

Department of Health Care Services Capitated Rate Development Division and Mercer All Plan Meeting



December 14, 2012

SPD Rates / GHPP

SPD Rates

- Updated rates sent last Friday, December 7, 2012
 - 15 and 18 Month Rates for July 1, 2011 through September 30, 2012 (December 31, 2012 – GMC counties)
 - 12 Month CP 12-13 Two-Plan (October 1, 2012 – September 30, 2013) and GMC (January 1, 2013 – December 31, 2013)
- Methodology updates included:
 - Shift to 75/25 FFS/Risk adjusted managed care from 50/50
 - Managed care adjustments applied to FFS were scaled back
 - CY 2009 and CY 2010 base FFS data used throughout
 - April 2012 member assignment of transitioning population used for transitioning risk adjustment factor
- Outstanding issues:
 - SB 208 / SB 335
 - GHPP adjustment for Two-Plan counties
 - Minor ADHC/ECM adjustments for 15 and 18 month rates

SPD Rates

Comparison of Updated Rates to FFS Costs

	FFS Costs before Rebates {A}	FFS Costs After 43% Rebates {B}	{B} / {A}	Managed Care Costs before State Rebates {C}	Managed Care Costs after 32% State Rebates {D}	{D} / {C}	True Managed Care Savings {D} / {B}
CP 11-12							
Two-Plan	\$631	\$531	84.2%	\$541	\$497	91.8%	93.5%
GMC	\$654	\$546	83.5%	\$574	\$526	91.6%	96.3%
Two-Plan & GMC	\$635	\$534	84.1%	\$547	\$502	91.8%	94.0%

- *Note: Assumes 43% pharmacy rebates in FFS and 32% in managed care.*
- *Additionally, the FFS costs are only the medical costs (with FQHC adjusted to reflect managed care costs), the managed care costs include the admin/profit/risk contingency expense for managed care in addition to the medical costs*

Healthy Families Program

Healthy Families Program

- Previously discussed during February 27, 2012 and June 8, 2012 webinars and also September 7, 2012 All Plan meeting
- January 1, 2013 Phase I Transition (3 Month Rates)
 - Draft Rates were delivered to DHCS on 10/31/12
 - 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 Medi-Cal managed care
 - All HFP members will be transitioning
 - Rates were developed utilizing usable managed care experience by age-bands applied to existing Adult & Family experience
 - Rates are Plan Specific
- Phase II and Phase III details to be forthcoming

Healthy Families Program Rate Development Approach - Background

- The Governor's budget includes the transition of Healthy Families Program (HFP) eligible children into Medi-Cal managed care
- DHCS asked Mercer to develop capitation rates for these HFP members to be enrolled in Medi-Cal managed care
- Medi-Cal Managed Care currently serves well over 2.5 million Medi-Cal eligible children age 0 through 18. This provides a very robust data set to use in developing capitation rates that is applicable for the HFP children, if served through the Medi-Cal managed care program.
- Mercer utilized the Adult and Family category of aid (COA) group eligibility, encounter data, and related capitation rates as the basis for rate development, since this is the COA group that has the vast majority of Medi-Cal eligible children.

Healthy Families Program Rate Development Approach

- In general, we calculated the proportion of utilization and costs reported via managed care encounter data attributable to the children in the COA group and applied those proportions to the full COA group capitation rates. This approach allowed us to utilize actual Medi-Cal managed care experience, while not being impacted by any encounter reporting issues (e.g., missing or under reported data).
- The Medi-Cal managed care and HFP populations' demographic mixes, for members age 0 through 18, have been compared and significant differences were found. Therefore, the rate development methodology included steps to address these demographic differences. To accomplish this, the following age band groupings were utilized: less than age 1, age 1-5, age 6-13, age 14-17 and age 18-20. The age 18-20 Medi-Cal data was assumed to be appropriate for the age 18 HFP population subset.

