



New York Medicaid Redesign Fully Integrated Duals Advantage Program

Finance Workgroup

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FIDA Finance Work Group Participants

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Agenda

- Introductions
- Finance Work Group Goals
- Recap of Second Work Group Meeting
- Information for Plans and Providers
- New York State Data Book
- Work Group Recommendations
- Questions and Answers
- 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 Second Work Group Meeting

- The aim of the second work group meeting was to have a more detailed discussion of the methodology that will be used to calculate integrated premiums .
- Representatives from CMS's technical assistance contractor (ICRC) and DOH's actuary (Mercer) presented pertinent information on the rationale and application of the rate calculation.



Final Work Group Meeting Objectives

- Allow the State to estimate a risk-adjusted Medicare baseline rate more representative of the experience in New York
- Disseminate information to stakeholders that may be useful in CMS applications due February 21, 2013.
- Discuss issues and recommendations that can be applied during development of integrated Medicaid-Medicare premiums.

Information for Plans and Providers



Medicare Fee-for-Service County Rates

- ✓ CMS' Office of the Actuary publishes the Medicare standardized FFS county rates in the spring of each year for the upcoming contract year (CY)
 - For example, CMS posted rates for CY 2013 (effective January 1, 2013) in April 2012.

- ✓ Rates can be found at:
<http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Ratebooks-and-Supporting-Data-Items/2013Rates.html>

- ✓ The file can be accessed as follows:
 - Under “Downloads”, select “2013 Rate Calculation Data”
 - Then, select file risk2013.csv
 - Information is listed by county and state.
 - The standardized FFS county rate can be found in Column Q (2013 FFS Rate excluding Phase-out IME).



Medicare Advantage Penetration

Enrollment for Full Benefit Duals in MAPD and D-SNP (in 8 County Region as of January 2012)

SSA County	Total Number of Full Benefit Medicare-Medicaid Enrollees ¹	Total MAPD Enrollment		D-SNP Enrollment										MAPD-Only Enrollment	
				Total D-SNP Enrollment		Institutional		Dual-Eligible		Chronic or Disabling Condition		FIDE SNP			
		Number ²	% of Total	Number	% of Total MAPD	Number	% of D-SNP	Number	% of D-SNP	Number	% of D-SNP	Number	% of D-SNP	Number	% of D-SNP
Bronx	71,749	29,903	41.7%	25,017	83.7%	1,133	4.5%	22,513	90.0%	93	0.4%	1,278	5.1%	4,886	16.3%
Kings	124,321	31,069	25.0%	23,828	76.7%	960	4.0%	20,726	87.0%	113	0.5%	2,029	8.5%	7,241	23.3%
Nassau	25,056	3,194	12.7%	1,996	62.5%	270	13.5%	1,590	79.7%			136	6.8%	1,198	37.5%
New York	75,537	25,252	33.4%	20,088	79.6%	1,049	5.2%	17,830	88.8%	65	0.3%	1,144	5.7%	5,164	20.4%
Queens	83,323	21,680	26.0%	15,787	72.8%	647	4.1%	14,041	88.9%	41	0.3%	1,058	6.7%	5,893	27.2%
Richmond	13,196	3,293	25.0%	2,212	67.2%	685	31.0%	1,213	54.8%			314	14.2%	1,081	32.8%
Suffolk	27,602	1,839	6.7%	938	51.0%	263	28.0%	574	61.2%			101	10.8%	901	49.0%
Westchester	20,143	2,429	12.1%	1,556	64.1%	260	16.7%	1,191	76.5%			105	6.7%	873	35.9%

Notes: ¹ Includes total number of full duals (with or without Part D enrollment.)

² Reflects both DSNPs and non-DSNPs.

Data Source: PEAR as of 12/28/12



Clinical Risk Scores for Dual Eligible Population

- ✓ DOH and CMS are in process of identifying risk scores for Medicare-Medicaid enrollees.
- ✓ Preliminary analysis conducted on risk scores by county for all duals (including “community well” and “institutional” cohorts)
- ✓ Data availability for target population (i.e., “community-based long term care” cohort) is contingent upon:
 - Creation of file with indicators identifying beneficiaries eligible to participate in FIDA Demonstration

New York State Medicare- Medicaid Data Book



New York State Data Book

- As discussed in previously, exploration of options to provide data to stakeholders has commenced.
- New York State will be compiling a Data Book on the dual eligible population utilizing formats similar other states (e.g., Massachusetts).
- The Data Book will address the following:
 - ✓ Data Dictionary/Definitions
 - ✓ Demographic and Enrollment data
 - ✓ Category of Service
 - ✓ Expenditures
 - ✓ County/Demonstration Region
- Data Book will be released in three phases.
 - ✓ Phase 1: 2010 Data (Release Date: February 1, 2013)
 - ✓ Phase 2: Supplemental Data (Release Date: *TBD*)
 - ✓ Phase 3: 2011 Data (Release Date: *TBD*)



