Overview of the Rate-Setting Structure for Cal MediConnect

Background:

The enacted 2012-13 state budget established the Coordinated Care Initiative (CCI), which outlines changes to the medical care and long-term services and supports (LTSS) systems. The main components of the CCI include: 1) provisions of the Cal MediConnect demonstration program; 2) mandatory enrollment of dual eligible individuals and other previously excluded seniors and persons with disabilities into Medi-Cal managed care, and 3) integration of Medi-Cal-funded LTSS into Medi-Cal managed care. The CCI is slated for implementation in eight counties (Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa Clara) no sooner than April 1, 2014.

Rate-Setting Structure for Cal MediConnect:

The Memorandum of Understanding signed on March 27, 2013, between the State of California and the Centers for Medicare and Medicaid Services (CMS) outlines the general parameters of the Cal MediConnect program, including the rate-setting structure. While the rate methodology has been made public through the MOU, the specific rates that will be paid to each health plan have not been released.

As provided in the MOU, the rate-setting structure for Cal-MediConnect includes the following components:

- Blended Payments: Health plans will be paid a "blended" capitated monthly amount for each enrolled beneficiary that combines the Medicare and Medi-Cal capitated rates. However, CMS maintains responsibility for establishing the Medicare portion of the rate, whereas the state maintains responsibility for establishing the Medi-

Cal portion of the rate. Plans will be paid separately from CMS and the state for the respective portions of the rates.

- Baseline Cost Rate: Baseline Medicare (Medicare Parts A, B and D) and Medi-Cal costs will be constructed using estimates of what would have been spent each year on eligible beneficiaries if Cal MediConnect did not exist.

- Savings Percentages: CMS and the state expect that health plans will achieve savings as part of the Cal MediConnect demonstration. Thus, minimum and county-specific savings percentages will be applied to (subtracted from) the Medicare (Parts A and B, not Part D) and Medi-Cal portion of the baseline rate.

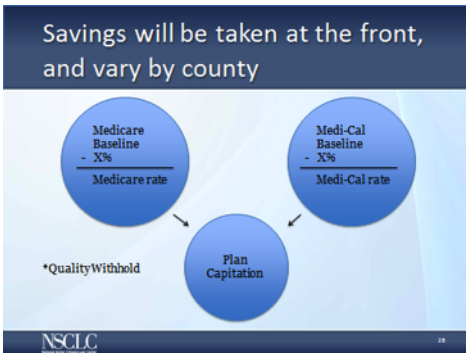
    - Minimum Savings Percentages: For the three years of the demonstration, the following minimum savings percentages will be subtracted from the baseline rate:

        - Year 1: 1 %
        - Year 2: 2 %
        - Year 3: 4%

    - County-Specific Savings Percentages: Each county will be given a specific savings percentage that will be applied on top of the minimum savings percentage. Therefore, each health plan will have a total savings percentage applied to the baseline rate that is based on the minimum savings percentage as well as the county-specific savings percentage.

      Note: the illustration that follows is headed, “Savings will be taken at the front, and vary by county.” It shows three circles: in the first circle, the Medicare Baseline minus that year’s minimum savings rate equals the Medicare rate; in the second circle, the Medi-Cal baseline minus that year’s minimum savings rate equals the Medi-Cal rate. Arrows point these to

circles at the third circle: “Plan Capitation.” The graphic was prepared by the National Senior Citizen’s Law Center.



- Quality Withhold: Health plan performance will be evaluated based on specified metrics. CMS and the state will withhold a percentage of the respective Medicare and Medi-Cal components of the capitation rate. If a health plan does not meet the quality metrics, then the health plan will not earn back the withheld amount of the rate.

    - Year One Quality Withhold: 1%
    - Year Two Quality Withhold: 2 %
    - Year Three Quality Withhold: 3%

Breaking it Down: Understanding the Medicare and Medi-Cal Rates:

As indicated above, health plans will be paid a “blended” capitated monthly amount for each enrolled beneficiary that combines the Medicare and Medi-Cal capitated rates. Plans will be paid separately from CMS and the state for the respective portions of the rates. It is important to understand how each base rate is established in order to understand the financial incentives for health plans.

