

DHCS Capitated Rates Development Division All Plan Webinar

June 8, 2012

Agenda

1. Opening remarks and introductions
2. Potentially Preventable Admissions (PPA)
3. CBAS – Interim Payment/Rate Development
4. Healthy Families Program (HFP) Rates
5. Affordable Care Act (ACA)
6. Rate Timeline
7. Open Forum
8. Closing remarks

Potentially Preventable Admissions (PPA)



PPA

- Current status
 - PPA analysis has been run on CY10 encounters
 - Mercer and DHCS reviewed comments received from the health plans and made adjustments to methodology
- Prior discussions and/or presentations on PPA
 - May 5, 2010
 - August 12, 2010
 - March 22, 2011
 - July 21, 2011
 - October 18, 2011
 - February 27, 2012
 - April 5, 2012

PPA – Health Plan Feedback/Discussion

- Goals
 - Establishing benchmarks, goals
- Data
 - Blinded results
 - Individual member level and claims detail data
 - Member level Medicaid Rx scores
- Methodology/Assumptions
 - Duration factors
 - Admissions through the ER
 - County level differences in disease prevalence
 - Dual eligible populations
 - Analysis using historical data
 - Lack of encounter data due to delegated model

PPA – Current Methodology

Step 1: Extract members based on Medicaid Rx Risk Score.

- Risk scores assigned to the entire population, by category of aid group (Adult/Family or Aged/Disabled Medi-Cal only) and by county
- Top decile (10%) of members with the highest risk scores removed by category of aid group and by county
- Applied to the entire population rather than only those members with a PPA qualifying event

Step 2: Identify IP related encounter data, define the PQIs and PDIs.

- CY10 inpatient hospital encounters (facility component only) extracted as input into the analysis

Step 3: Extract and summarize IP encounter data that satisfies the PQI and PDI diagnosis code, procedure code, and exclusion criteria.

- Inpatient hospital encounter data extracted based on the PQI and PDI definitions developed by AHRQ
- PQI 02: Perforated Appendix Admission Rate excluded from analysis

PPA – Current Methodology

Step 4: Analyze IP PQI and PDI data by Enrollment Duration.

- Individuals with an enrollment duration ranging from four to twelve months (varies by PQI and PDI) considered for the analysis

Step 5: Determine the dollars/days associated with PQI/PDI admissions.

- The total dollars/day for the remaining admits are then summarized by health plan, population, and PQI/PDI.

Step 6: Determine benchmarks.

- Health plans (Two-Plan, GMC and COHS combined, separately by COA grouping) were ranked in order of PPA results (lowest level of PPA admissions to highest)
- Benchmark set based on the lowest level of PPA admissions achieved by the Medi-Cal health plans representative of 10 percent of the membership.

PPA – Current Methodology

Step 7: Apply benchmark methodology to health plans and apply managed care model averages to health plan results determined to be unreliable due to data issues.

- Health plans that have achieved the benchmark PPA level do not receive a PPA adjustment
- Health plans that did not achieve the benchmark receive an adjustment equivalent to their actual results less the benchmark level
- Health plans that have been found to have unreliable data receive an adjustment equivalent to the health plan average PPA adjustment less the benchmark level.

Next Steps

- CY10 health plan-specific and blinded results to be shared

CBAS – Interim Payment/Rate Development



CBAS – Interim Payment/Rate Development

- CBAS Payment Rates – Interim Approach Goal
 - To provide sufficient cash flow to contracting health plans for CBAS facility services provided to Medi-Cal beneficiaries until a fully integrated rate can be developed and approved by CMS.
- Issues
 - 2012-13 Capitation Rates may not be completed and approved by CMS until March 2013.
 - Contracting Health Plans expressed concerns about the extensive amount of cash flow needed to fund CBAS facility services.

CBAS – Interim Payment/Rate Development

- CBAS Implementation Schedule
 - COHS Plans (with the exception of Ventura) will be providing facility services July 1, 2012.
 - TPM and GMC Model Plans – Will begin providing facility services October 1, 2012.

CBAS – Interim Payment/Rate Development

- Approach to Payments
 - The rates must reflect some level of risk in order to get CMS approval.
 - Desire to keep reporting and payments simple.
 - Payment methodology incentivizes plans to appropriately manage the utilization of CBAS services.
 - Payment will be county-specific and monthly.
 - Payment system is prospective and NOT based upon actual historical utilization in arrears.
 - Plans will be required to submit a roster of members utilizing CBAS services on a monthly basis (after month end).
 - Plans will be required to submit actual utilization and payments 30 to 45 days in arrears.
 - DHCS is working on record layout and data submission systems and will be communicating with plans shortly on this issue.

CBAS – Interim Payment/Rate Development

- Rate Setting Methodology
 - Fee for Service (FFS) Facility utilization and mix will be examined for CBAS beneficiaries.
 - Based upon the results of the analysis DHCS/Mercer will project average Facility Utilization per CBAS utilizing member on a prospective (monthly) basis.
 - DHCS and Mercer will calculate an average facility cost based upon prior utilization and facility mix in FFS.

