of the savings generally is attributable to estimated pharmacy savings. No savings were assumed for long term services and supports (LTSS), which includes both long term care and waiver services. In order to estimate savings for the long term care and waiver services, a plan of managed care would need to be obtained and evaluated.

DISCUSSION OF RESULTS

Care Select and Community, and M.E.D Works Populations

Care Select

The Care Select population has lower estimated claims savings relative to the community non-dual population, because they are already in a managed FFS program. A review of historical experience data indicated lower inpatient hospital utilization in the Care Select population relative to the community non-dual population. However, the chronic illnesses prevalent in many of the individuals in this population also make it suitable for care management. The Care Select program currently makes a monthly payment to medical providers who manage Care Select individuals. The administrative expenses with this program are not included and are discussed later in this report.

Community

The community non-dual population offers the most potential for savings on a percentage basis. As with most populations, most of the estimated savings is in the inpatient service category. This population is currently not managed and may experience reduced claims costs under a healthcare management program.

The estimated savings is significantly less for the community dual population than the community non-dual population, because Medicare would be the primary beneficiary of any healthcare management program. The opportunity for savings may be greater if a financial alignment initiative was agreed upon with CMS. Claims data limitations with the dual population also create more uncertainty regarding potential managed care savings from this population.

M.E.D. Works

The M.E.D Works non-dual population's estimated claim savings is 4% lower than the community non-dual population's best estimate. The difference in estimated potential claim savings is attributable to the different cost profiles of the populations. The M.E.D. Works non-dual population experiences approximately $225 PMPM less in inpatient claims, where the majority of potential cost savings is estimated. This population's estimated PMPM savings is the fifth highest of the populations defined in this report.

As with the community dual population, managed care savings for the State are limited because of shared coverage responsibility with Medicare.

Waiver Populations

The waiver populations' claims cost is largely attributable to the cost of waiver services, and no claims cost savings were estimated to be attainable for the waiver services. In order to estimate savings for the waiver services, a plan of managed care would need to be obtained and evaluated.

Aged and Disabled Waiver

Relative to the other waivers, the Aged and Disabled Waiver offers the most potential for claims savings. The Aged and Disabled Waiver non-dual population's high inpatient costs ($1,117 PMPM) offer opportunity for management. Actual waiver expenses, which were not evaluated for potential claims savings, are approximately 25% of the non-dual population's costs.

As with the other dual populations, managed care savings for the State are limited because of shared coverage responsibility with Medicare.

Family Supports Waiver

Relative to the Aged and Disabled non-dual population, the Family Supports Waiver non-dual population is characterized by lower inpatient and emergency room costs, which results in less opportunity of reducing claims costs through managed care. Actual waiver expenses, which were not evaluated for potential claims savings, are approximately 60% of the non-dual population's cost.

As with the other dual populations, managed care savings for the State are limited because of shared coverage responsibility with Medicare.

Community Integration and Habilitation (CIH) Waiver

Relative to the Aged and Disabled Waiver non-dual population, the CIH Waiver non-dual population is characterized by lower inpatient and emergency room costs, which results in less opportunity to reducing claims costs through managed care. Actual waiver expenses, which were not evaluated for potential claims savings, are approximately 80% of the non-dual population's cost.

As with the other dual populations, managed care savings for the State are limited because of shared coverage responsibility with Medicare.

Institutional Populations

The institutional populations' claims cost is largely attributable to the cost of institutional services, and no claims cost savings were estimated to be attainable for the institutional services. Institutional costs are typically managed by diverting less medically needy individuals to a home and community based setting. The State already has waiver programs in place designed to move suitable individuals from an institutional setting to a home and community based setting. It is not clear whether a managed care plan would be able to achieve any additional claims cost savings with an institution diversion program or any similar program. In order to estimate savings for the institutional services, a plan of managed care would need to be obtained and evaluated.

Nursing Home

Relative to the other institutional populations, the nursing home non-dual population offers the most potential for claims savings. The high inpatient costs ($2,275 PMPM) of this population indicates opportunity for management. LTSS expenses, which were not evaluated for potential claims savings, are approximately 55% of the non-dual population's costs.

Approximately 40% of individuals entering a nursing home were not Medicaid eligible before entering a nursing home.

As with the other dual populations, managed care savings for the State are limited because of shared coverage responsibility with Medicare.

Other Institutional

The non-dual population's estimated PMPM savings is the third highest, but the savings as a percent of total costs is not as high relative to the other populations. LTSS expenses, which were not evaluated for potential claims savings, are approximately 75% of the non-dual population's costs.

