Medicare Payment Update

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Session Objectives

- Medicare Payment Update (slides 2-21)
  - Risk Adjustment Methodology
  - 2012 through 2016 Experience
  - Looking Ahead to 2017
- Medicare ESRD Payment Update (slides 22-49)
  - Risk Adjustment Methodology
  - 2012 through 2016 Experience
  - Looking Ahead to 2017
- Encounter Reporting Update (slides 43-47)
CMS-HCC Risk Adjustment Models

- CMS-HCC for Parts A and B (aka Part C) non-ESRD beneficiaries and functioning graft patients
- CMS-HCC ESRD for Part C dialysis and transplant patients
- Rx-HCC for Part D
Medicare Risk Adjustment Components

- County Benchmark Payment Rate
- Participant’s HCC Risk Score
- Normalization Factor
- MA Coding Intensity Adjustment
- Frailty Adjuster

Note: Frailty Adjustor not applied to LTI or ESRD
Frailty Adjustment

- Accounts for variations in PACE participants’ Medicare costs not explained by the CMS-HCC model
- Organizational-level frailty adjuster added to HCC risk score for community-based and “new enrollees”
- Frailty adjuster based on functional impairments reported by each PACE organization’s enrollees on Health Outcomes Survey-Modified (HOS-M)
Part C Risk Score and Payment Calculation

- **Raw Risk Score** = Demographic Relative Factors + Disease Relative Factors
- **Normalized Risk Score** = Raw Risk Score/Normalization Factor
- **Adjusted Risk Score (for MA Coding Intensity)** = Normalized Risk Score * (1 – MA Coding Intensity Factor)
- **Adjusted Risk Score with Frailty** = Adjusted Risk Score + Frailty Factor
- **Risk Adjusted Payment** = Monthly Capitation Rate * Adjusted Risk Score with Frailty
County payment rates are the greater of:

- prior year’s rates trended forward (using MA Growth rate)
- average per capita fee-for-service payment amounts

Payment rates vary significantly across counties, e.g., in 2017 (rounded):

- New Orleans, LA (St. Bernard county): $1540
- Miami, FL (Dade county): $1463
- Oakland, CA (Alameda county): $1063
- Pittsburgh, PA (Allegheny county): $950
- Portland, OR (Multnomah county): $898
- Big Stone Gap, VA (Dickenson county): $780
Community Resident

- 82 year-old woman: .517
- Medicaid eligible: .213
- CHF (HCC85): .361
- COPD (HCC111): .388
- Dementia (HCC 51): .616
- CHF_COPD (INT4): .255

Unadjusted Risk Score = 2.35
- Normalization Factor: 1.051

Normalized Risk Score = (2.35/1.051) = 2.235
- MA Coding Intensity Adjustment: 5.66%

Adjusted Risk Score = 2.285 * (1-.0516) = 2.108
Community Resident

- HCC Adjusted Risk Score* = 2.108
- Frailty Adjuster = .105
- County Payment Rate = $922.68**
- Payment = (2.108 + .105) * $922.68 = $2041.89

* After normalization and coding intensity adjustment
Medicare Risk Scores in PACE

2012–2016

Year


Risk Factor

2.40 2.45 2.44 2.54 2.52
Frailty Adjusters in PACE

2012-2016


0.300

0.250

0.200

0.150

0.100

0.050

0.000

0.148

0.158

0.156

0.148

0.142

0.052
Medicare Part A/B PMPM Payments to PACE*

2012-2016

* Payments are averages across all beneficiaries
Note: The HCC component makes up the largest percent of a risk score and is the portion that is determined by the diagnostic information submitted by each PACE site.
% of Enrollees with 0-4+ HCCs by PACE Site

August 2016

Avg Risk Score for this Site: 3.212

Avg Risk Score for this Site: 1.72
HCCs for the Top 20% Most Costly PACE Participants

August 2016
Looking Ahead: What Changes in 2017?

