

State of California – Medi-Cal Managed Care Proposal for Implementation of Affordable Care Act (ACA) Section 1202: Increased Payments for Medicaid Primary Care Services

Section 1902(a)(13)(C) of the Social Security Act (SSA) as amended by the Affordable Care Act (ACA) requires that state Medicaid programs incorporate the requirement for increased payment to primary care providers for years 2013 and 2014 into contracts with managed care organizations and the corresponding capitation payments. In technical guidance provided by the Centers for Medicare and Medicaid (CMS) States were provided flexibility to implement this provision using methodologies consistent with current rate-setting practices. The options provided in CMS' technical guidance include Model 1: Full risk prospective capitation; Model 2: prospective capitation with risk sharing that incorporates retrospective reconciliation; and Model 3: non-risk reconciled payments for enhanced rates.

This document details the methodology for how future payments will be made from the State of California (State) through our contracted Managed Care Plans (MCPs) to primary care providers (PCPs). The methodology encompasses all of the pieces of the Affordable Care Act (ACA) Section 1202 PCP rule compliance, including:

- Compliance with the Centers for Medicare and Medicaid Services (CMS) regulations regarding the needed contractor payment increases for computed 2013/2014 Medicare rates.
- Certification of the actuarial soundness of Medicaid managed care capitation rates under the contract per 42 CFR 438.6(c)(2).
- Explanation of the State's methodology to CMS in a manner consistent with risk payments, compliance with all relevant CMS regulations, including required documentation, and the State's chosen payment option.
- Explanation of the State's claiming for the federal matching funds utilizing the July 2009 baseline Medicaid capitation payment amounts.

The methodology encompasses all required elements of the two methodologies as required by CMS, including:

- Determining the July 1, 2009 "base" in managed care capitation payments (i.e., a reasonable methodology, based on rational and documented data and assumptions, for identifying the payments that would have been made by the contractor for eligible primary care furnished as of July 1, 2009).
- Determining the difference between the July 1, 2009 base amount and the 2013/2014 increases (i.e., a reasonable methodology, based on rational and documented data and assumptions, for identifying the differential in payment between the provider payments that would have been made by the contractor on July 1, 2009, and the amount needed to make payments at the required Medicare levels).

This methodology is being submitted to CMS by March 31, 2013, and once approved by CMS, will be inserted into the MCP provider agreement and reflected in the actuarial certification of the final additional rates.

Summary of Methodology

The State has opted to utilize the prospective capitation risk model with a retrospective “100% true-up” reconciliation (Model 2). Model 2 was chosen by California to meet our goals of providing important payments to providers in the most timely manner possible, minimizing the financial risk to our MCP partners and encouraging more robust MCP encounter data reporting. Under this approach, the higher costs associated with complying with the PCP rule will be reflected in separate additional MCP-specific capitation payments through a programmatic change adjustment and certified by the State’s actuary. The State will pay the required capitation payment to the contractor prospectively, and there will be reconciliation retrospectively.¹ Thus, the separate additional MCP-specific capitation rates paid would be inclusive of the enhanced rates and expected utilization, with actual data being used to reconcile the expected utilization with actual utilization for the specified primary care services. Based on the difference in utilization actually experienced, the State and CMS would reimburse or recoup from MCPs the unit cost differential for amounts differing between original (Medicaid) 2013/2014 and updated (reflecting Medicare fees) 2013/2014 aggregate unit costs, multiplied by the differing utilization. This is at 100% federal match.

Provider Attestation

The State will develop an online registry for providers to self- attest their qualification for the higher payment. MCPs will be given the option of using the online registry or they may utilize their own methodology. MCPs using their own methodology may utilize the State’s online registry for out of network providers.

All physicians must self-attest to practicing in a specialty/sub-specialty of family medicine, general internal medicine, or pediatric medicine recognized by the American Board of Physician Specialties, the American Board of Medical Specialties, or the American Osteopathic Association; AND, that they are either:

- Board certified with a specialty or subspecialty from the boards above
OR
- Billing at least 60% of services rendered of the specified evaluation and management (E&M) or vaccine administration (VFC) codes.

Providers need to self-attest regardless of how they qualify. California will verify provider attestations in accordance with the approved fee for service (FFS) State Plan process. There will be no limit on retroactive attestation for eligible physicians through CY 2014.

The implementation considerations below describe the relevant and available sources of data, as well as the material assumptions, methods, and processes by which the

¹ Note that the separate additional MCP-specific ACA Section 1202 capitation rates are effective January 1, 2013, and the State will make retroactive payment adjustments.

separate additional MCP-specific capitation rates will be calculated. Each step references the applicable CMS Technical Guidance (TG) section.

