



*Redesigning*  
THE MEDICAID PROGRAM



# New York Medicaid Redesign Fully Integrated Duals Advantage Program

Finance Workgroup

December 14, 2012



# FIDA Finance Work Group Participants

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<b>Erika Ange</b> , United Healthcare Community & State	<b>Bruce Darling</b> , Center for Disability Rights
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<b>Nataliya Averyanova</b> , VillageCareMax	<b>Koy Dever</b> , Loeb and Troper, LLP
<b>Joe Baker</b> , Medicare Rights Center	<b>Sean Doolan</b> , Hinman & Straub
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<b>Tara Buonocore-Rut</b> , AgeWell New York	<b>Rose Duhan</b> , New York Health Plan Association
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<b>Maura Cahill Bordas</b> , HHH Choices Health Plan, LLC	<b>Leah Farrell</b> , The Center for Disability Rights
<b>Thomas Carlson</b> , United Healthcare Community & State	<b>Anthony Fiori</b> , Manatt, Phelps and Phillips, LLP
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<b>Pat Conole</b> , Home Care Association of NYS	<b>Christina Gahan</b> , Healthcare Association of NYS
<b>Kevin Conroy</b> , WellCare of New York, Inc	<b>Doug Goggin-Callahan</b> , Medicare Rights Center
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# FIDA Finance Work Group Participants

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<b>Felicia Johnson</b> , Elderplan, Inc	<b>Aimee Rigney</b> , Office for People with Developmental Disabilities
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<b>Eric Price</b> , VNSNY CHOICE	<b>Anne M. Weeks</b> , Aetna Better Health



# Agenda

- Introductions
- Finance Work Group Goals
- Recap of Initial Work Group Meeting
- CMS Capitated Rate Methodology – Medicare
- Calculation of Integrated Premiums – Medicaid
- Data on Medicaid-Medicare Enrollees
- Work Group Recommendations
- Next Steps

# **FIDA Finance Work Group**



# FIDA Finance Work Group Goals

- The FIDA Finance Work Group has brought together the expertise of 57 participants representing health care organizations, state agencies and other stakeholders
- The Finance Work Group was created to:
  - 1) Discuss integrated premium development and options for Medicaid rate setting;
  - 2) Identify potential issues that require further discussion with CMS; and
  - 3) Formulate steps that can be taken from a finance and reimbursement perspective to ensure that plans, providers and members are ready for the transition to managed care.



## Recap of Initial Work Group Meeting

- The initial work group meeting sought to provide participants with an overview of the FIDA demonstration program and rate setting methodology as well as relevant data on the State's dual eligible population.
- The result was a comprehensive discussion in which participants indicated topics for further consideration.
- Overall, participants were concerned with the policy, design and rationale behind the components of the rate setting methodology.



# Recap of Initial Work Group Meeting

- ✓ Baseline Spending - Methodology for calculating baseline estimates, in particular (a) concerns about relying on MAP data to determine Medicaid component; (b) factoring costs into the baseline for new services not previously provided; and (c) potential issues with splitting out service hours between Medicare and Medicaid episodes; (d) restricting analysis to those who are eligible for the program (i.e., plans with duals that are not Medicaid only); and (e) Part D methodology and comparison of State's cost to national bid amount.
- ✓ Risk Adjustment - Computation of risk adjustment under two separate methodologies with New York State utilizing CRGs and CMS relying on the HCC approach and whether there is any intention to transition to one risk adjustment approach across programs. In addition, application of HCC model in such a way to incentivize care for more acute patients (e.g., frailty adjustment).
- ✓ Quality Withhold - Determination of benchmarks and whether there will be a statewide or national comparison of plans regarding quality measures.