- Normalization Factor for PACE will increase from 1.042 to 1.051
- MA Coding Intensity Adjustment will increase from 5.41% to 5.66%
- MA Growth Rate increased 3.08%
Looking Ahead: What Doesn’t Change in 2017

1) PACE will retain the current CMS HCC Risk Adjustment model (v21)

<table>
<thead>
<tr>
<th>ADL Count</th>
<th>Non-Medicaid</th>
<th>Medicaid</th>
</tr>
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<td>-0.062</td>
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<td>1-2</td>
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<td>0.000</td>
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<td>3-4</td>
<td>0.272</td>
<td>0.147</td>
</tr>
<tr>
<td>5-6</td>
<td>0.272</td>
<td>0.380</td>
</tr>
</tbody>
</table>

Frailty Adjuster Factors will be the same as in 2016:

Example: Calculation of a site-specific frailty adjuster

<table>
<thead>
<tr>
<th>ADL Count</th>
<th>Non-Medicaid*</th>
<th>Medicaid*</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0.2% * (-.062) = -0.000124</td>
<td>13.4% *(-.189) = -0.025326</td>
<td></td>
</tr>
<tr>
<td>1-2</td>
<td>0.3% *.152 = .00456</td>
<td>23.6% * 0 = 0.00</td>
<td></td>
</tr>
<tr>
<td>3-4</td>
<td>0.4% * .272 = .002568</td>
<td>24.0% * .147 = .03528</td>
<td></td>
</tr>
<tr>
<td>5-6</td>
<td>0.8% * .272 = .002176</td>
<td>37.3% * .380 = .14174</td>
<td></td>
</tr>
</tbody>
</table>

Frailty Adjuster: .00918, .151694, 0.161

* Percentages in each cell are the results of the HOS-M Survey
Relationship of Adjustments to Payment

- Direct Relationship — Higher Factor Increases Payment
  - PACE County Payment Rate
  - Medicare Growth Rate
  - Participant’s HCC Risk Score
  - Frailty Adjustor

- Inverse Relationship — Higher Factor Decreases Payment
  - Normalization Factor
  - MA Coding Pattern Differences Adjustment
How Do These Changes Affect Risk Scores And Payments?

Net Estimate: Approximately 2% increase in Payments to PACE

- An Increase in Normalization Factor * decreases Risk Scores
- An Increase in MA Coding Intensity Adjuster * decreases Payment
- An Increase in MA Growth Rate increases Payment

* If coding held constant

Will Decrease Risk Scores
Will Increase County Risk Rates

HCC Model v21 and Frailty Factors are unchanged
Estimated Impact of 2017 Payment Changes

- PACE organizations’ average county benchmark payment amount increased by approximately 2%
  
  \[
  2016 = 895.11 \quad 2017 \text{ interim} = 922.68
  \]

- PACE participants’ average total risk scores decreased by approximately 1.5%
  
  \[
  2016 = 2.54 \quad 2017 \text{ interim} = 2.52
  \]

- In general, PACE organizations’ interim PMPM payments will increase due to a higher MA Growth Factor
  
  \[
  2016 = 2,315.75 \quad 2017 \text{ interim} = 2,361.78
  \]
• Sequestration continues into 2017

• 2% reduction to Medicare Part C payments
  • Applies to what CMS would have otherwise paid, under current law
  • Not cumulative, year to year

• Shown in Monthly Plan Payment Reports
• Who are Enrollees with ESRD?

- For the purpose of MA payment, “ESRD beneficiaries” means beneficiaries with ESRD, whether entitled to Medicare because of ESRD, disability, or age, and includes beneficiaries in dialysis, transplant, and post-transplant functioning graft statuses.
Since CY 2006, CMS has had the authority to determine whether and how to incorporate costs for ESRD enrollees into the bidding methodology, per regulation.

To date, ESRD enrollee costs have not been included in plan bids for non-prescription drug benefits, and CMS continues to pay MA organizations for ESRD plan enrollees using the MA capitation rates.
The ESRD CMS-HCC model differs significantly from the CMS-HCC risk adjustment model used for payment for non-ESRD enrollees.

The ESRD model is a three-part model that distinguishes payments for:

- dialysis patients
- patients receiving kidney transplants
- beneficiaries with functioning kidney grafts
• The risk factors in this model reflect disease and expenditure patterns specific to dialysis patients.
• Patients’ risk scores are multiplied by a statewide rate (in contrast to county rates used for non-ESRD enrollees).
Recognizing the high one-time cost of a transplant, CMS makes payments over three months to cover the transplant and immediate subsequent services.

As with dialysis patients, payments for transplant patients are calculated using statewide rates.
Risk adjustment for these beneficiaries is based on the CMS-HCC risk model for the general population, although a few HCCs have been removed and extra terms have been added specific to being in functioning graft status, e.g. to recognize Medicare coverage of immunosuppressive drugs.