Data Sources (CMS TG Section 4.1)

Data Request — Requirements for the Data Each MCP Will Send to the State

The State and the State's actuary, Mercer, have determined that data to determine the amount of the 2009 and calendar year (CY) 2013/2014 capitation rates associated with the qualified codes being provided by qualified PCPs under this regulation is not available in the necessary detail required and/or excessively costly and burdensome to the State to gather. Because of multiple difficulties and impossibilities of breaking down the base data in the level of detail desired, and then tracing it through the capitation rate development process, the most appropriate, comprehensive, and practical data approach (Actuarial Standard of Practice No. 23 — Data Quality http://www.actuarialstandardsboard.org/pdf/asops/asop023_141.pdf) for determining the amounts built into the 2009 and 2013 capitation rates for eligible primary care services is through a detailed data request (with review and potential adjustment) to the MCPs.

Because California's capitation rates are developed from an aggregate level data source rather than a detailed data source reflecting procedure codes and providers, the assumed utilization and unit cost for each procedure code impacted by the ACA PCP fee increase reflected in the July 1, 2009 capitation rates is unavailable. Instead, the State will gather utilization and unit cost data through an ad hoc data request of the MCPs to determine how much PCPs were paid in 2012 and how much the PCPs were paid in 2009 for the prescribed codes and appropriate providers. The information gathered from the MCPs via this data request will help the State's actuary estimate what percentage of the aggregate amounts built into the 2009 and 2013 capitation rates were/are for the specific codes eligible for the increase and provided by eligible physicians. This will require the MCPs to do additional analysis in determining and including the utilization and unit cost structure of any sub-capitated arrangements they may have with providers. Comparative reports between MCPs and to existing reports (for example, rate development templates utilized for rate setting) will also be developed in order to determine the reasonableness of results. The ad hoc MCP 2009 and 2012 data will be adjusted, if necessary, to improve consistency with more aggregate known claim cost components of the 2009 and 2013/2014 capitation rates and to provide support for the unit cost basis of the financial data that was used to develop the capitation rates for 2009 and 2013. Adjustments may be made to address submissions with utilization that is very low or high relative to known and reasonable experience or unit costs that are not consistent with the unit cost used to develop capitation rates for the time period in question.

Specific remedies that may be taken to adjust data to address the identified data limitations will include consideration of data from other comparable plans and reasonable estimations of actual experience. The State's actuary will provide documentation of any adjustments made to the data (or an explanation of why no adjustments were needed) and provide this documentation to DHCS, which can be made available to CMS upon request. An example of when an adjustment may be

needed to plan data is if the reported PMPM costs from the data request exceeds the total PMPM built into capitation for the entire primary care category of service line. This could be indicative that the plan over-reported utilization or used a unit cost that is not reflective of data used to develop capitation rates. This is an example of potentially needed adjustments to the plan data to align with the data utilized within the capitation rate setting process. There may similarly be concerns if the PMPM from the data request was well below capitation for the primary care category of service.

This overall approach takes into consideration the availability of data and the costs and burden of administering the method while producing a reliable and accurate result to the fullest extent possible

For Medicaid beneficiaries dually eligible for Medicare, the State will ensure that the 100% FFP match will only be claimed where it exceeds the amount that would have been payable under the state plan in effect on July 1, 2009. The State will estimate the amount eligible for FFP utilizing the methodology discussed in this document.

For any populations that are new to managed care, e.g. aged, blind or disabled (ABD) children that will be mandatorily enrolled in managed care, they did not have managed care experience in 2009 and/or 2012. Therefore, the State and Mercer will determine the utilization and unit cost amounts assumed within the 2013/2014 capitation rates to similarly calculate the claim cost component for these additional payments. In order to determine the claim for enhanced match, the State will use the FFS schedule in effect in July 2009 to establish the baseline to compare to the Medicare levels.

Rate Setting and Reporting Analysis and Development

In order to calculate the additional payment, the State and Mercer will develop a process to:

- Determine the utilization and unit cost amounts for the additional capitation rates covering CY 2013/2014. When compared to the applicable CY 2013/2014 Medicare unit costs, this analysis will develop the claim cost component for the proposed payments for each MCP.
- Determine appropriate amounts and percentages for any MCP administration, underwriting gain, taxes, fees, and any other applicable non-claim load to the additional payment (not subject to enhanced claiming).
- Identify the necessary documentation of the services provided.
- Confirm and validate the applicable procedure codes on the submitted files.
- Develop and implement the required reporting mechanism with one of the objectives being to verify MCP compliance with the regulation.
- Produce payments to the MCPs for the correct amount.

