New York Fully Integrated Duals Advantage (FIDA) Program

Perspectives of a Certifying Actuary

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Prepared for:

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1. INTRODUCTION

Milliman, Inc. (Milliman) has been retained by the New York Health Plan Association, Inc. (HPA) to create this report using funds provided by the New York State Health Foundation. This report contains an educational foundation related to rate-setting considerations for the proposed New York Fully Integrated Duals Advantage (FIDA) program. The FIDA program is New York's version of a fully capitated integrated care program demonstration for Medicare and Medicaid dual eligible individuals offered by the Centers for Medicare and Medicaid Services (CMS) as authorized in the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA).

The scope of this report included a focus on potential rate-setting methodologies and assumptions from the perspective of the actuary charged with certifying the capitation rates. The specific questions posed included:

- What is the target population for FIDA?
- What data should be used to establish the baseline costs of this population?
- What are the sources for the data?
- What assumptions should be made regarding participation of enrollees in FIDA?
- What assumptions should be applied regarding changes in utilization between Medicare and Medicaid services?
- What assumptions should be made regarding cost and utilization of new long-term services and supports (LTSS) benefits?
- What risk adjustment methodologies should be considered?
- How will the quality incentive withhold be implemented?
- What rating categories should be used?
- What risk mitigation strategies may be applied?
- How should the amount and the timing of targeted aggregate savings be established and applied?
- How should future rate adjustments be determined and implemented?

These questions formed the basis of our analysis and presentation. It should be noted that we do not recommend or promote any particular decision related to the FIDA program. Additionally, this report does not calculate or prescribe any particular capitation rate-setting methodology. The views and opinions presented in this report are those of the author and do not reflect the collective opinions of Milliman or other Milliman consultants.

The information provided is for background and discussion purposes only. It should not be used for any other purpose. Readers of this report should consider their unique circumstances and not place reliance upon this information that would replace or otherwise contradict their own analytics and financial evaluations.

This report was created by Jeremy D. Palmer, FSA. Mr. Palmer is a Principal and Consulting Actuary in the Indianapolis office of Milliman. Jeremy is a Fellow of the Society of Actuaries and Member of the American Academy of Actuaries. Mr. Palmer meets the qualification standards for performing the analyses contained in this report.

Mr. Palmer offers insights and considerations from the perspective of an actuary responsible for developing and certifying Medicaid capitation rates for a dual demonstration program. Mr. Palmer is not the certifying actuary for the New York FIDA program, but does have this responsibility in other state dual demonstration programs.

2. EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, collectively referred to as the Affordable Care Act (ACA) introduces the ability to develop, test, and validate programs to integrate the care for Medicare/Medicaid dual eligible beneficiaries. The State of New York is pursuing a demonstration project under this authority currently referred to as the Fully Integrated Duals Advantage (FIDA) program, which is to be effective in 2014. The demonstration is subject to approval by CMS, pending the execution of a memorandum of understanding (MOU) between CMS and the State of New York.

This report provides comments and considerations intended to educate key stakeholders in the decisions that face the development of the FIDA program specifically as it relates to the capitation rate-setting methodology and assumptions. The perspectives included are that of an actuary responsible for certifying the Medicaid capitation rates as being actuarially sound.

The capitation rate-setting methodology has been outlined by CMS and will be a joint process with each of the states planning to operate a dual demonstration program. This methodology resembles the legacy "Upper Payment Methodology" for Medicaid programs prior to the establishment of actuarial soundness requirements directed by section 42 CFR 438.6(c) of federal regulation. We refer to the CMS method in the report as the budgetary method, and we refer to an alternative method as the Medicaid actuarially sound rate (ASR) method.

The capitation rates will need to strike a balance between achieving program savings through managed care efficiency and providing sufficient funding such that the health plans will be willing to participate. This balance translates into finding the intersection of the budgetary method and the Medicaid ASR method. The ultimate success of the demonstration, as it relates to financing, lies in the ability of health plans to successfully achieve an integrated program that produces savings, enhances access to necessary care, and proves administratively feasible to maintain.

Without delving into specific costs and rate-setting assumptions, this report contemplates that a balance may be achieved, but it will hinge on several primary considerations as the actual rate-setting process unfolds. Our review uncovered the following areas where collaboration and creative thinking may be especially beneficial to the resulting FIDA program:

- Application of actuarial soundness requirements for the Medicaid component of the capitation rate. It is anticipated that the certifying actuary will perform the calculations necessary to conclude that the CMS methodology produces actuarially sound rates for the Medicaid component of the capitation rate, and that conclusion takes into account the aggregate of the Medicare and Medicaid components.
- Defining program savings to include any state administrative costs that may be avoided in the demonstration because they will be the responsibility of the managed care plans.
- Defining program savings to recognize the likely source of savings for the Medicaid long-term services and supports (LTSS) costs involves the rebalancing of individuals from an institutional setting to a community setting. This recognition is expected to be a challenge for FIDA because the institutional individuals are not part of the population eligible for the demonstration.
- Ability of risk adjustment to account for the difference between the Medicare population in total (duals and non-duals) and the FIDA-eligible population (community LTSS duals) for the Medicare Parts A, B and D components of the capitation rates.
- Many Medicare Advantage Dual Eligible Special Needs Plans contract with providers at 100% of Medicare. If the same holds true for FIDA plans then they will have higher crossover costs than is included in the historical Medicaid costs.
- Medicare net savings may be diluted by the amount of current managed care penetration for the FIDA eligible population because this program is already in managed care. The rate for this portion of the enrollment will be based on Medicare Advantage payment rates, which may be more or less than the county FFS costs.

