

DHCS Capitated Rates Development Division All Plan Meeting

September 7, 2012

Agenda

1. Opening remarks and introductions (10 minutes)
2. Rate Development Template – CY 2011 (20 minutes)
3. SPD – Status of our review of the historical SPD rates (30 minutes)
4. CP 12-13 Rates (30 minutes)
5. Ongoing Rate Issues (60 minutes)
 - ACA – 100% of Medicare fee schedule reimbursement for certain PCP services
 - CBAS and ECM
 - SB208 (Public Hospital IGTs) & SB335 (Hospital Fee)
 - HFP transition to Medicaid
 - COHS retro-eligibility
 - AB97
6. MCO Tax (10 minutes)
7. Copayments for ER Visits (10 minutes)
8. Questions / Open Forum (10 minutes)
9. Closing Remarks

Rate Development Template (RDT) – CY2011

Rate Development Template (RDT) – CY2011

Overview

- The RDT is designed to enable the health plans to provide summarized input regarding their Medi-Cal managed care related costs to DHCS/Mercer
- DHCS/Mercer have observed a continued increase in the quality of submissions over the years
- The purpose of this section of the presentation is to:
 - Review Alterations from the CY2010 RDT
 - Discuss timeframes for the CY2011 RDT process
 - Review the adhoc CY2011 SPD RDT

Rate Development Template (RDT) – CY2011 Enhancements

- **Category of Aid (COA): Adult & Family**
 - Previous Layout – Family and Adult COA groups accounted for separately
 - New Layout – Combine Family and Adult, then report by age groups “18 and Under” and “Over 18”
- **Category of Aid: Disabled Medi-Cal Only & Aged Medi-Cal Only**
 - Previous Layout – reported separately
 - New Layout – Combine these two COAs to form the “Aged/Disabled/Non-Dual” COA
- **Identification of dual eligibles**
 - Previous logic – Duals identified as anyone having Part A, Part B, or both
 - New logic – Duals identified as only those having Part A, Part B, and Part D. Part A only and Part B only individuals will be classified as “Non-Duals”. Going forward, the term “Medi-Cal Only” will be replaced with “Non-Duals”

Rate Development Template (RDT) – CY2011 Enhancements

- **COA Layout**

- New order – Adult & Family (18 and under), Adult & Family (Over 18), Aged/Disabled Non-Dual, Disabled/Dual, Aged/Dual, BCCTP, Aids/Non-Dual, Aids/Dual, LTC/Non-Dual, LTC/Dual, OBRA

- **Additional Health Plans/Counties selection options**

- CalViva Health (Fresno, Kings, and Madera) – effective 3/1/11
- Anthem Blue Cross (Kings and Madera) – effective 3/1/11
- Gold Coast HP (Ventura) – effective 7/1/11
- Partnership HP (Marin and Mendocino) – effective 7/1/11

- **Comments about submissions**

- For plans in effect for only a portion of CY2011, please only submit information for that portion of the year
- Please only include actual cost and utilization, do not annualize any of your experience

Rate Development Template (RDT) – CY2011 Timing

- August 27th (Monday) – Plans received the RDT template
- October 5th (Friday) – Health Plan deadline for RDT submission
- November 2012 thru January 2013 – Conference calls with individual health plans to review/discuss submissions

Rate Development Template (RDT) – CY2011 Special Adhoc SPD RDT

- A part of our continuing analysis in response to the concerns raised by health plans related to the SPD rates (NOTE: An update on the SPD analysis will be discussed in the next section of the presentation)
- This request will provide us with information about each of our contracting health plans' utilization, cost, and enrollment information with regards to existing and transitioning SPD members for CY2011
 - Existing SPDs – Existed in managed care prior to 6/1/11
 - Transitioning SPDs – New to managed care 6/1/11 or later
- Duals Logic – please use the same duals logic as the CY2010 RDT
 - Part A only & Part B only = dual eligible
 - Same COA logic as CY2010 RDT Disabled/Medi-Cal Only and Aged/Medi-Cal Only
- Timeframes
 - Delivered: August 27th (Monday)
 - Deadline: September 10th (Monday)