# Recap of Initial Work Group Meeting

- ✓ Targets - Methodology for determining targets and if approach will be a flat percentage or varying percentages related to components (e.g., differing percentage related to pharmacy).
- ✓ Premiums - Calculation of premiums to take into account regional variation (e.g., Medicare is likely using a county based approach) and how to address counties that do not have enough Medicaid cost experience.
- ✓ Other Programmatic Concerns –
  - Consideration of a FIDA SNP for individuals residing in a nursing home although this group is not in the initial FIDA target population.
  - Assumptions regarding utilization and care management
  - Roles of federal and state government in the rate setting process
  - Future process for evaluating the adequacy of the rate and making on-going adjustments as needed.
  - Comparison of Medicaid FFS to existing managed LTC benefit packages (i.e., which benefits are reimbursed at comparable Medicaid FFS rates and what services would be reimbursed a lower Medicaid FFS rates).



# Financial Alignment Demonstration Capitated Model Medicare Rate Methodology

*New York FIDA Finance Workgroup  
December 14, 2012  
Maria Dominiak, FSA, MAAA*

# Guiding Principles

- ▶ Medicare and Medicaid components of rates based on baseline spending (what would have been spent absent the Demonstration)
- ▶ Medicare methodology will be consistent across all States participating in the Demonstration
- ▶ Medicare methodology builds off of existing Medicare payment and risk adjustment approaches

# Overview of Medicare Component of Demonstration Rate

- ▶ Medicare Part A/B Baseline
  - Fee for Service (FFS)
  - Medicare Advantage (MA)
  - County Baselines Based on Projected Enrollment
- ▶ Medicare Part D
- ▶ Risk Adjustment
- ▶ Savings Target
- ▶ Quality Withhold

# Baseline – FFS

- ▶ For beneficiaries coming from Medicare FFS
- ▶ Uses Medicare standardized FFS county rates (reflect historical costs of Medicare FFS population in that county)
- ▶ Standard FFS county rates are established each calendar year (CY 2013 rates released in April 2012)
- ▶ Baseline for beneficiaries coming from FFS may be modified for significant program changes (Major changes in Federal law, e.g. SGR)

# Baseline – Medicare Advantage

- ▶ For beneficiaries coming from Medicare Advantage
- ▶ Baseline reflects MA plan payments for year prior to the Demonstration, including Part C rebates, trended forward to the Demonstration year
- ▶ Baseline includes rebates derived from star ratings, average across MA plans in the county weighted by beneficiary enrollment
- ▶ Rates are normalized for a 1.0 risk score
- ▶ Generally follows the current MA rate setting process with a few exceptions
- ▶ Rates updated annually, consistent with current MA rate process

# Baseline – County Baselines

- ▶ Each county baseline is a weighted average of the FFS and MA baseline costs based on the expected proportion of enrollment from FFS and MA
- ▶ The same county baseline will apply to all Demonstration plans operating in that county

# Medicare Part D

- ▶ Set at the Part D national average monthly bid amount (NAMBA) for the payment year
  - Not based on bids submitted by each individual Part D plan, as is done outside the Demonstration
  - NAMBA is announced in August for the following year (\$79.64 for CY 2013)
- ▶ Payments will be reconciled after the end of each payment year, as in the current Part D process
- ▶ CMS will estimate average monthly payment for low-income cost sharing and Federal reinsurance subsidy amounts, which will also be cost reconciled

# County Baseline Example

	Base Year CY2013	Projected CY2014	Projected CY2015	Projected CY2016
(A) MA penetration for Demonstration population in county	25%	25%	25%	25%
(B) FFS county rate	\$850.00	\$875.00	\$900.00	\$975.00
(C) Weighted average MA plan rate in county <sup>(1)</sup>	\$1,000.00	\$1,010.00	\$1,020.00	\$1,030.00
(D) Medicare A/B Baseline Demonstration Rate $[(A*C)+((1-A)*B)]$		\$908.75	\$930.00	\$988.75
(E) Medicare Part D NAMBA	\$79.64	\$85.00	\$90.00	\$95.00
(F) Total Medicare Baseline Demonstration Rate [D+E]		<b>\$993.75</b>	<b>\$1,020.00</b>	<b>\$1,083.75</b>

*Note: Numbers are presented for illustrative purposes only. Actual assumptions and rates will be developed by CMS for the Demonstration years.*

*<sup>(1)</sup> Weighted average MA plan rate in county for plans in which beneficiaries would have enrolled, including Part C rebates*