Healthy Families Program Rate Development Approach - continued

- Calculations utilized Contract Period (CP) 2012–13 capitation rates, including maternity costs. The rates were trended to align with the implementation date of the HFP member transition.
- A 5% continuity of care adjustment was applied to the entire base.
- Administrative loads (percentages) are somewhat higher than what is used for the current rates, since this group of recipients has a lower average cost than the full Adult & Family COA group. This is to account for the fixed and variable components of the administrative costs.
- The profit/risk/contingencies loads are based on the same loading percentages used in the existing Medi-Cal managed care rate development.

ACA 1202 – Primary Care Rates

ACA: Primary Care Rates

- Overview
- Eligible Providers
- Services and Fee Schedules
- Capitated Rate Development
- Timing

PCP Rates: Overview

- Section 1202 of the Affordable Care Act increases rates to the Medicare equivalent for specified services for qualified providers.
- Final rule issued November 1, 2012 and guidance continues to be provided.
- States are required to submit a proposed methodology for managed care by March 31, 2013.
- Plans will be required to pay the increases rates retroactive to January 1, 2013.

PCP Rates: Eligible Providers

- Plans will need to determine which of their providers are eligible.
- According to the final rule, physicians must meet one of the following criteria to be eligible:
 - Board certified in family medicine, general internal medicine, and/or pediatric medicine. OB/GYNs and emergency physicians are not automatically eligible.
 - Board certified in a subspecialty related to one of the listed specialties.
 - At least 60 percent of the services billed to Medi-Cal fall within the E&M or vaccine administration codes covered by the regulation.
- The recognized boards are the American Board of Medical Specialties, the American Osteopathic Association, and the American Board of Physician Specialties.
- Physician extenders such as physician's assistants, nurse practitioners, and nurse midwives are eligible if they work under the supervision of an eligible physician.

PCP Rates: Eligible Providers

- Physicians self-attest their eligibility and identify specific eligibility criteria.
- Plans will likely be required to audit a statistically valid sample to ensure program integrity.
- Federally Qualified Health Centers and Rural Health Clinics are not eligible and will continue to receive their PPS rate.
- The rule is not explicit about community clinics that are reimbursed the same as a physician's office (rather than a PPS rate). We are seeking CMS guidance to verify eligibility.

PCP Rates: Services and Fee Schedule

- Evaluation and Monitoring Codes 99201-99499 and vaccine administration codes 90460, 90461, and 90471-90474 and their successor codes are eligible.
- Codes not currently reimbursed by Medicare are eligible.
- Medicaid programs that do not include one or more of these codes as a covered benefit are not required to cover them.
- The increase does apply to services provided to beneficiaries dually eligible for Medicare and Medi-Cal.
- The increase is to the higher of the 2013 Medicare Physician Fee Schedule (MPFS) or 2009 rates multiplied by the 2013 RVUs.

PCP Rates: Services and Fee Schedule

- CMS will provide the applicable computed 2013 Medicare rates (expect to use 2009 Medicare conversion factor multiplied by the 2013 RVUs) and will develop Medicaid-specific rates for services that are not covered by Medicare.
- Rates must be updated in 2014 based on the MPFS.
- Incentive payments, bonus payments, and performance-based supplemental payments that are only paid to physicians who meet certain goals are excluded from the calculation of any amount necessary to increase payments to Medicare levels.
- Volume-based supplemental payments are included in the calculation of any amount necessary to increase payments to Medicare levels.
- For MCO PCP reimbursement increases, DHCS/Mercer/MCOs will need to determine the "current" payment rates to PCPs and how to increase those reimbursement rates to the required 2013 computed Medicare payment rate. DHCS will also need to know the July 1, 2009 rate for federal claiming purposes.

PCP Rates: Services and Fee Schedule

- Other considerations include:
 - Individual service payment adjustments or quarterly lump sum payments.
 - Annual rate updates or more frequent updates if applicable.
 - Site of service rate adjustment.
 - Rate adjustment by geographic practice cost indices or use of a blended statewide rate (CMS developing statewide blended rates).