CBAS – Sample Interim Rate Development

Estimated average weekly CBAS utilization (days)	3.2
Conversion to monthly utilization (30.4 days per month)	13.9
Estimated average cost per CBAS day	\$76.27
Total estimated service cost	\$1,060.15
Add: Administrative load of 2%	\$21.20
Add: Profit/risk/contingency 2%	\$21.20
Total Sample CBAS Facility Rate	\$1,102.56

Projected Timing of Rate Approvals

- September 1, 2012 at the latest for COHS – Rates will be paid retroactive to July 1, 2012.
- October 1, 2012 for TPM and GMC.
- Anticipate Terminating Interim Payment Arrangements March 1, 2013 with the implementation of CCI and the implementation and development of a fully integrated rate with all CBAS services.

Comments/Questions

- Questions ?

Healthy Families Program (HFP) Rates



Healthy Families Program (HFP) Rates

Current Legislation

- October 1, 2012 Transition
 - Direct contractors (HFP and Medi-Cal Plan both contract within the county) will have HFP members passively enrolled to the Medi-Cal Plan
- January 1, 2013 Transition
 - In-Direct contractors (HFP Plan who subcontracts to a Medi-Cal Plan within the county) will have HFP members passively enrolled to the subcontracting Medi-Cal Plan
- March 1, 2013 Transition
 - Remaining members who were not part of the Direct or In-Direct contractors will be phased into Medi-Cal based on a to-be determined algorithm

Healthy Families Program (HFP) Rates

Rate Development Process

- Benefit package will be the same as existing Family Medi-Cal
- Transitioning members will be the “bright line” population (ages 6-19)
- Rates will be developed based on usable Managed Care Experience with consideration of the age bands transitioning (6-13, 14-17 and 18-19)
- Rates will be Plan Specific with some consideration of County Averages
- Ratesetting process will be reflective of transitioning member structure
 - Initial rates for October will be for direct contractor members transitioning
 - January rates will take into consideration the addition of indirect contractor members
 - Final March and beyond rates will consider full population

Affordable Care Act – Payments for Primary Care



Summary of Proposed Rule

- The Affordable Care Act (ACA) (Section 1202) mandates increased payments for Medicaid primary care in 2013 and 2014.
 - Medicaid FFS and managed care programs must reimburse primary care providers (PCPs) for these services at rates equal to Medicare.
 - The federal government will provide 100% federal match for this increase, which is intended to improve access to primary care services in Medicaid in preparation for the program's expansion in 2014.
 - This proposed rule defines primary care services, eligible providers, the applicable Medicare reimbursement rates and provides guidance on calculating the rate differential for the purpose of claiming the 100% federal match.
 - The rule also updates the interim regional maximum fees that providers can charge for the administration of pediatric vaccines under the Vaccines for Children (VFC) program.

Process

- In order for states to increase PCP payment rates and claim enhanced federal funding, the State must ensure that the provider is eligible for the increased payment, that the primary care service codes are eligible, that the State Plan and managed care contracts have been appropriately amended and that, for managed care, the amount of the differential in rates between CY 2009 and CYs 2013/2014 has been appropriately calculated, documented and approved by to the Centers for Medicare and Medicaid Services (CMS).

Eligible Primary Care Providers

- Providers eligible for the increase are physicians with a specialty designation of family medicine, general internal medicine or pediatric medicine and all subspecialists recognized by the American Board of Medical Specialties within these three specialty designations.
- Primary care services rendered by non-physician practitioners under the personal supervision of an eligible PCP are also eligible for the enhanced funding to the extent that eligible codes are billed using the provider number of the eligible supervising physician. Physicians and other providers outside of these specialty designations that provide primary care, as well as federally qualified health centers and rural health centers, are not eligible providers under the proposed rule.

Eligible Primary Care Providers - continued

- Providers may self-attest to being an eligible physician. However, under the proposed rule, self-attestation alone is not sufficient, and states must establish a system to verify provider eligibility **prior** to making an increased payment in one of three ways:
 - Verification of board certification status in one of the identified specialties or subspecialties (Note: States are not currently required to record or track board certification, so this may be a challenge.)
 - If a physician is not board certified, review the physician's billing history to ensure at least 60% of the Medicaid codes (not charges) billed by the physician for all of CY 2012 are for the eligible evaluation and management (E&M) codes and vaccine administration codes eligible under the proposed rule. CMS is seeking comments on the appropriateness of the 60% threshold.
 - For physicians not board certified and without 12 months of paid Medicaid claims history, data on codes billed must be reviewed from the date of enrollment through the end of the enrollment CY.

Eligible Primary Care Services

- Primary care services eligible for higher payment are limited to Healthcare Common Procedure Coding System E&M Current Procedural Terminology (CPT) codes 99201 through 99499 and vaccine administration codes 90460, 90461, 90471 through 90474 or their successor codes. This includes primary care service codes frequently billed in Medicaid, but not reimbursed by Medicare.