- If the data source used in risk adjustment calculations remains FFS in the later years of the program, there may be an issue with applying the coding intensity factor because FFS data is not believed to be advantaged with respect to increased HCC coding.

Finding an appropriate level of payment for the FIDA program should include collaboration on the issues above as the program is implemented. Each of these items are discussed in more detail in the remainder of this report.

3. RATE-SETTING METHODOLOGIES

The development of capitation rates for the New York Fully Integrated Duals Advantage (FIDA) program is a complex assignment requiring extensive thought and careful consideration by those responsible for its success. This responsibility resides primarily with the New York State Department of Health (NYSDOH), the Centers for Medicare and Medicaid Services (CMS), and their advisors and consultants. However, there are numerous other stakeholders in the process, who will assist in making the program a success, including: program eligibles, service providers, beneficiary advocacy groups, and health plans. The capitation rates will be among the largest financial components influencing the ultimate success of the three year demonstration. Rates that are too high may not produce the program savings required to provide a sustainable program, while rates that are too low may hinder health plan participation, member access to services, and overall financial stability of the program. Rate-setting must therefore strike a balance among stakeholders and find a middle-ground where savings can be achieved, access to services is appropriate, and health plan risk is manageable.

The concept of striking a balance in capitation rate-setting is not a new idea. In fact, CMS and the states currently carry out this philosophy in more traditional Medicaid rate-setting. One of the cornerstones of achieving appropriate capitation rates in Medicaid is the requirement of actuarial soundness included in Section 42 CFR 438.6(c) of the federal regulation. Through review of available documentation, we believe that the FIDA demonstration will also be subject to the actuarial soundness requirement. However, it does not appear that the Medicare portion of the rates will be certified as actuarially sound, though there is an expectation that the rates will be adequate. The memorandum of understanding (MOU) between the State of Ohio and CMS provides an insight into the apparent most recent thinking, as follows:

> *"Assessment of actuarial soundness under 42 CFR 438.6, in the context of this Demonstration, should consider both Medicare and Medicaid contributions and the opportunities for efficiencies unique to an integrated care program. CMS considers the Medicaid actuarial soundness requirements to be flexible enough to consider efficiencies and savings that may be associated with Medicare. Therefore, CMS does not believe that a waiver of Medicaid actuarial soundness principles is necessary in the context of this Demonstration."* [1]
>
> *"Both parties agree that there is reasonable expectation for achieving savings while paying ICDS Plans capitated rates that are adequate to support access to and utilization of medical and non-medical benefits according to beneficiary needs."* [2]

From this reference, it is expected that the certifying actuary will need to review the Medicaid capitation rate in conjunction with potential Medicare savings. A key question is how the certifying actuary will estimate potential Medicare savings—whether CMS will provide any type of analysis in this area. For purposes of this report, I have assumed that the Medicaid component of the rate follows 42 CFR 438.6(c) precisely, and that the Medicare components of the rate are not subject to actuarial soundness in the same way that the CMS payment rates for the Medicare Advantage program are not subject to actuarial soundness.

There are numerous methodologies that could be used to accomplish the rate-setting goals of the FIDA program. This report focuses on two broad categories of methodologies to illustrate the options and how they may (or may not) accomplish the rate-setting goals. The methodologies are defined as (1) capitation rates based on the cost of the current program (i.e., absent the FIDA demonstration) and (2) capitation rates based on the cost of the proposed FIDA program. Each of these methodologies are explored further in this section.

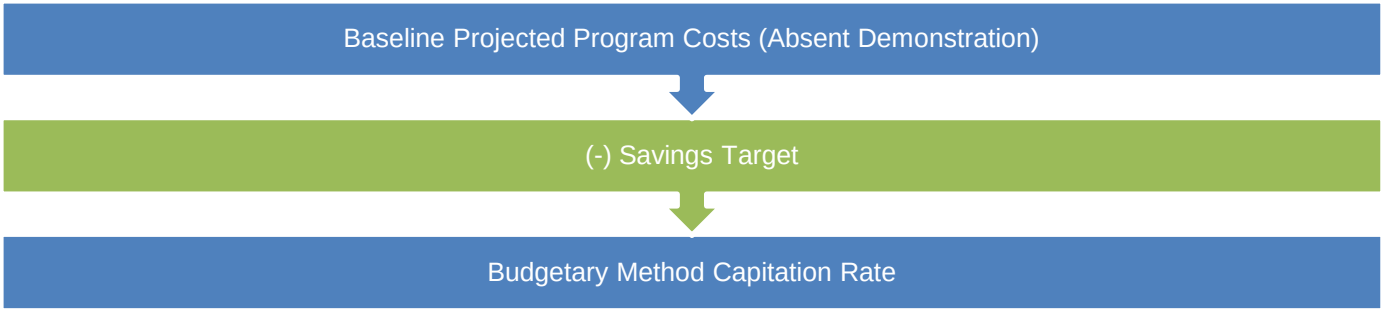
[1] Ohio memorandum of understanding p. 33.