The functioning graft payment automatically begins the month after the third transplant payment unless an enrollee has returned to dialysis.

As is the case with the CMS-HCC risk model for non-ESRD enrollees, payments are calculated using county payment rates.
ESRD Risk Adjustment Components

- State Benchmark Payment Rate
- Participant’s HCC Risk Score
- Normalization Factor
- County Benchmark Payment Rate*
- MA Coding Intensity Adjustment*

* Used in Functioning Graph Model only
CMS-HCC ESRD Payment Calculation

Dialysis

• **Raw Risk Score** = Demographic Relative Factors + Disease Relative Factors

• **Normalized Risk Score** = Raw Risk Score/Normalization Factor

• **Risk Adjusted Payment** = State Base Rate * Adjusted Risk Score
State Payment Rates CY2017

• Payment rates vary significantly across states, e.g., in 2017 (rounded):

  • New Jersey: $8195
  • Pennsylvania: $7067
  • Texas: $6785
  • Oklahoma: $6340
  • Iowa: $5960
  • North Dakota: $5488
Community Resident
- 82 year-old woman: 0.517
- Medicaid eligible: 0.213
- CHF (HCC85): 0.361
- COPD (HCC111): 0.388
- Dementia (HCC 51): 0.616
- CHF_COPD (INT4): 0.255

Unadjusted Risk Score = 2.35
- Normalization Factor: 1.051

Adjusted Risk Score = (2.35/1.051) = 2.235
Example Payment Calculation for Community Enrollee

Dialysis

- HCC Adjusted Risk Score* = 2.235
- State Payment Rate = $8195 (New Jersey)
- Payment = 2.235 * $8195 = $18,316

* After normalization
• **Raw Risk Score** = Demographic Relative Factors + Disease Relative Factors

• **Normalized Risk Score** = Raw Risk Score/Normalization Factor

• **Adjusted Risk Score (for MA Coding Intensity*)** = Normalized Risk Score * (1 – MA Coding Intensity Factor)

• **Risk Adjusted Payment** = County Base Rate * Adjusted Risk Score

* Coding Intensity Adjustment only applies to Post-Graft Model
Community Resident
- 82 year-old woman: .517
- Medicaid eligible: .213
- CHF (HCC85): .361
- COPD (HCC111): .388
- Dementia (HCC 51): .616
- CHF_COPD (INT4): .255

Unadjusted Risk Score = 2.35
- Normalization Factor: 1.051

Normalized Risk Score = (2.35/1.051) = 2.235
- MA Coding Intensity Adjustment: 5.66%

Adjusted Risk Score = 2.235 * (1-.0566) = 2.108
Example Payment Calculation for Community Enrollee

Functioning Graph

- HCC Adjusted Risk Score* = 2.108
- County Payment Rate = $1008 (Camden Co. NJ)
- Payment = 2.108 * $1008 = $2125

* After normalization and coding intensity adjustment
ESRD Payment in CY 2017

- No change in CMS-HCC ESRD models (dialysis, transplant, functioning graft)
- Normalization factors for the CMS-HCC ESRD models in 2017:
  - Dialysis model: 0.994
  - Functioning graft model: 1.051
- In PACE states, ESRD rates decreased by an average of approximately 1.4%
ESRD Group identifies the various types of ESRD enrollees enrolled in PACE organizations:

- Dialysis,
- Functioning Graft and
- ESRD MSP

Dialysis and functioning graft enrollees are described above.
ESRD MSP enrollees are those beneficiaries for whom Medicare is a secondary payer and for whom Medicare payments are reduced substantially as a result.

In all cases, ESRD MSP enrollees are dialysis patients.
Based on a review of the final MMRs for the period 2012-2016, there were no PACE enrollees identified as transplant patients.
Although it is possible that a kidney transplant patient may have been enrolled in PACE sometime other than the month of July or August during this five-year period, NPA staff are not aware of this having occurred.
ESRD Groups/Population in PACE