*To be developed by CMS from county specific data*

*To be published by CMS OACT annually*

*To be projected by CMS from Base Year to the Demonstration Year*

# Risk Adjustment

- ▶ Medicare payments will be risk adjusted based on profile of each enrolled beneficiary
- ▶ Medicare A/B based on CMS–HCC risk model
- ▶ Medicare Part D Direct Subsidy component based on RxHCC risk model
- ▶ HCC and RxHCC use demographic information (age, sex, disability, reason for Medicare eligibility–age/disability, Medicaid enrollment) and medical conditions to predict costs
- ▶ HCC and RxHCC also used to risk adjust Medicare Advantage and Part D payments outside of the Demonstration

# Savings Target

- ▶ CMS assumes Demonstrations can achieve overall savings through improved care management, administrative efficiencies
- ▶ State and CMS will develop aggregate savings target based on CMS modeling, input from State and other factors
- ▶ Varies by State and Demonstration year, and specified in each State's MOU
- ▶ Same target applied to both Medicare A/B and Medicaid for each Demonstration year
- ▶ No savings assumed for Medicare Part D (Part D costs will be monitored closely)

# Quality Withhold

- ▶ Portion of payment will be withheld to incent quality improvement
- ▶ Applies to Medicaid and Medicare A/B components of rate
- ▶ Part D payments not subject to quality withhold
- ▶ CMS and states will withhold a portion of the capitation payments that participating health plans can earn back if they meet certain quality thresholds
- ▶ Threshold measures to be combination of certain core quality measures, determined by State and CMS as part of MOU process
- ▶ Withhold amount will vary by year (e.g., 1% in Year 1, 2% in Year 2, 3% in Year 3)
- ▶ CMS and State to assess plan performance and calculate payments

# Demonstration Rate Example

	Medicare A/B	Medicare D	Medicaid	Total
(A) CY14 County Baseline	\$908.75	\$85.00	\$1,500.00	\$2,493.75
(B) Risk adjustment <sup>(1)</sup>	1.1	1.2	1.0	
(C) Savings factor <sup>(2)</sup>	1%	0%	1%	
(D) Total CY14 Demonstration Rate [A*B*(1-C)]	\$989.63	\$102.00	\$1,485.00	\$2,576.63
(E) Quality withhold	1%	0%	1%	
(F) Quality withhold amount [D*E]	\$9.90	\$ -	\$14.85	\$24.75
(G) Total CY14 Demonstration Rate Net of Withhold Amount [D-F]	\$979.73	\$102.00	\$1,470.15	\$2,551.88

Note: Numbers are presented for illustrative purposes only. Actual assumptions and rates will be developed by CMS and the State for the Demonstration years.

(1) Actual risk adjustment factor will vary at the beneficiary level and by Medicare A/B, Medicare D and Medicaid

(2) Actual savings factor will vary by state and reflected in the CMS/State MOU

# Comparison to current Medicare Advantage Approach

## ▶ Key differences

- No Medicare bid process – selection of participating plans subject to state procurement, CMS application
- Use of national average Medicare Part D bid
- Aggregate savings target
- Quality withhold

## ▶ Key similarities

- Baseline costs reflective of projected future costs for enrolled population
- Use of risk adjustment to better match payment to risk
- Plans allowed to offer enhanced benefits to attract members

# State Technical Assistance

- The *Integrated Care Resource Center* was established by CMS to help states develop and implement integrated care models for Medicaid beneficiaries with high-cost, chronic needs
- Focus on integrating care for: (1) individuals who are dually eligible for Medicare and Medicaid; and (2) high-need, high-cost Medicaid populations via the Health Homes state plan option as well as other emerging models
- Individual and group TA coordinated by Mathematica Policy Research and CHCS
- For more information, visit:

[www.integratedcareresourcecenter.com](http://www.integratedcareresourcecenter.com)

# Calculation of Integrated Premiums

*Ron Ogborne, FSA, CERA, MAAA  
Mercer*



# Medicaid Capitation Rates

## Program design decisions that impact capitation rates

- Medicaid capitation rate regional structure
- Premium group structure
  - Nursing Home Certifiable vs. Non-Nursing Home Certifiable
  - Separate Institutional rate cell?
- Risk adjustment
- Risk mitigation mechanisms
  - Risk corridors
  - Risk pools
  - Reinsurance