[2] Ohio MOU ibid. p. 39.

a. Capitation rates based on the estimated cost of the current programs (Budgetary Method)

CMS has indicated the intention of developing the capitation rates for the dual demonstration programs using a methodology that is based on the estimated cost of the programs in the absence of the demonstration. Adjustments are anticipated to be applied to reduce the program costs by an explicit savings component that will be stated in the memorandum of understanding (MOU) between CMS and the NYSDOH. This proposed methodology resembles the historical Medicaid rate-setting methodology referred to as the upper payment limit (UPL) approach. Essentially, the capitation rates must be at or below a baseline cost amount to ensure program savings. This report refers to this methodology as the "budgetary method". Figure 1 illustrates the general approach contemplated in the budgetary method.

Figure 1: Illustration of Budgetary Method



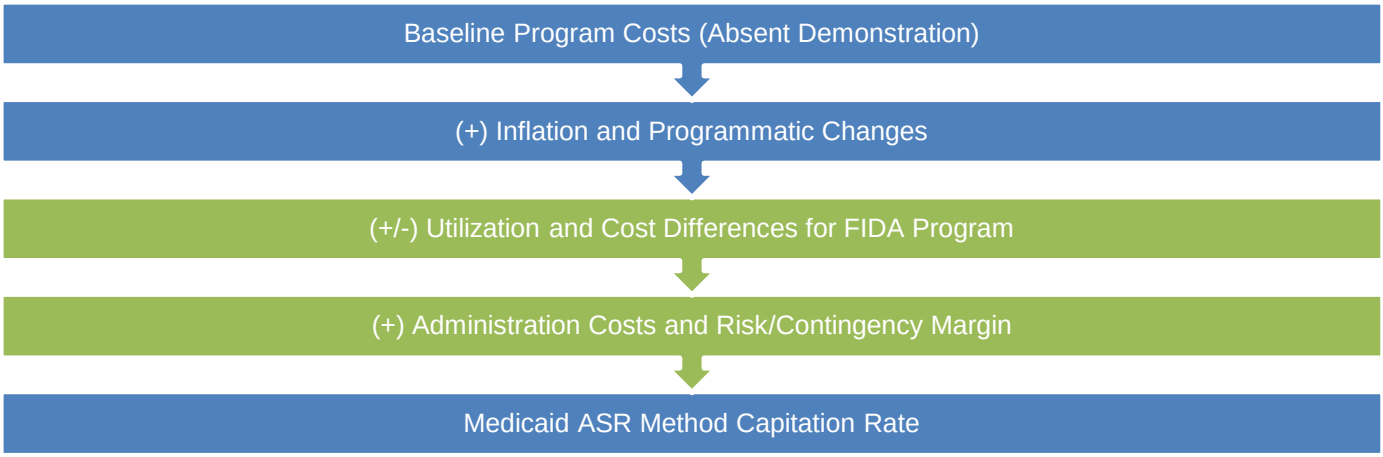
This approach allows for a transparent illustration of the program savings compared to the current program costs making it clear and understandable. This transparency ensures that a savings can be shown directly from the demonstration. Another defining characteristic of this methodology is that it does not require a significant amount of consideration of what the demonstration costs will be for the health plans as it is not based on the plan expected costs in the demonstration.

The budgetary method has the potential to create challenges for the certifying actuary. While the methodology appears reasonable and clearly communicated, the actuary will need to perform a separate rate calculation that complies with actuarial soundness requirements. The budgetary method on its own does not necessarily produce an actuarially sound rate, but could meet the requirements depending on the level of savings required and the assumptions made by the certifying actuary.

b. Capitation rates based on the estimated cost of the proposed program (Medicaid ASR method)

An alternative methodology for calculating capitation rates would directly follow the actuarial soundness requirements of 42 CFR 438.6(c) for the Medicaid component. The general nature of this methodology is that the rates are based on the estimated cost of the program that is being priced. This approach most often includes starting with a base population (e.g. historical fee-for-service) and applying adjustments to reflect the anticipated experience of the managed care program including items such as: utilization and reimbursement differences, morbidity differences, and administration costs for the health plans participating in the program. This report refers to this methodology as the "Medicaid actuarially sound rate (ASR) method". Figure 2 illustrates the general steps of the Medicaid ASR method.