As with the other dual populations, managed care savings for the State are limited because of shared coverage responsibility with Medicare.

Under 21 Populations

The under 21 population includes all individuals under the age of 21 who otherwise would be included in the above populations. Many of the under 21 year old individuals are already managed in the Care Select program, so there may be less opportunity for additional claims savings from managing these individuals.

Under 21

The under 21 non-dual population has relatively low inpatient ($198 PMPM) and emergency costs ($23 PMPM), resulting in limited opportunity for care management.

As with the other dual populations, managed care savings for the State are limited because of shared coverage responsibility with Medicare.

HOME AND COMMUNITY BASED SERVICES MANAGEMENT PROGRAM

The legislature directed FSSA to estimate the potential cost savings to Indiana under three types of managed care delivery systems: a risk-based managed care program, a managed FFS program, and a home and community based services management program. Estimates have been provided for risk-based managed care program and managed FFS programs. However, savings illustrated for home and community-based long term services and supports has generally been illustrated as 0%.

Under the current delivery system, waiver services are already managed. Each waiver includes case management services, which are generally mandatory. The role of the case manager is defined in the DDRS waiver manual as follows: "care planning, service monitoring, working to cultivate and strengthen informal and natural supports for each participant, and identifying resources and negotiating the best solutions to meet identified needs." More information on case management for DDRS is available on pages 98 – 104 of http://www.in.gov/fssa/files/Part_10_-_Service_Def.pdf. Corresponding information for case management services provided for Division of Aging waivers is on pages 47 – 49 of http://www.in.gov/fssa/files/DA_HCBS_Waiver_Provider_Manual.pdf. In addition to case management services, DDRS will provide Health Care Coordination services to CIHW recipients beginning January 2014.

Although waiver services are already managed, case managers normally focus specifically on waiver services rather than on the full spectrum of Medicaid services a participant receives, including hospital, physician, pharmacy, and home health services. It is possible that increasing the case manager's responsibility, or replacing case management with a more comprehensive management service, would lead to better managed care. However, any savings would probably have to be approached in an oblique manner – not directly through limitations or service restrictions. As noted in the Indiana-Specific section of this report, most of Indiana's previous attempts to limit services for this vulnerable population have been rejected by the courts.

An innovative solution is needed in order to access the potential savings available from the management of waiver services. The Indiana courts have made it clear that any savings must be achieved in a manner that does not compromise health and safety.

ADMINISTRATIVE COSTS OF MANAGED CARE

The estimated savings illustrated in the prior section do not include a provision for the administrative cost of managed care. The administrative costs of managed care include but are not limited to the cost of managing healthcare, claims adjudication, and a contribution to the health plan's surplus or profit. Administrative costs are dependent upon the cost of these items, as well as the population under management and contractual provisions. Table 8 illustrates the estimated savings from the previous section, the estimated administrative cost, estimated health insurer fee load, and net savings by population.

Table 8

STATE OF INDIANA
Family and Social Services Administration

Aged, Blind, and Disabled Analysis
Estimated Percent Net Savings by Population
SFY 2011 and 2012 Combined

	Best Estimate Savings			
Population	% Claims Savings	Admin %	Health Ins Fee	Net Savings
Community Non-Dual Care Select	11.0%	(6.5%)	(2.4%)	2.1%
Community Non-Dual	14.6%	(6.5%)	(2.4%)	5.7%
Community Dual	5.2%	(10.0%)	(2.0%)	(6.7%)
M.E.D. Works Non-Dual	11.3%	(6.5%)	(2.5%)	2.3%
M.E.D. Works Dual	2.2%	(10.0%)	(2.2%)	(9.9%)
Aged & Disabled Waiver Non-Dual	8.4%	(4.5%)	(1.5%)	2.5%
Aged & Disabled Waiver Dual	0.9%	(6.0%)	(0.3%)	(5.4%)
Family Supports Non-Dual	3.7%	(6.0%)	(0.8%)	(3.1%)
Family Supports Dual	0.2%	(6.0%)	(0.3%)	(6.0%)
CIH Waiver Non-Dual	1.5%	(6.0%)	(0.4%)	(4.9%)
CIH Waiver Dual	0.1%	(6.0%)	(0.1%)	(6.0%)
Other Institutional Non-Dual	3.2%	(4.0%)	(0.5%)	(1.3%)
Other Institutional Dual	0.3%	(6.0%)	(0.6%)	(6.3%)
Nursing Home Non-Dual	10.6%	(4.0%)	(1.1%)	5.5%
Nursing Home Dual	0.5%	(6.0%)	(0.1%)	(5.6%)
Under 21 Non-Dual	3.1%	(6.0%)	(1.6%)	(4.5%)
Under 21 Dual	0.7%	(6.5%)	(0.5%)	(6.3%)

Notes

1. Net Savings = % Claims Savings + Admin % + Health Insurer Fee.
2. Values have been rounded.
3. Net savings values may differ from values in Table 1a due to rounding.