# Medicare and Medicaid Capitation Rates

## Development of Baseline Historical Costs

- Blending and linking Medicare and Medicaid baseline spending
  - Medicare baseline
    - Fee-for-Service county rates
    - Medicare Advantage plan payments
  - Medicaid experience data
    - Functional assessment data
    - Fee-for-Service claims
    - Encounter/Health Plan financial data
- Identify the appropriate cost base for each premium group
  - Identify eligible individuals in the historical data and classify them according to the proper FIDA premium group
  - Remove any non-covered services



# Medicaid Capitation Rates

## Development of Base Medicaid Capitation Rates

- Adjust for programmatic changes
  - Account for factors related to benefit and/or eligibility changes between the base period and the contract period
- Project historical experience to the contract period
  - Adjust for price inflation, changes in Medicaid reimbursement levels, utilization trends and the availability of new services
- Apply net managed care savings factors
  - Accounts for differences in pricing and utilization patterns across delivery systems
  - Recognizes opportunities for savings versus historical spending levels
  - Offset for increase Health Plan costs related to administration and care management activities
  - Savings factors for each contract period will be negotiated by CMS and the State



# Medicaid Capitation Rates

## Health Plan-specific Medicaid Capitation Rates

- Base Medicaid capitation rates will be risk adjusted **independently** of Medicare capitation rates
  - Medicaid spending is dominated by LTC services therefore the Medicaid risk adjustment process is likely to be similar to the one that the State uses to risk adjustment MLTC Program capitation rates
  - The risk adjustment methodology will be tailored to be consistent with all risk mitigation mechanisms included in the program

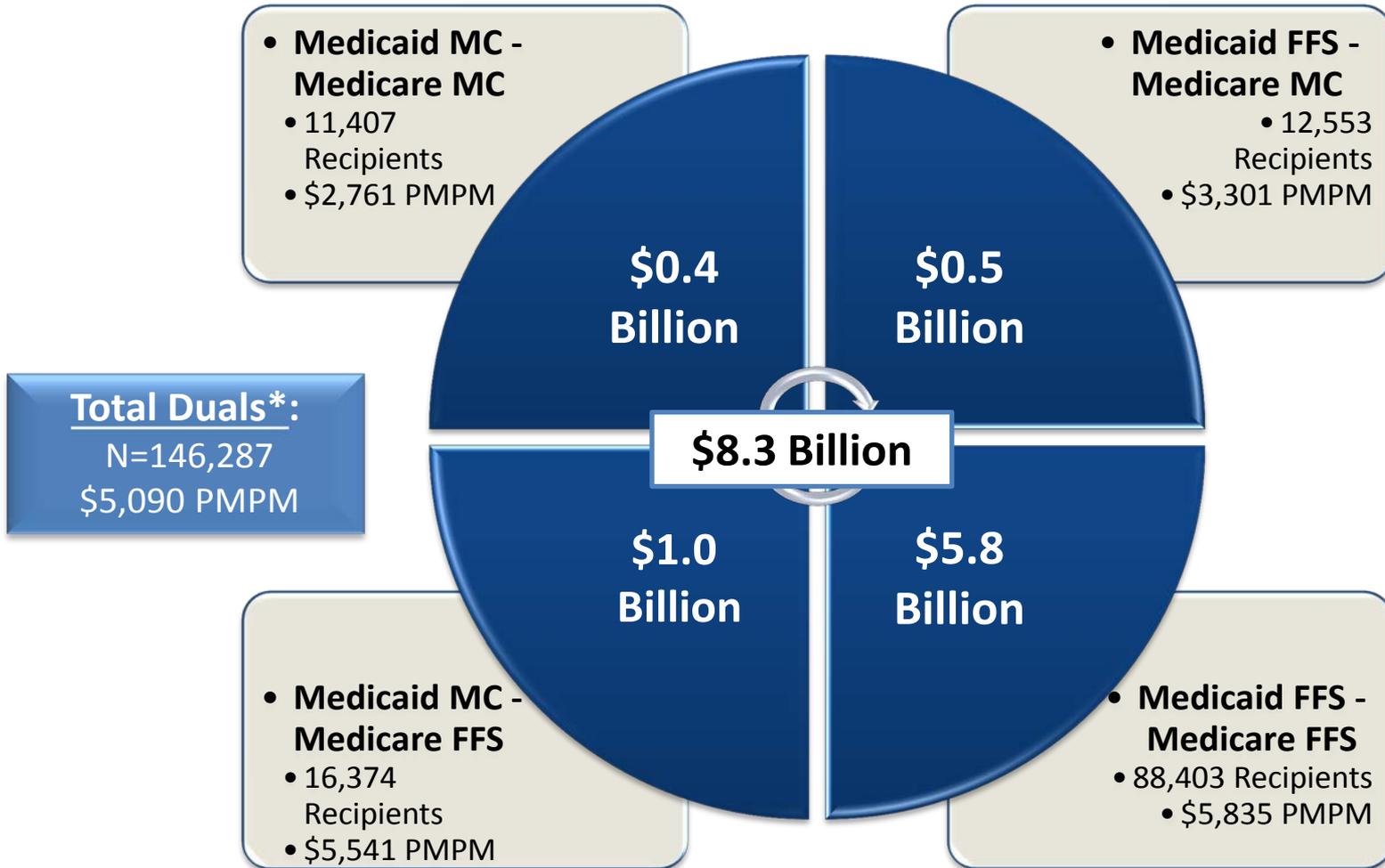
# **New York State Data on Medicare-Medicaid Enrollees**