SPD – Status of Review of the Historical SPD Rates

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1. Concerns raised by Health Plans/Coalition
2. Risk Differential Review
3. Member Months – Projected/Actual
4. Capitation Rates Utilized
5. Emerging Experience - Category of Service Detail
 - Supplemental RDT submissions
6. Next Steps
 - Review of data submissions
 - Update of historical capitation rates

Contract Period (CP) 12-13 Rates

Contract Period 12-13 Rates Overview

- Base Data
- Program Changes
- Trend
- Efficiency Adjustments – MAC and PPA
- Administrative Load and Profit/Risk/Contingency
- Rate Ranges
- Risk Adjustment
- Next Steps/Questions

Contract Period 12-13 Rates Base Data

- Calendar Year 2010 Encounter data
- Calendar Year 2010 RDT data
- Fee-For-Service (FFS) data
- Average contract model (smoothed) Encounter data and RDT data

Contract Period 12-13 Rates Program Changes

- Adjustments to the base data are necessary to account for program changes made that would not appear in the base data (retro and prospective)
- Mercer reviews and utilizes policy change analyses from Medi-Cal Managed Care (in some cases Mercer develops these) and Policy Change Reports from Fiscal Forecasting
- Limited Program Changes for CP 12-13
 - Adjustment for risk of new ADHC members
 - Adjustment for ECM costs of new ADHC members
 - Hospice and LTC services
 - Prior provider payment reductions

Contract Period 12-13 Rates Trend

- Trend factors are developed by Unit Cost and Utilization for each COS. LTC COS is handled through Program Change section
- We utilize the same COA/COS trend factors for all health plans within a Contract Model type
- Trend is applied to the 2010 data to get it to the midpoint of the CP 12-13 contract period for the rates
- Multiple sources for trends, including MCO data, FFS, CMAC adjustments, CPI, and various industry and government reports

Contract Period 12-13 Rates Maximum Allowable Cost (MAC)

- MAC adjustments applied to CP 12-13 rates
 - CY10 base data
 - Analysis included review of dispensing fee costs and rebates
- Health plans will receive health plan and county-specific MAC analysis summaries
- MAC list will be provided to health plans

Contract Period 12-13 Rates Potentially Preventable Admissions

- PPA adjustments applied to CP 12-13 rates
 - CY10 base data
 - Analysis included review of inpatient admissions
- Health plans have received health plan and county-specific PPA analysis summaries

Contract Period (CP) 12-13 Rates Administrative Load and Profit/Risk/Contingency

- An administrative load is added to all rates
- Utilize a fixed and variable approach
- For Two-Plan and GMC, model-specific administrative loads are developed (currently they are the same)
- At the midpoint, a 3 percent load is built in across all managed care Contract Models
- The low end of the rate range utilizes a 2 percent assumed load. The high end of the rate range utilizes a 4 percent assumed load
- Mercer has implicitly and broadly considered the cost of capital within our rating assumptions. Assumptions surrounding the UW Profit/R/C load, along with Investment Income generated, are sufficient to cover at least minimum cost of capital needs for the typical health plan

Contract Period 12-13 Rates Rate Ranges

- Mercer builds up base data and applies the various adjustments described previously to develop a midpoint rate
- Separate upper bound and lower bound trend, administration, and underwriting profit/risk/contingency loads are utilized to develop the upper and lower bound rates
- Results consider the natural statistical variation associated with components of reasonable, appropriate, and attainable rates

Contract Period 12-13 Rates Risk Adjustment

- County-average rates are risk adjusted using the Medicaid Rx Model developed by UCSD. Weighting of 65% Plan Specific and 35% risk adjusted county average for CP 12-13 rates on Adult/Family and SPDs
- The Medicaid Rx Model uses National Drug Codes (NDCs) to classify individuals into various disease categories
- The cost weights within the Medicaid Rx Model have been updated to include California-specific Medicaid data and represent the covered benefits under the Two-Plan Models and GMC
- Two-Plan and GMC Model Plans will receive the 2012-13 base rates today
- Plans will receive detailed risk score information September 11 and MAC Letters

Contract Period 12-13 Rates Next Steps / Questions

- Current CP 12-13 rates are considered “baseline” rates
- Further updates are forthcoming for the CP 12-13 rates
- Questions?