Figure 2: Illustration of Medicaid ASR Method

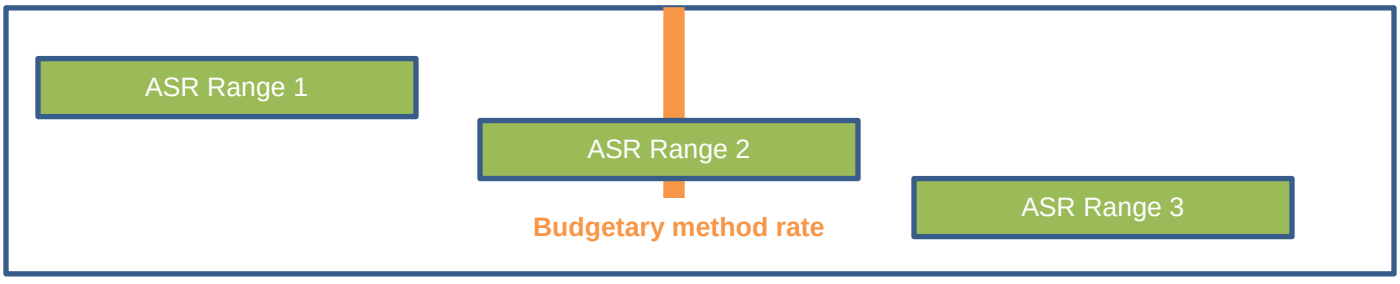


This approach allows for a capitation rate directly related to the anticipated experience of the FIDA program and better aligns with the requirements necessary to certify the capitation rates as actuarially sound. However, the primary trade-off is that it is not clear that the resulting capitation rates produce program savings without performing a comparison to the costs of the current programs in the absence of the demonstration.

c. Combination of the Budgetary Method and the Medicaid ASR Method

The budgetary and Medicaid ASR method each has its advantages and disadvantages. Ultimately, it is anticipated that there will need to be an optimal point in which these methods intersect for the program to be successful. The certifying actuary will need to be comfortable that the CMS-selected method meets the requirements of actuarial soundness on the Medicaid rates given that such certification is not being waived in the demonstration. An analysis similar to the Medicaid ASR method may be needed, even if the results of this analysis are not publicly disseminated. Figure 3 illustrates the concept of finding a balance between the budgetary and Medicaid ASR methods.

Figure 3: Illustration of Medicaid ASR Method



As shown in Figure 3, an actuarially sound range consistent with ASR Range 2 would allow for the budgetary method to be an appropriate level of payment because it falls within this range. Should the certifying actuary conclude that the actuarially sound range is below the budgetary method payment (ASR Range 1) or above the budgetary method payment (ASR Range 3), then the actuary may not be able to conclude that the budgetary method produces an actuarially sound payment and, as such, would not be able to certify the payments as being actuarially sound.

In reviewing the primary differences between the budgetary and Medicaid ASR methods (Figures 1 and 2), it can be observed that the intersection of the payments occurs when the net savings targeted in the budgetary method equal the net savings (utilization/cost savings from managed care less administrative costs needed to achieve the savings). Current thinking is that there is the ability to strike this balance, and the belief is that the targets selected by CMS were chosen with the net savings in mind. The ability of participating plans to achieve the savings in each year will depend on how quickly they are able to implement the infrastructure necessary to reach management efficiencies. The savings targets in early years are lower, but plans may be able to achieve more efficiency in later years after they have more experience with the FIDA program.

4. EXAMINATION OF PRIMARY RATE-SETTING PARAMETERS

The FIDA rate-setting process will require a significant number of assumptions to project the program costs and result in an appropriate capitation rate for the populations to be covered. Under both the budgetary method and the Medicaid ASR method, it is expected that items including selection of base data, projection of baseline spending, target savings, rate-cell definitions, quality withholds, risk adjustment, and other risk mitigation mechanisms will need to be considered and "priced" appropriately.

While there are other important parameters in this complex program, this report focuses on the most significant items included in the rate-setting methodologies. Each of the items is explored in detail below providing comments and considerations that may serve to provide insight in the development of capitation rates for the FIDA program.

a. Selection of base data

The availability of appropriate base data for use in rate-setting for the dual integration demonstrations has been the subject of numerous discussions and debate for many states. At the core of this issue are the Medicare Parts A, B, and D historical costs specific to the target population of the demonstration. Historically, this data has not been produced and shared with the states as the programs were largely disjoint with the exception of crossover (coordination of benefits) claims. CMS has recently developed new ways for states to obtain Medicare data for the evaluation of Medicare-Medicaid coordination, and on February 5, 2013, NYSDOH shared a Medicare-Medicaid Data Book containing summary cost information. However, data for both programs at the beneficiary level has been largely unavailable. If this data were available, a complete claim history could be reviewed on a seriatim basis to identify areas for more care coordination.