In order to produce net savings from transitioning the ABD population to a managed care program, the estimated claims cost savings must be greater than the increase in administrative costs and fees. The total percent cost of administration is divided between the administrative cost of the managed care plan and the excise tax on the health insurance industry that will be assessed annually starting in 2014.

Contracted entities were assumed to be subject to the ACA health insurer fee, which was estimated at 2.5% of the capitation rate. To the extent that that the state contracts with non-profit plans exempt from the fee, the state would realize additional savings in relation to the fee-for-service program.

The next section provides further information on the data and methodology used to develop this report.

DATA, ASSUMPTIONS, AND METHODOLOGY

This section provides further detail on the data, assumptions, and methodology used to develop this analysis. Certain methodology notes for the development of the claims cost savings estimates are outlined in the body of the report.

DATA

Medicaid claims and enrollment data were provided by the fiscal agent, Hewlett Packard (HP). Milliman relied primarily on claims with dates of service in State Fiscal Year (SFY) 2011 and 2012 (July 2010 through June 2012), with claims run-out through June 2013 or July 2013. Tables and appendices noted in the "Current ABD Enrollment and Expenditures" section used claims run-out through June 2013, and all other tables and appendices used claims run-out through July 2013.

Medicaid enrollment data includes the following information that was utilized in this report:

- Recipient ID
- Aid Category
- Level of Care
- Medicaid Program
- Medicare eligibility status
- Spend Down Status
- County

Medicaid claims data also includes the following for each claim:

- Recipient ID
- Category of Service
- Amount paid by Medicaid

SFY 2012 non-claims expenditure data was provided by the Office of Medicaid Policy and Planning (OMPP). This information was generally provided in aggregate, without population splits.

POPULATIONS

Populations were defined in the following manner, consistent with definitions used for the Monthly Financial Review. Certain tables displayed the populations using the population groupings defined in Appendix B.

- Nursing Home: level of care N, I10, I11, I13, or beginning with S.
- Other Institutional
    - ICF/ID: level of care I20
    - Hospice: level of care 51H, 52H, 53H, or 54H
    - PRTF facility claim (COS 0223 or HCPCS code T2048).
- Aging Waiver:
    - Aged & Disabled Waiver: level of care starting with A, B, J, X, Y, or Z
    - Money Follow the Person Grant: level of care 10M, 20M, 30M, 40M, 50M, or beginning with M
    - Traumatic Brain Injury Waiver: level of care starting with K or L
- DDRS Waiver
    - Family Supports Waiver: level of care starting with D
    - Community Integration and Habilitation Waiver: level of care starting with P, Q, T, U, V, or W

- DMHA Waiver: level of care starting with C or F
- Care Select: sub-program C.
- HIP ESP: MCO ID 155723420 (ICHIA)
- MA-U: Aid Category U
- M.E.D. Works: Aid Category DW or DI
- Spend Down: Spend down flag = Y
- Other Disabled: Any other individual in aid categories A, B, D, I, J, or L

ALLOCATION OF NON-CLAIMS EXPENDITURES

Non-claims expenditures were provided in aggregate, so in some cases these expenditures were allocated by population. This process was performed as follows:

- HAF for MA-U in managed care: Total managed care HAF payments for SFY 2012 were allocated to MA-U based on their share of managed care hospital expenditures. The remainder was allocated to the non-ABD managed care population and was not included in any exhibits in this report.
- Pharmacy Rebates: Allocated by pharmacy expenditures. A portion of the total SFY 2012 pharmacy rebates was allocated to non-ABD populations.
- ESP Transfer Payments: 100% allocated to the HIP ESP population. Allocated between Dual and Non-dual ESP enrollees based on relative claims expenditures.
- M.E.D. Works Premiums: 100% allocated to the M.E.D. Works population. Allocated between Dual and Non-dual M.E.D. Works enrollees based on relative claims expenditures.
- Medicare Buy-In: Allocated to the Dual and Partial eligible ABD population, allocated between them based on enrollment.
- Clawback Payments: Allocated to the Dual ABD population only, by enrollment except that spend down enrollees were assumed to only have a 25% chance of meeting spend down and incurring a clawback payment.
- DSH Payments: Allocated to population based on hospital claims expenditures.
- UPL Payments: The Nursing Home portion of the UPL payments ($155.9 million) was allocated to the nursing home population. The remainder was allocated to population based on non-hospital expenditures.

