

California Association of Health Plans (CAHP) and
Department of Health Care Services (DHCS)
Conference Call on May 20, 2010
Questions and Responses

Plan Rates

1. Can DHCS provide more detail on the 3.7-percent increase in Plan rates?

The rate increase was calculated based on cost and utilization data reported by managed care plans, including rate-development templates (RDTs), encounter data, and financial statements. This base data is adjusted through the actuarial process, which utilizes economic and statistical analysis, actuarial judgment, and the application of appropriate cost and utilization trends. This rate increase is an average percentage of all rate adjustments across all Medi-Cal managed care plans and models.

- a. What does the rate reflect? For instance, is this a per-member-per-month (PMPM) increase?

The increase is the average percentage of the change in rates calculated based on the overall increased percentage of plan costs and utilization as compared to the previous year, as determined through the actuarial process.

- b. Is the 3.7-percent rate increase net of other proposed reductions?

The increase includes a pharmacy adjustment as discussed in the next question. Please note that the 2010-11 rates in DHCS's May Revise budget estimate are draft rates that may change based on the outcome of State Budget negotiations between the State Legislature and Governor. Because the savings proposals included in the May Revise have not yet been approved by the State Legislature, none of the proposals have been implemented in the 2010/11 rates yet.

2. Was an efficiency factor applied? If yes, how?

Yes, an adjustment for the maximum-allowable-cost (MAC) drug pricing efficiency adjustment is included in the 2010-11 rates. See question number 8 below for information of the methodology.

3. Can DHCS break down the increase for the models of managed care?

The average increase for all Plans by Model type is as follows:

- Two-Plan Model (TPM) is 3.8 percent.*
- County-Operated Health System (COHS) model is 3.1 percent.*
- Geographic Managed Care (GMC) model is 7.2 percent.*

4. Does the 3.7-percent rate increase include long-term care (LTC) facility increases?

No, there are no LTC facility increases included in the 2010/11 rates.

5. Does the 3.7-percent rate increase include hospital funds provided under AB 1383 (assuming CMS approval)?

No, the average rate increase only reflects existing data and program policy and does not include any funding for AB 1383.

6. Do the rates for 2010-11 reflect the additional revenue available under AB 1422, the managed care organization (MCO) tax?

Yes, the impact of AB 1422 (through 6/30/11) has been factored into the draft 2010-11 rates.

7. Will DHCS share Plan enrollment forecasts by aid code so Plans can perform budget and resource modeling?

DHCS develops enrollment forecasts by aid code groupings. Staff is currently compiling this information, which must be financially and legally vetted before its publication can be authorized; however, DHCS will publish this information once this authorization has been received.

8. How did DHCS develop the pharmacy pricing adjustment, and what criteria did DHCS use to make the \$17-million adjustment to the 2010-11 rates?

The pharmacy adjustment for each managed care model type is:

- COHS is estimated at \$17 million,*
- TPM is estimated at \$29 million, and*
- GMC is estimated at \$3 million.*

The criteria used to make these adjustments were discussed at the all-Plan meeting on May 5, 2010. Please see the Department's website for the Medi-Cal Managed Care program at:

<http://www.dhcs.ca.gov/dataandstats/reports/Pages/MMCDCapRateandDevRpt.aspx> for information on the rate-setting method. Please select "May 5, 2010" under All Plan Rate Development Meetings, and scroll down to slide 35 for an outline of Medi-Cal Pharmacy Cost Management Efficiency Analysis.

9. How can Plans anticipate how this rate-setting method will be applied to them?

These adjustments appear as line items for each managed care model in DHCS's budget estimate submitted to the Department of Finance for consideration of the State Legislature and Governor. Individual Plan information is not available at this time.

10. Regarding the radiologist rates being cut to 80 percent of Medicare: does this include the facility component of those rates?

DHCS assumed that managed care plans are already compensating radiology services at 80 percent of Medicare or below; therefore, no reduction in radiology was applied to managed care rates.

Enrollment

1. How will the proposed elimination of CalWORKS affect the Medi-Cal eligibility of persons whose Medi-Cal eligibility was based on their CalWORKS enrollment? Although we assume their Medi-Cal eligibility will continue, if they are required to re-apply because their aid code changes to something unrelated to CalWORKS, then they might fail to re-apply and Plans may lose these persons as members.