The current solution proposed for detailed population-based data is only applicable to the Medicaid component of the capitation rate. The rate-setting for the Medicaid component will use historical fee-for-service (FFS) and/or managed care experience from legacy managed care programs in the state to form the base data.

For Medicare Parts A and B, CMS has indicated that rate-setting will use data available through the current Medicare Advantage bid process: (1) FFS county benchmark data for FFS members, and (2) managed care average payment amounts by county (net of Part C rebates). For Medicare Part D, the National Average Monthly Bid Amount (NAMBA) will be used.

b. Projection of baseline spending

The projection of baseline spending is defined in this report as the amount the individual legacy programs would have cost in the absence of the FIDA demonstration. The CMS proposed method for calculating this amount differs by the program components and current source of coverage as follows:

- The Medicaid baseline will take into account historical costs, and will include consideration of Medicaid managed care plan level payment (if the State currently serves Medicare-Medicaid enrollees through capitated managed care) as well as FFS costs. This step may include the Managed Long-term Care program payments to the extent that the state continues with statewide mandatory implementation plans prior to the FIDA demonstration.

- For beneficiaries coming from Medicare FFS, the baseline costs will be calculated using the published Medicare standardized FFS county rates, which reflect historical costs (including federal administration costs) of the Medicare FFS population. (Note: the standardized FFS county rates are calculated by CMS as part of the annual Medicare Advantage rate announcement and were released on April 2, 2012 for calendar year 2013.) The standardized FFS county rates will be increased if Congress acts to delay or reduce the

physician fee cuts caused by the sustainable growth rate (SGR) formula. This adjustment is being applied to 2013 standardized FFS county rates. Standardized FFS county rates for CY 2014 will be released by CMS in April 2013.

- For beneficiaries coming from Medicare Advantage (MA), the baseline will reflect the estimated amounts that would have been factored into payments made to MA plans in which the beneficiaries would have been enrolled in the absence of the demonstration, including Part C rebates. Rebates will be calculated based on the county benchmarks that incorporate quality bonuses.

- The Medicare Part D projected baseline for the Part D direct subsidy will be set at the Part D national average monthly bid amount for the payment year, which is calculated in early August of each year. CMS will estimate an average monthly payment amount for the low-income cost sharing and federal reinsurance subsidy amounts; these payments will be 100% cost-reconciled after the payment year has ended.[3] It is not clear if standard Part D risk sharing will apply. The Joint Rate-Setting document does not specifically reference Part D risk sharing, the Ohio MOU states on p. 39: "*Cost reconciliation under Part D will continue as-is under the Demonstration*." But it may be referring to reinsurance and low-income cost-sharing settlements. [4]

The proposed methodology of calculating baseline spending does not appear to directly contemplate three potentially significant factors: (1) state administrative and other ancillary expenses attributable to the legacy programs in the absence of the FIDA demonstration, (2) costs of related programs that may be impacted by the demonstration, and (3) the treatment of Medicare crossover payments by Medicaid programs.

Because the baseline spending will be the value from which a target savings will be applied, it seems reasonable to include the costs of administering the current legacy programs so that any savings resulting from this expense can be attributed to the demonstration. However, there may not be any administrative savings to the state, depending on how much additional administration is needed to manage the FIDA program and whether the reduced FFS administration costs are largely marginal costs. The baseline for Medicare Parts A and B includes some federal administrative costs in the standardized FFS county rates according to documentation from CMS.[5] Typical spending on these types of programs by the state are in the range of 1% to 3%, which could serve to meet a material portion of the targeted savings to the extent they are reduced or removed under the demonstration—if the state believes it will achieve some administrative savings.

The second factor involves the definition of the FIDA-eligible population. Because the FIDA population only includes community LTSS individuals, the baseline spending will only include this cost component. Traditionally, program savings in the long-term care population result from rebalancing the mix of individuals away from institutional and into community settings. By defining the baseline spending as only community LTSS, the savings from the rebalancing (discussed more in the next subsection) is not automatically credited to the demonstration program. This result is due to the FIDA program reflecting the higher number of community LTSS members but not the lower number of institutional members, and therefore not including the savings from the new mix of membership between these settings.

The third factor is due to the way most state Medicaid agencies pay Medicare crossover claims (those for which Medicare has paid a portion). Most Medicaid agencies compare the amount that Medicare has paid to what would be paid if the service were only covered by Medicaid. The state would pay the difference needed to reach the Medicaid only payment amount. Many Medicare fees, reduced for beneficiary cost sharing, will still exceed what Medicaid

[3] CMS Joint Rate-Setting Document (2/8/2013) pp. 1-2

[4] Ohio memorandum of understanding p. 33

[5] CMS Joint Rate-Setting Document (2/8/2013) p. 4

would pay if the service were only covered by Medicaid. Thus many times Medicaid will not make any additional payment for a crossover claim. Many Medicare Advantage Dual Eligible Special Needs Plans contract with providers at 100% of Medicare. If the same holds true for FIDA plans then they will have higher crossover costs than is included in the historical Medicaid costs.

c. Net savings assumptions for managed care

As shown in Section 3 above, the intersection of the budgetary method and the Medicaid ASR method will result when the net savings assumed under each method are equal, with all other factors being constant. Net savings are defined in this report to be the gross savings resulting from the coordination of care and anticipated efficiencies from the FIDA health plans that will serve to reduce the overall claim cost of the combined programs minus the additional cost of non-claim items required to fund the administrative costs and risk that the health plans will incur to achieve these program savings. Said differently, the net savings is the total claim savings minus the cost to produce the savings.