*Nicholas Asimakopoulos  
NYS Department of Health*



# Dual Eligible Participation in Managed Care

## “Community-Based LTC” Cohort (150,000 approx.)



\*Total includes 17,550 beneficiaries (which are not reflected in any of the four quadrants) that have had some MC or FFS experience during the year (\$0.7 ; \$3,660 PMPM) .



# Community-Based LTC Cohort: Category of Service

Duals not Enrolled in Medicare Advantage Plan (MAP) in 8 County Region (N=86,409 Enrollees)

COS	Medicaid \$	Medicare \$	Total \$	PMPM \$
Inpatient	78,558,013	935,796,391	1,014,354,404	1,037
SNF	25,351,326	129,192,257	154,543,583	158
Hospice	1,934,607	14,267,148	16,201,755	17
Non-ER HOPD	31,366,198	78,498,375	109,864,573	112
ER (HOPD)	1,823,778	13,018,409	14,842,187	15
FS Clinic	33,872,966	67,846,090	101,719,056	104
Home Health Care	1,390,229,249	173,079,253	1,563,308,502	1,598
Physician/Specialist	33,716,058	408,460,824	442,176,882	452
DME	52,999,590	58,476,828	111,476,418	114
Pharmacy	40,083,932	0	40,083,932	41
Capitation	617,131,386	0	617,131,386	631
Personal Care	1,313,230,238	0	1,313,230,238	1,342
Waiver Services	23,259,996	0	23,259,996	24
ICFDD	0	0	0	0
ALP/Adult Day Care	202,134,252	0	202,134,252	207
Case Mgmt.	5,138,286	0	5,138,286	5
Other Services	164,806,638	157,557,155	322,363,794	329
<b>Total</b>	<b>4,015,636,514</b>	<b>2,036,192,729</b>	<b>6,051,829,243</b>	<b>6,185</b>