Persons eligible for CalWORKS are automatically eligible for Medi-Cal. If CalWORKS is eliminated when the State Budget is approved, these beneficiaries would not be required to re-apply; rather, we anticipate at this time that Health Care Options would automatically roll them over into another applicable aid code under 1931(b), probably under aid code 3N.

Section 1115 Waiver

The recently published May 2010 Medi-Cal Estimate assumes that the managed care capitation rates for carved-in services will be 90 percent of fee-for-service (FFS) costs; the estimate is based on a comparison between current FFS costs for the non-enrolled seniors and persons with disabilities (SPDs) and Two-Plan and GMC rates for SPDs currently enrolled in these Plans.

1. Please detail how the managed care rate for the mandatory SPD population was developed. What was the base? How was the base discounted for services carved out in managed care, such as long term care?

Final rates have not been determined; the estimated expenditures shown in the May Revise were developed with the assumption that the same rates would apply to both the current and the new population of SPDs. A study performed by DHCS's consulting actuaries indicated that there would be, on average, no difference in costs between SPD populations under the Medi-Cal managed care and FFS models.

2. How will county funds that are matched with State funds to draw down federal financial participation (FFP) for county hospital services be incorporated into the Medi-Cal managed care rate?

- *If this question is referring to the quality assurance fee associated with AB 1383, federal approvals have not yet been obtained, and no adjustment has been made yet to the rates.*
- *If a county chooses to participate in the IGT process, DHCS will work with the Centers for Medicare and Medicaid Services (CMS) to obtain approval for federal matching funds and will implement the process so that it is consistent with current policies.*

3. How to guarantee an actuarially sound rate AND budget neutrality?

DHCS is still in the process of performing calculations for the 1115 waiver; however, DHCS believes that capitation rates can be developed that are both actuarially sound and budget neutral.

Medi-Cal Cost Containment – Utilization and Copay Caps – Optional Benefits

1. How will copays/utilization caps impact managed care rates?

Capitation rates are expected to decrease along with the decreasing costs to Medi-Cal providers based on decreased beneficiary utilization.

2. Over-the-counter drugs: What will be the saving of not covering non-legend cold/cough and acetaminophen-containing products? How will this affect Plan rates?

As noted in the May Revise policy change (PC) 198, 2010-11 total-funds managed care savings are estimated at \$2.1 million assuming an implementation date of October 1, 2010. This reduction has not been included in the draft rates.

3. If spending limits are established for the optional benefits, can a Plan elect to provide them anyway?

Yes, but DHCS will not include the Plan's cost or utilization data for optional benefits in its capitation rates.

4. Regarding the six-prescription-per-member listing: Is there a specific listing of excluded drugs other than just the term "life-saving drugs"?

A specific listing of excluded drugs has not yet been developed. Once it is available, we will release it to our plans.

GMC TBL

1. Regarding the trailer bill language for GMC Program Administration: The proposed language for Welfare & Institutions (W&I) Code, Section 14089(c)(1)(B), includes preserving the voluntary nature of managed care enrollment. Does this need to be changed considering the [pending SPD] waiver?

Yes, the law would need to be changed along with waiver changes.

2. TBL contains new language re: disclosure of the contracts, rates, rate manuals, etc. How is this different from current or previous rate development practice?

Per Government Code Section 6254(q), rates and documentation related to rate setting are considered confidential if negotiated by the California Medical Assistance Commission (CMAC). Once DHCS takes over this process, the information is no longer considered confidential. However, anything related to CMAC negotiations will be kept confidential for four years.

Long-Term Care (LTC) Rates and AB 1629

Specific to LTC-facility room and board:

1. What is the status of any reauthorization of AB 1629? Is it up? Is there a reauthorization?

AB 1183 extends the sunset of AB 1629 to July 31, 2011.

2. Are there AB 1629 rate increases in the May revise? If so, how much is in the budget? Are there funds for Plans in the budget for these increases?

The rate increase to AB 1629 facilities in the May revise is calculated on a statewide basis; DHCS is still in the process of determining how this will affect specific managed care plans.

3. What's the status of the facility COLAs? Again, are there funds for Plans in the budget?

The May Revise does not include a COLA for long-term care facilities for 2010-11; therefore, no funds have been budgeted for managed care plans.