The budgetary method selects a specific net savings attributed to the program in each year. The Medicaid ASR method builds the net savings expected using specific assumptions for claim savings and administrative related costs. The key concern for the certifying actuary is whether the methods intersect. For example, can the actuary justify total claim savings that are high enough to provide for all administrative requirements and net a 1% savings as anticipated in year 1 of the demonstration? This net savings target may grow to a range of 4% to 5% by year 3 of the demonstration.

To illustrate the net savings concept, ranges of typical claim savings and administrative costs are shown for the FIDA program components in Figure 4.

Figure 4: Illustration of Net Program Savings

PROGRAM COMPONENT	GROSS COST / (SAVINGS)	ADMINISTRATIVE COST	NET COST / (SAVINGS)
Medicare A/B FFS	(10) – (14)%	8 - 12%	(0) – (4)%
Medicare C	0%	0%	0%
Medicare A/B/C Composite	**(8) – (11)%**	**6 - 10%**	**(0) – (3)%**
Medicaid Community -LTSS	2 – (2)%	5 – 7%	3 – 9%
Medicaid Institutional-LTSS	0%	1 – 3%	1 – 3%
Medicaid LTSS Composite	**(4) – (8)%**	**3 - 5%**	**(0) – (4)%**
Composite			**(0) – (3)%**

Note: The values illustrated have not been established to represent the appropriate values for the FIDA program. Such specificity was beyond the scope and availability of data for this report.

The concept of net savings is simple in general terms but becomes complex when considering the interaction of various programs and the sources of program savings. The primary observations from the illustration include:

- **Medicare net savings may be diluted by the amount of current managed care penetration** for the FIDA eligible population because this program is already in managed care. The rate for this portion of the enrollment will be based on Medicare Advantage payment rates, which may be more or less than the county FFS costs.
- The Medicaid net savings depends significantly on the resulting composite savings from both community LTSS and institutional LTSS. This item results from the source of savings being driven by the mix of individuals moving from an institutional setting to a community setting and not by the reduction of costs of either specific category. The challenge with this source of savings is that **the FIDA program excludes the institutional LTSS and, as such, excludes the net savings resulting from the mix of individuals shifting toward community LTSS** (rebalancing).

d. Rate cell definitions

Rate cells are generally used in the development of capitation rates to reflect that different population segments exhibit unique cost characteristics. Rate cells are often used to distinguish between age cohort, gender, and program eligibility.

With respect to the FIDA demonstration, the following rate cell categories should be considered: (1) under and over age 65, and (2) individuals eligible through the New York State Office for People with Developmental Disabilities (OPWDD). The consideration should include a balance of cost/risk differences and the credibility of the resulting populations as rate cells are introduced. For example, individuals who are dual eligible under 65 are generally qualified as disabled and dual eligibles over 65 may or may not be disabled. This difference often leads to higher costs (often approximately 10% to 30%) for the under-65 dual eligible population, especially related to the Medicaid services.

To the extent that individuals eligible or not for institutional LTSS (i.e., community well) were included in the demonstration, rate cells at that level should be additionally considered.

e. Quality Withholds

Quality withholds and bonuses are a common component of most Medicaid managed care programs in place today. The general approach is to provide financial incentives to improve program outcomes and measure the quality of the care being delivered to the enrolled population. The application of capitation withholds is contemplated in the CMS rate-setting process. The specific parameters are as follows:

- To provide incentive for quality improvement, CMS and the State will withhold a portion of the capitation payments that participating health plans can earn back if they meet certain quality thresholds.
- CMS expects the threshold measures to be a combination of certain core quality measures (consistent across all demonstrations under the Financial Alignment Initiative), which will be a subset of a larger integrated quality reporting measurement set, and state-specified performance measures that are more specific to the target population of each demonstration. Each state will work with CMS as part of its MOU negotiation to develop the state-specific performance measures that will be used for the purposes of the quality withhold.
- In year 1, encounter reporting may be utilized as the basis for the 1% withhold, plus any additional CMS or state-proposed requirements. CMS expects that the quality withhold will be of increasing amounts (2% in year 2 and 3% in year 3) and will be based on performance in the core demonstration and state-specified measures. (Note: Part D payments will not be subject to a quality withhold.)[6]

In the context of actuarial soundness, any capitation withholds and resulting payments must be actuarially sound. As stated previously, this applies directly to the Medicaid component of the capitation rate and indirectly to the Medicare component of the capitation rate. The key consideration with any type of withhold is that the measures and targets should be actionable and result in the desired program outcomes. The targets should be set such that a moderate to highly performing plan can achieve the targets, and the capitation rate must be actuarially sound even if the withhold is not returned to the health plan.