Establish the 2009 Base Rate (CMS TG Section 4)

The State and Mercer will analyze the ad hoc data request from the MCPs to provide support for the unit cost basis of the financial data that was used to develop the 2009

capitation rates. The State and Mercer will analyze FFS utilization and unit cost for any new populations. Mercer will multiply the July 1, 2009 unit cost (described above) by individual procedure code by the expected 2013/2014 utilization and will divide by the total 2013/2014 utilization to establish the 2009 base unit costs in aggregate. These aggregate unit cost levels will represent the 2009 base rate levels reflective of 2013/2014 utilization. For any procedure code with expected utilization in 2013/2014 where there was no unit cost rate assumed in the 2009 capitation rate even though it was a covered procedure, the unit cost and associated 2013/2014 utilization included in the calculations described above will be excluded from this weighting calculation (this exclusion is anticipated to have immaterial impact on the final aggregate unit costs). For any procedure code that was not a covered procedure in 2009, the 2009 unit cost is considered to be zero. This same 2013/2014 utilization will also be applied to the Medicare fee schedule to establish a similar aggregate unit cost level. The difference of the July 1, 2009 and Medicare aggregate unit cost levels, when multiplied by the anticipated utilization in the separate additional 2013/2014 capitation rate, will determine the base for the 100% federal match.

Calculate the 2013/2014 Capitation Rate (CMS TG Section 5)

Capitation rates will be developed in accordance with the requirement that the MCP pay PCPs at least 100% of the 2013/2014 computed Medicare fee schedule (in accordance with the State Plan amendment for the PCP increase) for eligible primary care service codes furnished by a qualified physician. The development of the claim cost components is discussed further below.

To calculate the capitation rate attributed to qualifying PCP services in CY 2013/2014, Mercer will first establish the estimated utilization for applicable providers and services. Mercer will then also determine the unit cost levels associated with this utilization with particular attention to unit cost levels relative to the Medicare fee schedule. Only base utilization below the Medicare fee schedule will be considered in the rate adjustment. The unit cost levels will then be compared to the Medicare fee schedule at the procedure code level to determine the needed rate that will compensate the MCPs to be able to pay the qualifying providers at least the Medicare fee schedule. The development of the 2013 Medicare fee schedule rates and 2013 utilization is described below.

2013 Medicare Fee Schedule Rates

The 2013 Medicare fee schedule rates are based on the 2009 conversion factor and 2013 relative value units (RVUs), consistent with the geographic practice cost index (GPCI) schedule published by CMS in January 2013. The 2013 Medicare rates utilized will conform to the approach used in California's FFS program for each of the specified evaluation and management and vaccine billing codes.

Note that the increased payment is not applicable to services provided by a physician delivering services under the federally qualified health center (FQHC) or rural health clinic (RHC) benefits because, in those instances, payment is made on a facility basis and is not made according to the physician fee schedule.

2013 PCP Utilization

Mercer will base the expected utilization of eligible primary care services on the base data utilization in 2012, with adjustments as necessary. These data will be trended forward to 2013 using rate setting trend assumptions.

In addition to the typical utilization trend, Mercer will work with the State and MCPs to evaluate the need for additional PCP utilization increases to reflect any impact of the increased payment levels. The magnitude of such a utilization adjustment depends on several factors, including the size and timing of the PCP fee increases, provider self-attestation levels, whether access issues exist in the California Medicaid managed care program, and whether the higher fees will attract more providers or expand current provider capacity for California Medicaid managed care recipients. In addition, Mercer may assess whether increased PCP utilization may result in decreased utilization of other higher cost services such as inpatient admissions and emergency room visits.

Non-Claim Cost Components

Any applicable, non-claim cost amounts and percentages for MCP administration, underwriting gain, taxes, fees, or any other non-claim load to the additional capitation payment (not subject to enhanced claiming) should be considered, and if appropriate be accounted for and quantified.

Actuarial Certification (CMS TG Section 7)

The State will submit rate package documentation that will include an actuarial certification demonstrating compliance with 42 CFR 438.6(c). This documentation will include a description and certification of the process used to establish the CY 2013/2014 additional capitation rate, an indication of the risk model selected by the State, and a description and certification of the process used to establish the amount that is eligible for 100% federal financial participation (as described herein), and a description of the retrospective reconciliation for Model 2 (as described herein). The PCP capitation increase amount will not be risk-adjusted.

State Payment to Contractor through Capitation Rates

The State will pay the MCPs capitation rates under the newly certified rates once rate approval is received from CMS. The State will pay the contractor retroactively for any payments due from January 1, 2013 to the date of CMS approval.

Contractor Requirements for PCP Payment, Including FFS PCP Payments, and Requirements for Contractor PCP Subcapitation Arrangements (CMS TG Section 8)

MCP requirements for PCP payment: MCPs pay PCPs at least 100% of the 2013 computed Medicare fee schedule. The State contract with the MCPs will reflect this

requirement. MCPs and their association will work with the State and Mercer to establish a uniform understanding of the change and its implementation. The State has decided to pay the office-setting rate, using the January 2013 Medicare published rate adjustments. The enhanced payment requirement is effective retrospective to January 1, 2013 for all units rendered by a qualified provider, as indicated by the State above under the provider attestation section, billed using a qualified billing code under an MCP contract.