# Community-Based LTC Cohort: Category of Service

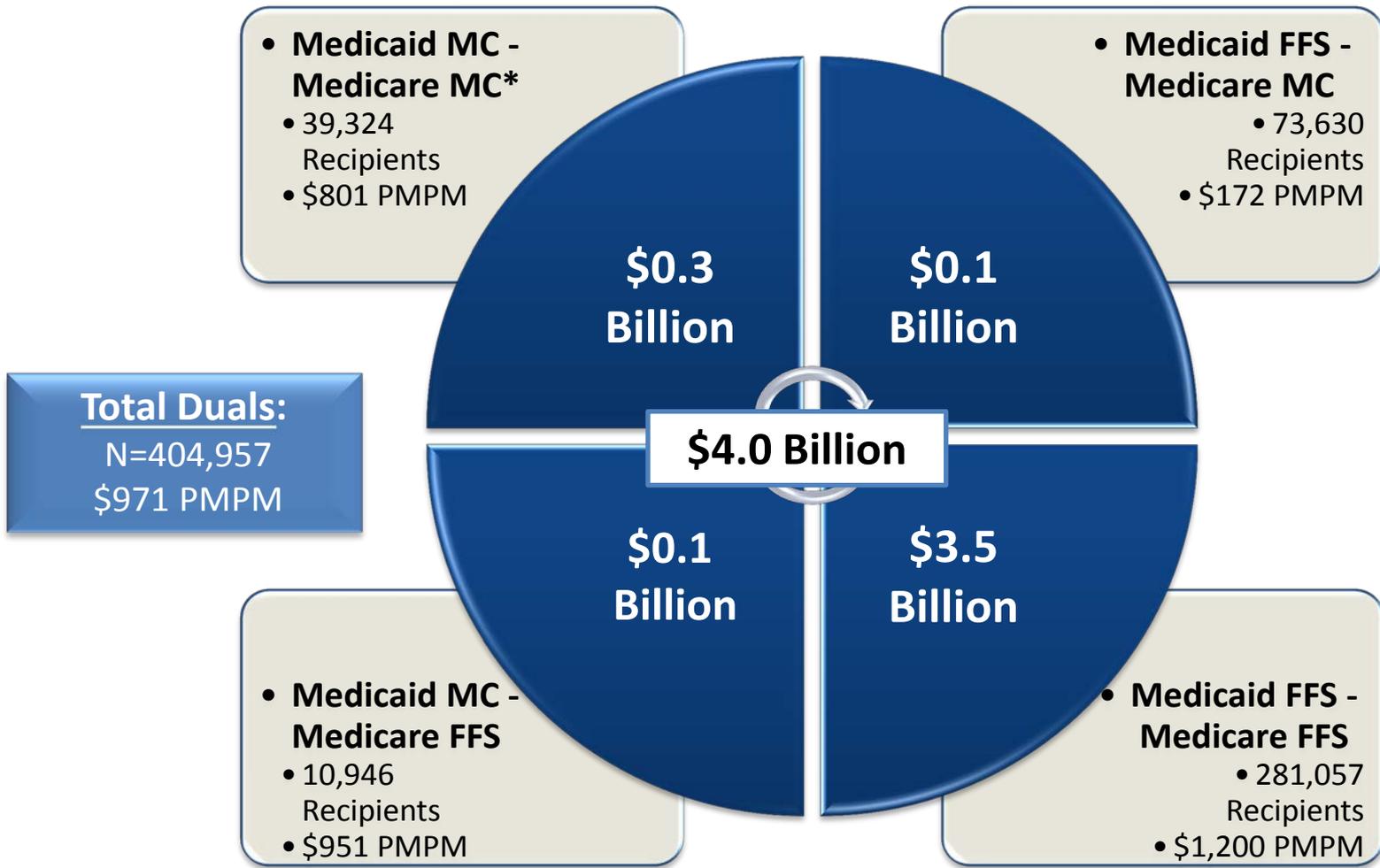
Duals not Enrolled in MAP and Medicaid Managed Care Plan in 8 County Region (N=70,032 Enrollees)