The amount of the withhold observed in the MOUs published to date for other states appear in line with general levels used in current Medicaid managed care programs. Another important note is that the FIDA plans will not be eligible for the CMS star rating bonus program currently available in the Medicare Advantage program. The average level of star rating bonus for the Medicare Advantage plans that previously enrolled FIDA participants will be included in the Medicare payment rate for those individuals.

f. Risk adjustment

Risk adjustment takes many forms in current practice. The primary use of risk adjustment is to reflect unique characteristics of various population cohorts. Rate cells (discussed previously) are a form of risk adjustment and are often used in conjunction with other methods such as diagnosis-based methods that categorize individuals based on historical disease prevalence observed in the claim data. Most frequently, risk adjustment is used to vary payments to health plans based on the illness burden they enroll compared to a base 1.0 rate. For this reason, the majority of risk adjustment methodologies used in Medicaid programs are setup to be budget-neutral, meaning that if one plan had higher than average risk then other plans would have lower-than-average risk. Payments to the health plans would be adjusted from the base to reflect this difference in enrolled risk. Medicare Advantage risk adjustment is

[6] CMS Joint Rate-Setting Document (2/8/2013) p. 3

intended to adjust for differences in risk between the Medicare FFS program and those beneficiaries actually enrolling in Medicare Advantage.

Risk adjustment in a dual demonstration program such as FIDA would need to be applied to the different components of Medicare Parts A and B, Medicaid, and Medicare Part D. The segmentation is necessary because of the characteristics that make up differences in cost structures. For example, individuals with specific diseases may exhibit significant cost differences for Medicare Parts A and B while their Medicaid LTSS costs vary based on other factors such as level of need and community resources available. The risk adjustment process will need to account for the differences among the individual components even in an integrated program.

CMS has indicated its intent to use the current Hierarchical Condition Categories (HCC) risk adjustment methods currently used in Medicare Advantage and Medicare Part D. This decision is an important consideration for the FIDA program as the baseline expenditures will be based on all Medicare beneficiaries (by county) and the risk adjustment will be tasked with changing the revenue from a base 1.0 (all Medicare populations) to an adjusted base of the dual eligible population enrolling in FIDA. For this reason, the risk adjustment will not likely be budget-neutral around the base rate, specifically for the FIDA population. The risk adjustment will include both a base population adjustment and a plan–to-plan variation component.

As with the Medicare Part A and Part B risk adjustment, the Part D risk adjustment is intended to adjust from a 1.0 (all Medicare populations) to capture the base FIDA beneficiary adjustment as well as the plan-to-plan variation component. The key difference, besides the underlying HCC model used, is that the Part D component is a base of the national average monthly bid amount (NAMBA) and not a county-based metric.

Risk adjustment methods are generally based on a form of regression model that identifies key contributory variables and estimates the best fit or maximum likelihood function of explaining the differences among populations. One primary consideration as it relates to the proposed CMS methodology is that general regression models tend to under-adjust at the extreme points of the cost curve. In other words, risk adjustment tends to overestimate the risk of lower-cost populations and underestimate the risk of higher-cost populations. When a risk adjustment mechanism is centered around a 1.0 population, this issue is somewhat mitigated and tends to offset itself; however, the use of risk adjustment to estimate the shift in base from an all-Medicare population to a FIDA-eligible population has the potential to underestimate the risk of the higher-cost FIDA population in the aggregate.

The risk adjustment methodology for the Medicaid LTSS component of the FIDA program should be considered separately from the Medicare components for the reasons previously stated. The NYSDOH has indicated their intention to use a needs-based assessment methodology of risk adjustment similar to the current New York managed long-term care (MLTC) process. The specific details of the proposed approach were not available as of the date of this report. However, in general, this process is the current practice for adjusting risk in several Medicaid long-term care programs.

g. Risk mitigation mechanisms

Risk adjustment as discussed previously is a form of risk mitigation. There are several other forms of risk mitigation in use in risk-based healthcare programs such as Medicaid and Medicare including reinsurance/stop loss and risk-sharing provisions/corridors. Together with risk adjustment, these risk mitigation mechanisms have been elevated to commonplace discussion as one result of the Affordable Care Act (i.e. the “3 Rs”). However, these methods have been in place for numerous Medicaid programs across the country for a significant period of time and in Medicare Part D since its beginning in 2006. Risk mitigation is often used to protect against insolvency concerns for small health plans or to bridge the gap for new programs where a credible historical cost basis is unavailable. Both of these uses are a concern in the proposed FIDA program.

Reinsurance or stop-loss is generally used to protect against the risk of extreme cost fluctuation in a population (e.g., protecting a small plan against multimillion dollar claims). This form of risk mitigation can be performed through the program itself in the form of a large claim pooling program or health plans can be required or encouraged to purchase commercial reinsurance on the open market. This decision is of an administrative or oversight preference and was not considered in this report.