Amount of Required Minimum Payment (Application of the Medicare Physician Fee Schedule (MPFS) for CY 2013 and 2014

- For eligible primary care services in CYs 2013 and 2014, states must pay the lesser of:
 - The Medicare Part B fee schedule rate applicable to the site of service and geographic location of the service (i.e., multiply the Medicare Conversion Factor (CF) in effect at the beginning of the CYs 2013 and 2014 (or the 2009 CF if higher) and the CYs 2013 and 2014 relative value units (RVUs)). Note: Through the use of the greatest of the 2013/2014 or the 2009 CF, the rule proposes to make the calculation of the PCP increase independent of Medicare payment reductions that would be caused by Medicare's sustainable growth rate mechanism. This proposed methodology also accounts for the site of service (for example, physician's office or outpatient department of a hospital) and geographic location of the provider.
 - The provider's actual billed charge for the service.

Additional Fee Schedule Considerations

- CMS will develop a fee schedule for services reimbursed by Medicaid but not Medicare prior to the beginning of CYs 2013 and 2014. The rates for non-Medicare reimbursed services would be established using the Medicare CF in effect in CYs 2013 and 2014 (or the CY 2009 CF, if higher) and the RVUs recommended by the American Medical Association's Specialty Society Relative Value Update Committee and published by CMS for CYs 2013 and 2014. CMS seeks comment on this methodology.
- Medicare primary care incentive payments made under section 5501 of ACA would not be included in calculation of the Medicare MPFS rate. These payments are not made as increases in fee schedule amounts and are not reflected in the MPFS.

Payments for Primary Care

- Affordable Care Act (ACA) - Approach and Timing
 - Adjustment to 12/13 rates with an implementation date of 1/1/13
 - Rate adjustments will have to be retroactive (impossible to calculate prospectively before 1/1/13)
 - Rate adjustments will likely have to be plan specific
 - There are a host of challenges with this that are yet to be worked through
 - The State will be commenting on the proposed rules and would encourage health plans to do the same if they feel it is appropriate.

Rate Timeline



Rate Timeline

- Ratesetting Issues
 - AB97 – Provider Rate Reduction
 - ADHC/CBAS
 - SB 208 – Designated Public Hospitals & CBRC
 - SB 335 – Hospital Rate Increase
 - Never Events

Rate Timeline

- Timeline for Future Rates
 - **Baseline CP12-13 rates (Two-Plan & GMC)** – by July 1st Mercer will produce rates that include 1) risk adjustment 2) updated efficiency adjustment 3) updated enrollment projections for transitioning vs. existing SPD enrollment 4) Exclusion of AB 97 provider cuts 5) ADHC (Enrollment risk differential and Enhanced Case Management) 6) CBAS supplemental payment.
 - **Two-Plan CP12-13 rates (Oct - Dec 2012)** – By October 15th Mercer will produce rates that include ADHC/CBAS, SB 335, SB 208, and CBRC for LA County. These rates will be trended to the midpoint of this time period (November 15).
 - **Two-Plan CP12-13 rates (Jan - Sept 2013)** – Mercer will produce rates (timing TBD, but after 1/1/13) that include ADHC/CBAS, SB 335, SB 208, CBRC for LA County, and the ACA PCP 100% of Medicare fee schedule adjustment. These rates will be trended to the midpoint of this time period (May 15).
 - **GMC CY2013 rates** – Mercer will produce rates (timing TBD) that include ADHC/CBAS, SB 335, SB 208, and the ACA PCP 100% of Medicare fee schedule adjustment.

Rate Timeline

- Timeline for Future Rates (continued)
 - **Two-Plan 10-11 rates (Jul-Sept 2011)** – Mercer has produced “baseline” rates for DHCS that include the exclusion of AB 97 provider cuts. By October 15th Mercer will produce rates that also include SB 335, SB 208 and CBRC for LA County.
 - **GMC CY2011 rates (Jul-Dec 2011)** – Mercer has produced “baseline” rates for DHCS that include the exclusion of AB 97 provider cuts. By October 15th Mercer will produce rates that also include SB 335, SB 208, and ADHC (Assessments and enrollment risk differential).
 - **Two-Plan 11-12 rates** - Mercer has produced “baseline” rates for DHCS that include the exclusion of AB 97 provider cuts. By October 15th Mercer will produce rates that also include SB 335, SB 208, CBRC for LA County and ADHC (Assessments, enrollment risk differential, and Enhanced Case Management).
 - **GMC CY2012 rates** - Mercer has produced “baseline” rates for DHCS that include the exclusion of AB 97 provider cuts. By October 15th Mercer will produce rates that also include SB 335, SB 208, ADHC (Enrollment risk differential and Enhanced Case Management), and CBAS.

Open Forum/Closing Remarks