LIMITATIONS

The information contained in this report has been prepared for the State of Indiana, Family and Social Services Administration, to provide information that may assist the agency with studying the ABD population, as directed by HB 1328, Section 28. The data and information presented may not be appropriate for any other purpose.

The services provided for this project were performed under the signed Consulting Services Agreement between Milliman and FSSA approved May 14, 2010, and last amended September 23, 2013.

The letter may not be distributed to any other party without the prior consent of Milliman. Any distribution of the information should be in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the information presented.

Milliman makes no representations or warranties regarding the contents of this correspondence to third parties. Likewise, third parties are instructed that they are to place no reliance upon this correspondence prepared for FSSA 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.

Milliman has relied upon certain data and information provided by the State of Indiana, Family and Social Services Administration and their vendors. The values presented in this letter are dependent upon this reliance. To the extent that the data was not complete or was inaccurate, the values presented in our report will need to be reviewed for consistency and revised to meet any revised data.

It should be emphasized that actual results will differ from those presented here if experience does not emerge consistent with the assumptions contained in this correspondence.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. I am a member of the American Academy of Actuaries, and I meet the qualification standards for performing the analyses in this report.

Appendix A

STATE OF INDIANA Family and Social Services Administration Aged, Blind, and Disabled Analysis Estimated Aggregate Net Savings by Population SFY 2011 and 2012 Estimated Aggregate Annual Expenditures Under a Full Risk-Based Program and Excluding MRO Services				
	Estimated	Annual Claim	Best Estimate	
Population	Enrollment	Expenditures	Net Savings	% Net Savings
Community Non-Dual Care Select	24,200	$ 479,600,000	$ 12,800,000	2.7%
Community Non-Dual	22,900	470,000,000	28,200,000	6.0%
Community Dual	52,300	107,200,000	(4,300,000)	(4.0%)
M.E.D. Works Non-Dual	1,300	27,800,000	700,000	2.5%
M.E.D. Works Dual	1,700	3,900,000	(300,000)	(7.7%)
Aged & Disabled Waiver Non-Dual	1,000	68,100,000	1,700,000	2.5%
Aged & Disabled Waiver Dual	6,000	180,500,000	(9,700,000)	(5.4%)
Family Supports Non-Dual	1,300	17,800,000	(500,000)	(2.8%)
Family Supports Dual	2,200	20,800,000	(1,200,000)	(5.8%)
CIH Waiver Non-Dual	1,600	130,600,000	(6,400,000)	(4.9%)
CIH Waiver Dual	4,900	318,600,000	(19,000,000)	(6.0%)
Other Institutional Non-Dual	1,200	114,900,000	(1,400,000)	(1.2%)
Other Institutional Dual	4,400	261,100,000	(16,400,000)	(6.3%)
Nursing Home Non-Dual	1,800	176,000,000	9,600,000	5.5%
Nursing Home Dual	24,500	1,048,500,000	(58,600,000)	(5.6%)
Under 21 Non-Dual	19,700	348,000,000	(15,100,000)	(4.3%)
Under 21 Dual	200	4,500,000	(300,000)	(6.7%)
Over 21 Community Non-Dual	47,100	949,600,000	41,000,000	4.3%
All Other Non-Dual	27,900	883,200,000	(11,400,000)	(1.3%)
Total Dual	96,200	1,945,100,000	(109,800,000)	(5.6%)
Total (State and Federal)	171,200	$ 3,777,900,000	$ (80,200,000)	(2.1%)
State Expenditures Only				
Over 21 Community Non-Dual	47,100	317,900,000	13,700,000	4.3%
All Other Non-Dual	27,900	295,700,000	(3,800,000)	(1.3%)
Total Dual	96,200	651,200,000	(36,800,000)	(5.7%)
Total (State Dollar)	171,200	$ 1,264,800,000	$ (26,900,000)	(2.1%)

Notes

1. State share values were estimated using the standard FFY 2015 FMAP of 66.52%. To the extent that certain expenditures may be paid out of the Medicaid Administration account, they will not be eligible for the standard FMAP.
2. State share savings includes total savings to all applicable funds: this includes the Medicaid Assistance account, the hospital assessment fee fund and the DMHA appropriation for MRO services.
3. Note: Values have been rounded.