Medicare Parts A and B Rate: Parts A and B of the Medicare rate will project an average of Medicare Advantage payments and Medicare fee-for-

service payments for the eligible beneficiaries. Baseline costs will be calculated as a per member/per month standardized cost.

Medicare Part D Rate: Medicare Part D rate will be based on the National Average Monthly Bid Amount (NAMBA).

Medi-Cal Rate: The Medi-Cal rate (reflecting LTSS and wrap-around Medi-Cal services) will blend four risk adjustment population categories into an overall blended rate paid to the health plan. The following reflects the four risk adjustment population categories:

- Institutionalized: Individuals in long-term care facilities for 90 or more days.
- HCBS High: Individuals identified as high-utilizers of home and community-based services. These individuals will meet one or more of the following criteria:
  - Individuals receiving Community Based Adult Services (CBAS)
  - Individuals who are clients of the Multipurpose Senior Service Program (MSSP); and
  - Individuals who receive In Home Supportive Services (IHSS) and are classified as "severely impaired."

- HCBS Low: Individuals identified as low users of HCBS. These individuals include IHSS recipients classified as "not severely impaired."
- Community Well: All other individuals living in the community with no Medi-Cal covered HCBS.

Each population described above will be assigned a "relative cost factor" based on the average cost per member/per month in the specified Medi-Cal population category.

Each health plan will have a "relative mix factor" that reflects how many people in that health plan fall within each population category.

Each health plan's relative mix factor will be multiplied by the established capitation rate for each population category to determine the blended risk-

adjusted payment rate for a per member/per month payment to the health plan. More information is needed regarding what data the state will use to develop rates for each risk adjustment category, whether it be Medi-Cal fee-for-service data, budget assumptions, or other means.

Three phases of the Medi-Cal risk adjustment payment rate:

The Medi-Cal risk adjustment process described above will be administered in three phases.

- Phase I: The methodology will be applied monthly on a retroactive basis to match actual enrollment into the health plan. This phase will continue through the 12-month initial enrollment period.
- Phase II: This methodology will be prospectively applied at the start of the quarter, and will weigh the risk categories based on the prior month's enrollment. This phase is for one fiscal quarter only (three months).
  Phase III: The health plan rate will be based on a targeted relative mix of the population and will not be adjusted during the year. This phase will last through the remainder of the Cal MediConnect demonstration.

Rate Development and Fiscal Incentives:

The state indicates that the rate structure intends to incentivize plans to move its members into less costly settlings, e.g., HCBS over institutionalization. The risk assumed by plans will be based on the above phasing period. By year three, plan rates will not be adjusted during the year. Accordingly, in year one, the plan rates will more or less reflect which risk-adjusted category a member actually belongs. By year three, plans will be at risk longer, as outlined below.

Year One: Rates reflect actual membership

Year Two: Plans assume risk for three of the twelve months

Year Three: Plans assume risk for entire twelve months

In practice, this means that plans will be receiving a rate in year three based on a population mix from the prior year. In order to minimize risk and maximize savings, plans will want to move as many members into the lowest cost setting.

Next Steps

At the time of publication, the health plans remain in negotiations with CMS and the state regarding the specific rates assigned for the Cal MediConnect program. The specific rates and requirements will be outlined in the three-way contract between the health plans, the state and CMS.

Note about Medi-Cal Managed LTSS Rates Outside of Cal MediConnect

The rates described in this document reflect the rate structure for the Cal MediConnect program only. It is important to note that the state has not released its rate structure for Medi-Cal managed LTSS outside of the Cal MediConnect program. The Medi-cal managed LTSS rate structure is not going to be constructed from the Cal MediConnect rate.

All Medi-Cal managed care health plans residing in the eight county demonstration area will be required to provide managed LTSS as part of the benefit package for Medi-Cal only Seniors/People with Disabilities who are already enrolled in Medi-Cal managed care as well as dual eligibles who are not enrolled in the Cal MediConnect program.

~ September, 2013

Prepared for the California Collaborative by an internal working group.