Risk corridors, if contemplated, would need to be implemented as part of the FIDA program structure, as this mechanism can only be operated from the program administration level. Medicaid actuarial soundness requirements allow for the use of risk corridors within a specific amount, but it is not clear where this discussion is with the New York FIDA MOU. The advantage of a risk corridor element within the FIDA program is solvency protection for participating plans, helping to ensure program stability and viability. However, with this advantage is the issue of demonstrating program savings. Risk corridors could result in payments through the demonstration that are higher than the targeted savings amount would allow. Ultimately, it appears that there is actuarial justification for a risk corridor mechanism given the uncertainty of demonstration costs; however, it is not clear whether and how this fits into the demonstration savings goals. As with reinsurance, this decision is of an administrative or oversight preference and was not considered in this report.

h. Future period rate adjustments

The FIDA program, along with all other dual demonstration programs, will be implemented under a demonstration opportunity that is three years in duration. This report focuses on the methodology and assumptions primarily for the first year of the program. Most of the comments can be extrapolated to the second and third years; however, these later periods will include additional considerations. The primary areas of discussion relate to the inclusion of actual FIDA health plan experience in capitation rate-setting, the increased savings requirements, and the implementation of the Medicare Advantage risk adjustment coding intensity factor.

Capitation rate-setting that is based on historical program experience generally reflects data that is two to three years prior to the effective period of the rates. This delay is due to the time necessary to collect, analyze, and calculate the capitation rates, as well as the advanced timing required to complete the documentation and approval process. For example, capitation rates to be effective in calendar year 2014 will be calculated in 2013, using data from 2011 or 2012. The lag time between the historical data and the rate effective period is expected to result in capitation rates for FIDA demonstration years 1 and 2 that will not have the benefit of reviewing detailed FIDA program experience. Demonstration year 3 rate setting may or may not be able to include the actual FIDA experience. Because of this limitation, it will be important for the actuary determining the capitation rates to monitor health plan financial experience for the FIDA program to ensure that the comparable experience used (e.g., fee-for-service data) remains reasonable and appropriate.

The proposed rate-setting methodology requires specific savings targets for each year of the demonstration. While it has been stated that the savings targets may vary by demonstration state, it is expected to be common for programs with common characteristics, including: proportion of current Medicare Advantage enrollment and current mix of institutional and community LTSS. One common theme emerging is that the level of savings is expected to increase each year of the demonstration, most likely by 1% to 2% per year.

In addition to the increased savings targets expected each year, the proposed rate-setting methodology will begin using the Medicare Advantage coding intensity factor after 2013. The coding intensity factor is currently used in the Medicare Advantage program to recognize that health plans attempt to maximize HCC risk adjustment scores, which results in a coding advantage over the Medicare fee-for-service program. The factor is 3.41% for 2013 and 4.91% for 2014. The factor serves to reduce the Medicare Advantage risk scores. The primary rationale for not including the coding intensity factor in 2013 is that most of the individuals expected to enroll will be risk-adjusted based on historical fee-for-service data, and therefore would not have the risk adjustment advantage that the coding intensity

factor is intended to correct. It will be important to understand whether the data that will be used for HCC risk adjustment in years 2 and 3 will remain historical fee-for-service data or if actual FIDA program health plan experience will become available for risk adjustment purposes. For example, the risk adjustment for 2014 capitation rates will most likely reflect historical diagnosis data from 2012 because of the inherent delay in the risk adjustment calculation methodology, and as such, scores may be based on FFS data. Risk scores in 2016 are more likely to include 2014 health plan data, which would be more appropriate to use in conjunction with the application of the coding intensity factor. If the data source remains FFS, there may be an issue with applying the coding intensity factor because FFS data is not believed to be advantaged with respect to increased HCC coding. However, all Medicare Advantage plans have the coding intensity factor applied to them, even in their first year in Medicare Advantage.

5. LIMITATIONS AND DATA RELIANCE

The information contained in this report was prepared for the New York Health Plan Association (HPA). Milliman's work may not be provided to third parties without Milliman's prior written consent. Written consent is hereby granted for the New York State Department of Health, the Centers for Medicare and Medicaid Services (CMS), other appropriate New York state agencies, the Division of Budget, the Executive Chamber, and the HPA member organizations. The letter should be distributed in its entirety, including all supporting documentation.

Milliman does not intend to benefit and assumes no duty or liability to third parties who receive this letter, even if we consent to its release. Milliman recommends that any recipient be aided by its own actuary or other qualified professional when reviewing this letter.

In developing this report, we relied on data and other information obtained from the New York FIDA Finance Workgroup, CMS, and other public sources of information. We have not audited or verified this data and other information. We performed a limited review of the data used directly in our analysis for reasonableness and consistency. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

The services provided by Milliman to the HPA were performed under the signed agreement dated November 12, 2010.

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