New York State Data Book Assumptions

- Focuses on “Community-Based LTC” cohort in FIDA Demonstration Region
- Reflects Medicaid and Medicare Parts A and B Programs
- All data are fee-for-service (FFS)
- Represents 2010 data
- Reflects claims with service dates corresponding to valid Medicaid/Medicare eligibility span
- Data extracted from National Claims History and DOH Datamart
- Community-based LTC cohort is defined as:
 - ✓ Aged 21 or older; Not OMH Institutional or OPWDD
 - ✓ Full benefit duals
 - ✓ Nursing home certified or requiring 120 days or more of home health care services



Phase 1: New York State Data Book - Timeline

Data Book Exhibit (CY 2010)	Timeframe for Completion
Part D	January 11, 2013
Demographics	
Overview of Medicaid/Medicare and Duals	
Category of Service (Statewide and County)	
Category of Service (By Plan Enrollment)	January 16, 2013
Physician and Emergency Room	January 18, 2013
Inpatient	January 22, 2013
Home Health	
Personal Care	
End Stage of Life (By Age and CRG Score)	



Phases 2 and 3: New York State Data Book

- Data to be released in subsequent phases of Data Book will include:
 - ✓ Additional detail on Category of Service for Inpatient, Outpatient, Physician and DME
 - ✓ Data on utilization by chronic condition cohort
 - ✓ Demographic and county specific information
 - ✓ Data on functional assessment and chronic illness

Work Group Recommendations



Proposed Guiding Principles

1. Financing and payment structures should be transparent and published in a manner that is easily accessible and understandable to the public.
2. Through the methodology, ensure that rates support clinically appropriate care in the right setting and reinforce health planning and policy priorities.
3. Financing structures should incentivize quality of care and hold plans and providers accountable for performance.
4. Rates and payments should be fair and equitable, and appropriately reflect patient acuity and risk.



Proposed Recommendations - Medicare

- **Baseline/Rates and Services**

- ***Plans should pay providers an amount comparable to Medicare FFS*** - The amounts FIDA plans are required to pay providers should remain comparable to the cost of the services previously covered by Medicare FFS and should not be reduced to the Medicaid FFS amount.
- ***Plan contracts should address Organ Acquisition Costs*** - Plans should be required to address the reimbursement of Organ Acquisition Costs in their contracts (Medicare currently pays these costs on a pass through basis.)
- ***Plans that participate in FIDA should be required to offer hospitals an Periodic Interim Payments (PIP) option.***
- ***Medicare plans should be required to adjust for cost report settlements*** - Adjustments for cost report settlements should be required in all non-par situations as well as par situations unless alternative contract provisions are agreed to by parties.

- **Appeals**

- ***Establish independent appeals process*** - FIDA program should incorporate New York external appeal rights for providers to allow for independent unbiased reviews of plan payment denials.



Proposed Recommendations - Medicaid

- **Baseline/Rates and Services**
 - ***Establish county baseline in demonstration*** - A county baseline should be implemented in demonstration for the Medicaid risk adjustment methodology to accurately adjust for plan population.
 - ***Establish rates for high-needs individuals*** - The State should establish an outlier rate cell for the highest-need individuals, or at a minimum, establish stop-loss payments for community-based care for high-need beneficiaries.
 - ***Require plans to utilize nursing home services*** - To disincentive plans from avoiding costs of nursing facility care, plans should be required to contract with any nursing facility meeting specified standards.
 - ***Establish limitations on administrative expenses*** – The State should establish a minimum medical loss ratio limiting administrative expenses to a maximum of 15%.



Proposed Recommendations – Medicaid

- **Risk Adjustment**

- ***Utilize aggregate and individual enrollee information in determining risk***
- ***Include other validated measures in risk adjustment*** – Payments should be risk adjusted to include measures of functional status, diagnosis and other relevant socioeconomic and cultural factors (e.g., race, ethnicity, gender) as well as other social determinants of health such as access to housing, transportation and education.
- ***Develop “reinsurance” model for high risk enrollees*** – To prevent the segregation of beneficiaries with significant needs into a cluster of Plans, State should set risk adjustment across plans and provide for prospective reinsurance costs above a given threshold.