Dialysis

- 2012: 460
- 2013: 508
- 2014: 634
- 2015: 713
- 2016: 807

Functioning Graft

- 2012: 20
- 2013: 20
- 2014: 26
- 2015: 32
- 2016: 43

MSP-Transplant/Dialysis

- 2012: 4
- 2013: 2
- 2014: 2
- 2015: 0
- 2016: 1
Average ESRD PMPM in PACE

<table>
<thead>
<tr>
<th>Year</th>
<th>Dialysis</th>
<th>Functioning Graft</th>
<th>MSP-Transplant/Dialysis</th>
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<tr>
<td>2012</td>
<td>$9,254</td>
<td>$3,121</td>
<td>$1,602</td>
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<tr>
<td>2013</td>
<td>$8,638</td>
<td>$3,227</td>
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<td>2014</td>
<td>$8,562</td>
<td>$3,391</td>
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<tr>
<td>2015</td>
<td>$8,682</td>
<td>$3,708</td>
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<tr>
<td>2016</td>
<td>$9,012</td>
<td>$3,719</td>
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</table>
All Type ESRD vs Total PACE Enrollment

2011-2015

All ESRD Types

<table>
<thead>
<tr>
<th>Year</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
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<tr>
<td>Value</td>
<td>484</td>
<td>530</td>
<td>662</td>
<td>745</td>
<td>851</td>
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</table>

Total PACE population

<table>
<thead>
<tr>
<th>Year</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
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</thead>
<tbody>
<tr>
<td>Value</td>
<td>25443</td>
<td>28255</td>
<td>31654</td>
<td>34413</td>
<td>35725</td>
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</table>
Flow Chart of ESRD Payments

1. **PACE Participant**
   - Reduced kidney function?
     - Yes: Renal Center, Form 2728
     - No: CMS-HCC Model

2. **Renal Center, Form 2728**
   - Dialysis Model

3. **Dialysis Model**
   - Kidney Transplant Eligible?
     - Yes: Transplant Payments
       - Transplant Successful?
         - Yes: Functioning Graph Model
         - No: 4th month
     - No: Dialysis Model

4. **Transplant Payments**
   - 3 months – 50%; 25%; 25%
Currently there are 2 drivers:

**Federal** – CMS continues to devise ways to adjust the current payment model

**States** – Trending towards full Managed Care for Medicaid (i.e. New York, California, Wisconsin, Kansas)
Encounter Reporting Update

• NPA has continued to voice concerns towards encounter reporting requirements and PACE recognizing that this requirement is an ill fit and antithetical to the PACE model of care.

• NPA is encouraged by continuing conversations with CMS and their increasing understanding of the uniqueness of the PACE model and its differences as compared to MA Plans.
• PACE organizations are currently only required to submit encounter data for services in which they have claims.

• NPA has developed the Professional "Superbills" as a means for PO's to begin becoming accustomed to documenting and submitting this information and to assist them in constructing the organizational infrastructure to do so.

• Utilizing the professional superbills, NPA suggests that PO’s begin blending these with the claims already being submitted to CMS.

• This will allow PO’s to build into their existing systems a methodology for capturing and submitting the information well in advance of when CMS requires full-on encounter reporting.
Encounter Reporting Update

For PACE

• From the 2017 Advance Notice of Payment concerning Encounter Data Reporting and PACE:

  “For PACE organizations, we propose to continue the same method of calculating risk scores as used for the 2016 payment year, which is to use diagnoses from the following sources in equal measure (with **no blending/weighting**): (1) Encounter Data System (EDS) data valid for risk adjustment with 2016 dates of service; (2) Risk Adjustment Processing System (RAPS) data valid for risk adjustment with 2016 dates of service; and (3) Diagnoses from FFS claims valid for risk adjustment.”

• CMS confirmed this in the 2017 Final Notice of Payment

• There will be **NO** requirement for internal encounter reporting before **1/1/2018**.
Federal:

**CMS continues its push to fully utilize EDR for risk adjustment**
- CMS’s goal is to transition entirely from using diagnoses submitted to RAPS to using diagnoses from encounter data and they intend to continue transitioning away from a reliance on RAPS data for calculating risk scores.
- Currently in year 2 of transition to full EDR for MA risk adjustment
- Expectation is that risk scores will be 100% encounter data/FFS-based in 2020 (PY2019).

States:

**Effort continues towards the Managed Care Model in the absence of FFS data in establishing Medicaid rates; increasingly reliant on EDR**
- Recently released (May 6, 2016) Medicaid Managed Care final rule heavily influenced by the Medicaid Statistical Information System (MSIS) and Transformed-Medicaid Statistical Information System (T-MSIS)
- Provisions in final rule that relate to routine reporting of state encounter data as a condition for receiving federal matching payments for medical assistance
- States have graduated 3-year time period to be compliant with encounter data reporting requirements
Additional Resources

• 2017 Final Notice of Payment


• ESRD


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