Ongoing Rate Issues

Ongoing Rate Issues

Overview

- Rating Adjustments/Program Changes
 - ACA section 1202 – 100% of Medicare fee schedule reimbursement for certain PCP services
 - Community-Based Adult Services (CBAS)
 - Enhanced Case Management (ECM)
 - SB208 (Public Hospital IGTs)
 - SB335 (Hospital Fee)
 - Healthy Families Program (HFP) transition to Medicaid
 - Retro-eligibility (COHS plans only)
 - AB97 provider cuts
- Estimated timing of rate approval

Ongoing Rate Issues

ACA Section 1202: Proposed Rule on Increased Payments for Medicaid Primary Care Services

- **Summary of the Proposed Rule**

- ACA Section 1202 mandates increased payments for Medicaid primary care in 2013 and 2014. Under the law, Medicaid fee-for-service (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.
- The proposed rule defines primary care services, eligible providers, the applicable Medicare reimbursement rates and attempts to provide guidance on calculating the rate differential for 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. The VFC administration rates are applicable to this regulation in that the difference between the updated rates and the calendar year (CY) 2009 rates may be funded at 100% federal match under the rest of this rule.

Ongoing Rate Issues

ACA Section 1202: Proposed Rule on Increased Payments for Medicaid Primary Care Services

- **Eligible Primary Care Providers & Eligible Primary Care Services**
 - Providers eligible for the increase are physicians with a specialty designation of family medicine, general internal medicine or pediatric medicine and all sub-specialists 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.
 - 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.

Ongoing Rate Issues

ACA Section 1202: Proposed Rule on Increased Payments for Medicaid Primary Care Services

- **DHCS Request to CMS for Flexibility (select comments)**

- California needs to be allowed by CMS as much flexibility as possible in choosing the payment methodology for sub-capitation arrangements; specifically, we requested to use one of the following methods:
 - An actuarial sound cost accounting analysis where the enhanced FMAP for primary care payments is calculated based upon an historical cost accounting analysis of existing health plan data of the specific provider codes; similar to what is currently done to claim enhanced FMAP for family planning.
 - A “below the line” adjustment on a per member month basis specifically indicating the enhanced funding amount for each contracting Medicaid health plan. Based upon the calculation, each plan will appropriately identify the amount of enhanced funding that will be passed onto eligible providers. This would be outside the risk structure of the contract.

Ongoing Rate Issues

ACA Section 1202: Proposed Rule on Increased Payments for Medicaid Primary Care Services

- **DHCS Request to CMS for Flexibility (select comments)**

- Would it be acceptable to CMS for states to consider the additional Medicare fee schedule payments to providers to be beyond the scope of the risk portion of the managed care contracts?
 - The MCOs would still be required to pay the providers the proper amount, but the amount claimed by the state for 100 percent federal match would be based on calculations made from retrospective review of encounter data.
- In addition to the medical cost of the extra payments to reach 100 percent of the Medicare fee, will corresponding increases in the following managed care premium rate components be matched at 100 percent?
 - The Federal Health Insurer Fee, which will be collected as a percentage of premium in 2014 based on 2013 market share and includes some MCOs with Medicaid business, but excludes some not-for-profit MCOs.
 - Premium related taxes imposed by states – premium taxes and quality assessments generally collected as a percentage of premium.
 - Underwriting gain – a premium component to cover the cost of capital at risk in the insurance operation, generally calculated as a percentage of premium.
 - Administrative expenses – generally expressed as a percentage of premium or (at least in part) as a percentage of claim dollars.

Ongoing Rate Issues

ACA Section 1202: Proposed Rule on Increased Payments for Medicaid Primary Care Services

- **Methodology Concepts Under Consideration**

- DHCS submits a proposed methodology to CMS for approval. Proposal will include a mechanism for verifying that the MCOs have completely passed through the claim cost portion of the program change to the eligible primary care providers.
- Need for collaboration between DHCS, MCOs, and CMS.
- Outside of capitation or within capitation with reconciliation? Looking to accomplish the program change goals in the most efficient manner.
- Will need at least some retrospective aspect given timing.
- Look to use MCO's provider contract rates: 7/1/09, "Current", and 2013 (and 2014) Medicare Part B (Also need to factor in any Medicaid procedure code specific bonus information).
- Look to remove the utilization risk aspect of the program change.
- A large number of questions to CMS remain outstanding, including those around sub-capitation, applicability to Medicaid expansion and stand-alone CHIP, etc.