Each MCP must provide the State with the MCP's plan for compliance with ACA Section 1202 and how payments to the PCPs will be made. MCPs will pay the PCPs at least 100% of the 2013 computed Medicare rate promptly (after the MCP has received payment from the State) before receiving any reconciliation payment from the State. The MCO contracts will reflect this requirement, and the submission from the MCP will outline how each MCO will accomplish this.

Contractor Documentation of PCP Payments — Requirements for Ongoing Contractor Reporting (CMS TG Section 8)

MCP documentation of PCP payments: MCPs will continue to submit encounter data reflecting actual payments. MCPs will also submit an annual report documenting payments for all encounters (FFS and sub-capitated). This documentation will include the utilization and payments for applicable PCP services. The State will require each MCP to attest compliance with these elements to ensure accuracy and compliance with the PCP rate increase rule.

Model 2 Additional Payments or Recoupments Made through Annual Reconciliation

The State will reconcile the capitated payments in 2013/2014 for primary care made under this provision to each MCP utilizing the utilization data submitted by the MCP in their annual report. The unit cost differential between the Medicare level and the 2013/2014 Medicaid level will already be known as part of the MCP-specific additional capitation rate. This approach reduces duplicate payment concerns to the extent possible.

CMS TG Section 2.2 100% true up: The run-out period will be six months, so reconciliation will take place in July 2014 for CY 2013 and July 2015 for CY 2014. Because there is no limit on retroactive attestation, all claims for physicians attesting in CY 2014 will be reconciled in 2015; including CY 2013 claims.

Once the State receives the annual report documenting aggregate payments to the PCPs in the form of an Excel spreadsheet from the MCPs, the State will pay MCPs for the amount that the Medicare rate paid exceeds the rate differential in the capitation rates based on actual utilization. This step will include detailed instructions to the MCPs on how to document to the State the utilization and unit cost rate paid for PCPs.

Per revised CMS-64 reporting, the E&M and VFC components of the capitation and their reconciliation will be analyzed separately.

On an annual basis, the State will reconcile the amounts paid to the plan against the managed care plan's actual reported experience. Amounts due to or from the plans will be made through the reconciliation payment process. The State will be reconciling based on utilization and will not re-price unit costs. Utilization will be reconciled as follows:

Reconciliation to Actual:	Under	Over
Difference between base rate unit cost and Medicare unit cost	\$ 4	\$ 4
Multiply by 2013 utilization built into capitation	10	10
Sum (capitation amount to comply with policy)	<u>\$ 40</u>	<u>\$ 40</u>
Rate Differential based on capitation	\$ 4	\$ 4
Multiply by Actual utilization	8	12
Sum	<u>\$ 32</u>	<u>\$ 48</u>
Difference to be recouped/paid:	<u>\$ (8)</u>	<u>\$ 8</u>

Please note that if actual unit cost varies, there will be no re-pricing of unit costs. The reconciliation will be based on the unit costs built into the capitation rate. Additionally, the State will not be collecting or paying the 2013 base Medicaid payment amount if utilization is lower or higher than what is projected in the capitation. As shown above, reconciliation would only apply to the difference between the base Medicaid rate and the Medicare rate (\$4 per unit in the above examples)

Calculate the Differential that Qualifies for 100% Federal Financial Participation (CMS TG Section 6)

As the State is opting to use Risk Model 2, the amount of the 2013/2014 capitation payment that is eligible for 100% Federal financial participation is determined by calculating the difference between the base 2009 aggregate unit cost calculation and the aggregate Medicare unit cost in the 2013/2014 capitation rates, multiplied by the anticipated utilization within the updated 2013/2014 capitation rates described above, plus any additional payments (or recoupments) made through annual utilization reconciliation at the unit cost differential amount only.

State Claiming — The State's Plan for Claiming

The State will claim the amount of the capitation rate identified above, as well as any payments (or recoupments) made through the annual reconciliation at 100% Federal Medical assistance percentages (FMAP). The State will claim the remainder of the calendar year 2013/2014 capitation rate, minus the portion of the capitation rate identified, as the rate differential at the State's regular FMAP percentage. All amounts

for MCO administration and underwriting gain, including taxes and fees, will be claimed at the State's regular FMAP rate as they are not eligible for 100% federal match according to CMS requirements. The federal share of any MCO recoupments resulting from the reconciliation with the MCPs will also be returned to CMS in accordance with regular CMS 64 claiming rules.