PCP Rates: Capitation

- It is up to states to develop a methodology for CMS approval.
- Final rule does not address salaried physicians, sub-capitation to another plan or capitated provider groups.
- Possible approach is to make retrospective quarterly payments to plans:
 - Payments would be based on actual utilization reported by plans, which would minimize potential utilization-based risk.
 - Establish a reconciliation for claims paid outside the usual cycle.
 - Would be clear to demonstrate the plan received the appropriate funding level and passed funds on to providers if audited by CMS or OIG.

PCP Rates: Capitation

- Alternative approach is to build funding into the rates and then reconcile.
 - Plans would not be at risk for the incremental cost of the increase.
 - Plans would be at risk for at least some utilization if utilization differs from expectations.
 - Would require a base rate adjustment now and again when the increase sunsets.

PCP Rates: Timing

- DHCS requests data and compliance plan from health plans in December. Response by end of January along with methodology suggestions.
- DHCS sends draft contract amendments to plans in February.
- The managed care methodology submitted to CMS no later than March 31, 2013.
- Depending on the methodology chosen, DHCS provides draft capitation rates to plans.
- Implementation date depends on how quickly CMS approves contract amendments and actuarial certifications.

DRG

Diagnosis-Related Groups

- For private hospitals, fee-for-service admissions on or after July 1, 2013 will be reimbursed based on diagnosis-related groups (DRGs).
- DRGs will be used to set out-of-network payment for emergency and post-stabilization services provided to plan members consistent with the FFS transition.
- The contracting program will end upon transition to DRGs and the Office of the Selective Provider Contracting Program (formerly CMAC) will no longer publish rates.

Diagnosis-Related Groups

- This change applies to emergency and post-stabilization services provided by all out-of-network hospitals (including DPHs), but does not affect the following:
 - Reimbursement for services provided at contract hospitals.
 - Reimbursement for elective admissions to out-of-network hospitals.

Diagnosis-Related Groups

- DHCS is using version 29 of All Patient Refined DRGs in FFS.
- DHCS will publish a statewide base price for plans to use in DRG pricing.
- Geographic differences will be addressed with the Medicare wage index.
- A pricing calculator is available on DHCS' website.

Diagnosis-Related Groups

- Key attributes of a DRG system include:
 - Payment reform that helps ensure and improve access and rewards efficiency.
 - Payment based on patient need by setting payments based on acuity.
 - Improves transparency and fairness.
 - Rewards hospitals that reduce cost.
 - Rewards complete coding of diagnoses and procedures.

Diagnosis-Related Groups

- An all-plan letter has been distributed for comment and a formal letter should be released in the coming weeks.
- Plans would be required to conform to FFS policy decisions such as policy adjustors, transfer pricing, outliers, etc.
- Policies are reflected in the pricing calculator.
- More information is available at <http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx>.

Capitated Rates Development Division All Plan Meeting



December 14, 2012



SB 208

Purpose and Background SB 208

SB 208

This Bill enacts statutory changes necessary for the Department of Health Care Services (DHCS) and counties to implement a new proposed Comprehensive Demonstration Project Waiver (Section 1115 Waiver) in the Medi-Cal Program.

SB 208- Background

Since 2005, inpatient care (IP) for Fee For Service (FFS) members receiving care at Designated Public Hospital (DPH) facilities have been reimbursed under a cost based payment and financing structure.

SB 208- Background

The DPHs use a “Certified Public Expenditure” (CPE) methodology to draw down and receive the Federal Share (FS) of allowable costs associated with the IP services provided.

SB 208- Background

The State was not providing the state/local match portion of the cost of services provided by a DPH.

The CPE process satisfied the state/local match requirement.

SB 208- Background

The transition of FFS Seniors and Persons with Disabilities (SPDs) members to Managed Care created a need for a solution that would:

- Permit a DPH to continue to receive net per service reimbursement for IP services comparable to FFS
- Ensure that there are not any new State General Fund (GF) expenditures.