Proposed Recommendations – Savings Target

- **Savings Target**

- ***Providers should share in savings target*** - Since providers will need to reconfigure to adjust capacity and cost structures for the reduced volume of health care services delivered as a result of care coordination, and as a result should be able to share in savings.
- ***Consideration should be given to the fact that New York has costs above the national average (due to DSH and GME which result in higher inpatient rates) in calculation of savings target*** – Medicare utilization in New York is at or below national averages, and therefore should not be targeted for higher savings under FIDA



Proposed Recommendations – Quality

- **Quality Withhold**

- ***Providers should be able to directly participate in financial incentives*** – Rather than rely on the FIDA plan to pass along the incentive payments, providers should be eligible to participate directly in quality and other financial incentives.
- ***Benchmarks should be based on New York data rather than national data.***
- ***Develop performance measures to incentive community-based services*** – State should incentivize community-based services (e.g., nursing facility diversions and transitions, ensuring consumer directed is the for enrollees, compliance with quality of care and life measures)
- ***Establish incentives for performance*** – Measures should provide incentives for expeditious actions (e.g., timely enrollment, assessments and access to providers) and sanctions to plans failing to meet benchmarks.
- ***Ensure continued access to services*** - The State should ensure that cost savings are not the result of reductions in needed services.

Question and Answer Session



Q &A: Methodological

Baseline

- In example provided by CMS actuary, the FFS baseline total (A) is less than the demo rate of (G). How will demonstration produce savings, particularly since the payment is 2% higher than current FFS spending and the duals plans need to achieve 1% savings for both Medicare and Medicaid in year one? Will savings come in on the Medicaid side? Will this impact enrollees LTSS?

Risk Adjustment

- Will risk adjustment also take into account psychosocial factors that affect duals (i.e., depression, substance abuse, lack of social supports, housing)?
- Will consideration be given to the use of a “frailty” adjustment?

Savings Target

- How will savings targets be determined?
- Will providers be eligible for shared savings?

Quality Withhold

- How will quality withhold percentages be determined?
- Will providers be eligible to receive quality payments?
- Will Year 1 quality withhold be based on reporting and/or process measures only?

Other

- What will the escrow and contingent reserve requirements be under FIDA?
- Will there be a different contingent reserve (CR) calculation and % of revenue assumption for the Medicare piece of the premium versus the Medicaid premium?

- **Medicare**

- Impact of pending settlement of class-action lawsuit (Jimmo v. Sebelius) and whether the anticipated policy clarification will be used to revise the Medicare A/B fee-for-service baseline for rate calculation purposes
- Availability of Part D data for enrollees to allow plans to calculate accrual estimations from the start of demonstration versus development of estimates as plan experience builds
- Rates of payment to providers for services
- Reimbursement for out-of-network providers

- **Medicare (cont'd)**

- Inclusion of MAP enrollees in baseline calculations
- Allow plans to submit initial assessment diagnosis in Spring 2014 (one-time deadline), especially for members previously in FFS Medicare – with goal to properly risk adjust population by July 2014 in order to eliminate lag time on risk adjustment
- Verification that Medicare risk methodology will remain at the patient level using the same data files and member level funding adjustments
- Consideration for CMS to establish initial exception period to conduct medical evaluations and submit diagnosis for risk adjusting
- Contracting with LHCSAs for Medicare covered services (or will CMS require plans to contract only with CHHAs/LTHHCPs)

- **Medicaid**

- Timeframe for finalization of benefit package
- Capitation of home health and personal care services (at what percentage of FFS rates)
- Adequacy of Category of Service PMPM for all services , but in particular hospice, home health and personal care (Note: Hospice services are outside of FIDA plan)
- Pricing of “case management” services, such as “Case Management for Seriously and Persistent Mental Illness (SPMI)” within care management model
- Method for savings target and whether take into account consumer protections and state policies that restrict flexibility of plan management (e.g., 90-day continuity of care policy, out-of-network transition policy, Aid Continuing and minimum provider payment levels)
- Reimbursement of care coordination expenses (especially if increased care coordination costs are necessary to achieve savings associated with reductions in avoidable hospital admissions)



Discussion: Information/Data Requests

Medicare Baseline

- Assumptions for how enrollment will be calculated and trended forward
- HCC and HCC-Rx risk scores calculated from Medicare claims and pharmacy data
- Medicare 5% sample data extract

Medicare and Medicaid Baseline

- Data on MH services included in the proposed benefit package
- Data on court-ordered treatment/services
- Data on current “waiver services” included in proposed benefit package
- Information on how service costs will be trended going forward from the baseline calculations

Next Steps



Workgroup Next Steps

1. Development of integrated Federal and State timeline
2. Key decisions and work plan
3. Preparation of 2011 data files for Mercer
4. Release of Phases 2 and 3 of the New York State Data Book