Ongoing Rate Issues

CBAS and ECM

- **CBAS – Interim Payment/Rate Development**

- COHS Plans (with the exception of Ventura) began providing facility services July 1, 2012
- TPM and GMC Model Plans – Will begin providing facility services October 1, 2012
- 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

- **ECM**

- Adjustment for ECM costs of new ADHC members effective April 1, 2012 (affects CP11-12 and CP12-13 rates)

- **All ADHC member integration**

- Adjustment for risk of new ADHC members (affects CP11-12 and CP12-13 rates)
- Adjustment for assessments performed in October/November 2011 by health plans (affects CP10-11 GMC and CP11-12 Two-Plan rates)

Status of SB 208 (Public Hospital IGTs) & SB 335 (Hospital Fee)

- SB 208: DHCS is engaged in on-going discussions with the public hospitals
- Anticipate resolution by the end of November 2012
- Methodology and IGT amounts will be shared with Plans as soon as issues have been resolved with the hospitals
- SB 335: DHCS has received Federal Approval on the FFS Rate Methodology
- DHCS/Mercer have to determine if the combined amounts of SB 208/SB 335 meet the requirements of Actuarial Soundness.
- Based on statute SB 208 disbursements take priority over SB 335

Ongoing Rate Issues

HFP Transition to Medicaid

- **January 1, 2013 Phase I Transition**

- Direct contractors (HFP and Medi-Cal Plan both contract within the county) will have HFP members passively enrolled to the Medi-Cal Plan
- Benefit package will be the same as existing Family Medi-Cal
- All HFP members will be transitioning
- Rates will be developed based on usable Managed Care Experience
- Rates will be Plan Specific with some consideration of County Averages
- Draft Rates will be delivered to the plans by 10/31/12

Ongoing Rate Issues

Retro-eligibility (COHS plans only) & AB97

- **Retro-Eligibility**

- Effective July 1, 2012 COHS plans are no longer responsible for retro-active payments of medical expenses for new enrollees
- Current CP12-13 rates do not include an adjustment for removal of retro-eligibility obligation

- **AB97 provider cuts**

- Current CP12-13 rates do not include an adjustment for AB97
- Plan will receive updated NO AB97 rates for CP10-11 and CP11-12

Ongoing Rate Issues

Estimated Timeline for Future Rates

- **Baseline CP12-13 rates (Two-Plan & GMC)** – Mercer has produced rates that include 1) risk adjustment 2) updated efficiency adjustments 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 final CP12-13 rates (Oct - Dec 2012)** – October 31, 2012. Mercer will produce rates that include ADHC/CBAS
- **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 (if within capitation)
- **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 (if within capitation)

Ongoing Rate Issues

Estimated Timeline for Future Rates

- **Two-Plan 10-11 rates (Jul-Sept 2011)** – Mercer has produced “baseline” rates for DHCS that include the exclusion of AB 97 provider cuts; these rates do not include SB 335, SB 208 and CBRC for LA County. DHCS will be transmitting these rates within 2 weeks.
- **GMC CY2011 rates (Jul-Dec 2011)** – Mercer has produced “baseline” rates for DHCS that include the exclusion of AB 97 provider cuts. By October 31st Mercer will produce rates that include 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 31st Mercer will produce rates that also include 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 31st Mercer will produce rates that also include ADHC (Enrollment risk differential and Enhanced Case Management), and CBAS.

AB1422 MCO Tax

AB1422 MCO Tax

- MCO Tax sunset June 30, 2012
- DHCS will continue to pursue the reinstatement of this broad based tax
- Current approved rates are inclusive of the tax
- Recoupment will occur when 2012-13 rates are finalized

Copayments for ER Visits

Open Forum/Closing Remarks