SB 208- Non-Inpatient

Non-Inpatient services (hospital outpatient, physician, non-physician practitioner professional and non-hospital outpatient excluding FQHCs) provided within the FFS structure by a Public Provider were being reimbursed through a combination of

- Regulatory FFS for which the non-Federal share was supported with State GF
- Supplemental reimbursement above FFS financed through CPE

SB 208- CBRC

In Los Angeles County, all hospital and non-hospital outpatient services with the exception of *hospital emergency department* services are paid cost-based reimbursement with the nonfederal share fully funded with State general funds (CBRC).

SB 208- Non-Inpatient (continued)

These various FFS payment structures no longer occur with respect to SPDs once they are transitioned to managed care.

As a result, appropriate rate and other funding adjustments needed to be developed to reflect the historical patient reimbursement provided by these FFS methodologies to ensure access and funding for these safety net providers.

SB 208- Concept

Develop a unit cost enhancement for inpatient and non-inpatient services expressed in the terms of a per member per month (PMPM) increase.

- Adjustments needed for the baseline SPD capitation rate because of the transition of members from FFS.
- The adjustments will be used by the MCOs to make payments to the Public Providers that are similar to the level that the FFS payments would have been.

SB 208- Concept

- The Public Providers will provide the non-federal share of the adjusted capitation rates for the following areas:
 - Inpatient
 - Outpatient
 - Other Non-Inpatient
- A component of the nonfederal share will be funding part of the existing rate for the newly enrolled SPDs.

SB 208- Concept

- As with managed care in general, changes in utilization are anticipated. This methodology is only intended to provide similar compensation per unit of service, rather than similar compensation over all.

SB 208- IGT A

Takes into account the general fund component built into the transitioning SPD rates that was actually paid by the MCOs to the Public Providers that will be reimbursed by the Public Providers to the State.

SB 208- IGT B

Takes into account the unit cost enhancement that is needed on a PMPM basis that will give the Public Providers parity with a CPE based reimbursement structure.

SB 208 Timeline

- Wrapping up the specifics of the IGT agreements, plan provider agreements and methodology.

Timeline:

- Anticipate agreement on the methodology and agreements December 17, 2012
- Anticipate wrapping up discussion with CMS late December/early January
- Must have PMPM enhancements in the rates submitted to CMS in February 2013



SB 335

SB 335 Hospital Quality Assurance Fee (QAF)

- Similar to AB 1653 and SB 90
- Also occurring in FFS
- Provides for supplemental reimbursement to hospitals for inpatient, outpatient and emergency room services

SB 335 Hospital Quality Assurance Fee (QAF)

- Purpose :
 - Pay for health care coverage for children
 - Supplemental FFS payments for to private hospitals,
 - Increased capitation payments to Medi-Cal managed care plans for purposes of increasing reimbursement to hospitals
 - Supplemental payments for out-of-network emergency and post-stabilization services provided by private hospitals under the Low Income Health Program.

SB 335

- Anticipate rate enhancement amounting to
 - \$1.5B, 11-12 (Retroactive)
 - \$1.6B, 12-13 (Retroactive/Prospective)
 - \$1.7B, 13-14 (Prospective)
- Enhanced rates will be provided to CMS for approval February 2013
- Anticipate approval March/April 2013



Child Only Rate

Child Only Rate

- Anticipate effective date of July 1, 2014.
- Purpose to consolidate HFP and Medicaid rates to provide a singular blended rate.
- Will streamline administration.
- Definition of “child only” is being discussed.
 - Up to 19?
 - Up to 21?

Child Only Rate

- Examining system enhancements necessary to implement.
- Rate will be Risk Adjusted
- Questions?



Alignment of Rate Years

Alignment of Rate Years

- Rate years for COHS, GMC and TPM.
- One rate year for all three models
- Anticipate effective date of July 1, 2014
- Will require a nine month rate for TPM
 - (10-1-13 through 6-30-14)
- Will require a six month rate for GMC
 - (1-1-14 through 6-30-14)

Alignment of Rate Years

- Facilitates budgetary estimates as everyone will be on the State Fiscal Year (SFY)
- Will require that we start rate development earlier (around 7-1-13) and alter risk-adjustment cutoff dates for year of implementation SFY 2014-15.



Open Forum/Closing Remarks