COS	Medicaid \$	Medicare \$	Total \$	PMPM \$
Inpatient	63,852,553	787,819,049	851,671,603	1,059
SNF	25,180,968	112,184,760	137,365,728	171
Hospice	1,891,442	13,502,314	15,393,756	19
Non-ER HOPD	27,657,246	64,811,416	92,468,663	115
ER (HOPD)	1,378,899	10,839,386	12,218,286	15
FS Clinic	29,263,034	56,555,798	85,818,832	107
Home Health Care	1,385,338,935	147,824,189	1,533,163,124	1,906
Physician/Specialist	29,491,832	344,698,239	374,190,071	465
DME	52,241,149	50,004,411	102,245,559	127
Pharmacy	32,302,468	0	32,302,468	40
Capitation	0	0	0	0
Personal Care	1,304,937,502	0	1,304,937,502	1,623
Waiver Services	23,040,082	0	23,040,082	29
ICFDD	0	0	0	0
ALP/Adult Day Care	200,420,627	0	200,420,627	249
Case Mgmt.	4,854,862	0	4,854,862	6
Other Services	163,136,491	135,775,909	298,912,400	372
<b>Total</b>	<b>3,344,988,090</b>	<b>1,724,015,471</b>	<b>5,069,003,561</b>	<b>6,303</b>



# Dual Eligible Participation in Managed Care

## “Community Well” Cohort (400,000 approx.)



\*Total includes any dual enrollees with managed care experience in both Medicaid and Medicare during the year.



## Methodology for Matching Claims for Dual Eligible Enrollees

- Current matching process:
  - ✓ Member crosswalk based on SSN matches
  - ✓ Facility crosswalk based on Medicare Provider ID and NPI matches
  - ✓ Physician crosswalk on NPI matches
- Match Claims:
  - ✓ IP: Considered potential match if same Member ID, Facility ID and Admission Date
  - ✓ OP: Considered potential match if same Member ID, Facility ID and First Date of Service
  - ✓ PR: Considered potential match if same Member ID, Physician ID and Service Date



## Methodology for Matching Claims for Dual Eligible Enrollees

- Issues being addressed:
  - ✓ At which level of data cleansing stage do we first attempt matching?
  - ✓ Once claims are identified match, what merge rules apply?
  - ✓ For Medicare claims with no match to a Medicaid claim, how do we handle?
  - ✓ In cases where there is an incomplete Member, Facility or Physician crosswalk data, do these claims add value to final dataset?



## Data Repository

- Exploration of options to provide data to stakeholders has commenced.
  - ✓ Initial conceptualization entailed development of a data cube.
  - ✓ However, to increase responsiveness to stakeholder needs a data repository is under consideration
- Advantages of a data repository:
  - ✓ Shortened turn-around timeframe (i.e., interface development and programming no longer needed)
  - ✓ Provides similar tables and charts as data cube
  - ✓ Meets security requirements without necessary access to Health Commerce System
  - ✓ Compatible with DOH Commissioner's METRIX initiative



## Two-Payer Database

- DOH has initiated project with TREO to develop a two-payer database
- The database will be able to track each client through both Medicare and Medicaid episodes
- The ability to effectively track a patient through care, irrespective of payer will allow DOH to:
  - ✓ Identify patterns in utilization and service categories
  - ✓ Provide additional data on expenditures for dual population
  - ✓ Inform initiatives for financial alignment and care coordination.

# **Work Group Recommendations**



# Framing Work Group Recommendations for Calculation of Integrated Premiums

- Methodological Assumptions for Medicaid and Medicare
  - ✓ Remaining decision points
  - ✓ Items for further consideration
  - ✓ Discussion of unintended consequences
  - ✓ Data requirements
- Timing of Deliverables
  - ✓ Preparation of data
  - ✓ Discussions with CMS/MOU development
  - ✓ Draft rates to stakeholders
  - ✓ Ensuring feedback loop
- Roles and Responsibilities
  - ✓ Stakeholders
  - ✓ Work Group
  - ✓ CMS



# Next Steps for Finance Workgroup

- Formulate list of issues and questions to discuss with CMS and submit to the Department of Health
- Areas may include:
  - ✓ Programmatic Concerns
  - ✓ Funding Streams
  - ✓ Rate Calculation and Payment Issues
  - ✓ Plan Capacity
  - ✓ Development of Quality Metrics
  - ✓ Performance Appraisal



# Framing Work Group Recommendations for Calculation of Integrated Premiums

- Please send comments and feedback by Friday, January 5, 2013 to:  
**[fidawg@health.state.ny.us](mailto:fidawg@health.state.ny.us)**

# Next Steps



# Upcoming Meetings:

➤ **TBD: Mid-January 2013**