State of California—Health and Human Services Agency
Department of Health Care Services

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Director

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RATE METHODOLOGY LETTER

COMMUNITY BASED ADULT SERVICES (CBAS)

Effective July 1, 2012 in COHS counties (except Ventura) and October 1, 2012 in Two-Plan, GMC and Ventura counties, Medi-Cal managed care health plans will be required to provide CBAS services for their eligible members (i.e., only the CBAS-eligible members).

Contracting managed care plans have expressed concerns over the timing of payments for CBAS services and the overall timing of the rate development and approval process. They have indicated (a) that the CBAS facility-specific cost will be cash-flow intensive and (b) an unwillingness to provide the cash flows during the rate development and approval process.

Because there are so few (relatively) members that will utilize CBAS services and for the Two-Plan and GMC counties it is not yet fully known which health plans the CBAS-eligible members will enroll in, it will be difficult to appropriately build the risk of the CBAS service delivery into the normal COA group managed care capitation rates on a prospective basis. As a result, the Department of Health Care Services (DHCS) has developed a full risk payment process to cover the facility-specific component of providing CBAS services until an All Inclusive capitation rate can be developed and approved.

This full risk CBAS payment has been developed in a budget-neutral manner. Once rates are developed to cover all CBAS services (facility costs, assessments, and unbundled services), DHCS will clearly demonstrate to the Centers for Medicare and Medicaid Services the budget neutrality of this approach (costs related to the facility specific component of this approach would equal the facility costs of an All Inclusive rate). It is not DHCS's intent to reconcile and recoup the facility-specific payment. However, as stated previously, DHCS will clearly demonstrate the budget neutrality.

The payment is designed to cover the average projected cost of providing CBAS facility specific services to a utilizing member for a full month. As a result, health plans will receive payment for the additional risk assumed, but would not be guaranteed the funding would exactly match the actual costs of providing the facility specific component for CBAS. DHCS believes that this approach considers the element of risk necessary for an actuarial certification and will provide the proper incentives for the health plans to appropriately manage the utilization of CBAS services. In addition, DHCS can limit the

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payments to those members that have been assessed as being eligible for the CBAS service.

Rate Development Method

The base data is only for services covered under the definition of CBAS in the 1115 waiver and the calculated projection of services are only for Medicaid eligible individuals.

The rates do not include expenses that are the recipient's liability for recipients who establish eligibility for Medicaid by deducting incurred medical expenses from income.

For each plan, we obtained the total projected monthly cost for each beneficiary by multiplying the daily rate by the monthly number of days of service approved to obtain total days per month. These costs were summed across all beneficiaries in each plan to give a total projected monthly cost for the plan. Dividing this sum by the total number of monthly days of service for all beneficiaries in the plan gives the average cost per beneficiary per day.

It should be noted that there are two possible different daily rates payable. Each facility will receive one rate or the other for all beneficiaries based on whether it is identified as "Rural" or "Non-Rural." The daily rate for Rural facilities is $76.27. The daily rate for Non-Rural facilities is 90% of the Rural rate, or .90 x $76.27 = $68.64. Rural facilities are exempt from the 10% discount due to access issues. The average daily rate for a plan thus will be between the lower and higher of the two possible rates and will vary depending on the relative mix of beneficiaries in each type of facility. This data analysis showed that, in total, beneficiaries within a plan used a mix of the two types of facilities. An analysis was done to demonstrate that the months used to project the days per month and mix of Rural versus Non-Rural days are generalizations to future time periods.

Only the administrative costs directly related to the provisions of the approved 1115 waiver services to Medicaid eligible members are built into the rates.

No FQHC wrap-around amount was included in the calculation of the daily rate.

No adjustment was made for incomplete data as very current complete data was acquired from the Department of Aging.

A review of the data does not show evidence of catastrophic claims or high numbers of CBAS days, so there is no distortion of per capita costs due to those factors.

The full risk CBAS payment has been developed in a budget-neutral manner. No data smoothing was necessary. Once rates are developed to cover all CBAS services (facility costs, assessments, and unbundled services), DHCS will clearly demonstrate to the Centers for Medicare and Medicaid Services the budget neutrality of this approach (costs related to the facility specific component of this approach would equal the facility costs of an All Inclusive rate). It is not DHCS's intent to reconcile and recoup the facility specific payment. However, as stated previously, DHCS will clearly demonstrate the budget neutrality.

There are no stop loss, reinsurance, risk-sharing, or incentive arrangements in these rates.

Beneficiaries were identified and approved as eligible for CBAS services by qualified case managers under the sponsorship of DHCS and the health plans in each county. We then obtained the daily rate that is currently payable to the adult day care facilities on behalf of each approved beneficiary and the number of days per month that were approved.

The total current cost for each plan was divided by the number of beneficiaries to get the (average) claims cost per beneficiary per month. Amounts were then added to cover the plan's administration costs and profit (including contribution to surplus or reserve). The result is called the "Proposed Rate of Payment." The administration and profit loads amounts were set at 2% (of the total) each. The claims costs are rather large when compared to those for other categories (e.g. "healthy families"), since they cover a group that is defined as eligible for and receiving benefits. Thus the percentage loads for administration and profit should be a relatively smaller percent than other categories. Over all categories of members, the combined administrative and profit loads approximate 7%. We have discussed this issue (viz., the basis for the loads for administration and profit) with our actuarial consultants from the Mercer Consulting Firm and have deemed the loads reasonable.

Each plan is to receive the "Proposed Rate of Payment" multiplied by the estimated number of beneficiaries receiving adult day care services.

It should be noted that due to the nature of this data analysis, there are no "trend" factors applied. We are taking very current data and using it to pay the plans for costs of known users of adult day care facilities. This assumes that current experience applies to the near future, which is appropriate because all of the current CBAS beneficiaries have

recently been approved as eligible. Thus no adjustments to the base data are necessary for days per month or the mix of rural vs. non-rural. On average, these payments are actuarially sound and sufficient.

Below is a ***sample*** simplified outline of the proposed rate development elements and approach:

Sample CBAS Payment Development

Estimated average monthly CBAS utilization:	13.943 days per month
Estimated average cost per CBAS day:	$ 73.817 cost per day
Total estimated monthly service cost:	$1,029.21
(multiplication does not necessary match exactly due to rounding)	
Add in administrative loading (2% of total rate)	$21.44
Add in loading for profit/risk/contingencies (2% of total rate)	$21.44
Total Sample Facility Specific Payment	$1,072.09
Estimated number of beneficiaries receiving services	769
Monthly payment to health plan	$824,439

Please note that the estimated average cost per CBAS day was developed on a county-specific basis and is predicated upon the number of CBAS days and facility mix for eligible beneficiaries in the Fee for Service System. Payments will be made to contracting health plans prospectively during the month of service. It is DHCS's intent to terminate this payment arrangement coincident with the implementation of the California Coordinated Care Initiative. Additionally, contracting health plans will be required to submit in arrears data on historical facility cost and utilization. This data will be used to develop prospective rates for a future rate period.

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