Medicare Payment Update

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Session Objectives

• Medicare Payment Update
  • Risk Adjustment Methodology
  • 2011 through 2015 Experience
  • Looking Ahead to 2016
• Medicare ESRD Payment Update
  • Risk Adjustment Methodology
  • 2011 through 2015 Experience
  • Looking Ahead to 2016
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 Rate * Adjusted Risk Score with Frailty
County payment rates CY2016

- 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 2016 (rounded):

  - Miami, FL (Dade county): $1418
  - New Orleans, LA (Orleans county): $1212
  - Oakland, CA (Alameda county): $1028
  - Pittsburgh, PA (Allegheny county): $913
  - Portland, OR (Multnomah county): $871
  - Big Stone Gap, VA (Wise county): $786
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: 1.028
Normalized Risk Score = (2.35/1.028) = 2.285
- MA Coding Intensity Adjustment: 5.16%

Adjusted Risk Score = 2.285 * (1-.0516) = 2.17
Example of Payment Calculation for Community Enrollee

- HCC Adjusted Risk Score* = 2.17
- Frailty Adjuster = .105
- County Payment Rate = $845.21
- Payment = (2.17 + .105) * $845.21 = $1922.85

*After normalization and coding intensity adjustment
Medicare Risk Scores in PACE 2011–2015

![Box plot showing Medicare Risk Scores in PACE 2011–2015](image)
Frailty Adjusters in PACE: 2011-2015

* Payments are averages across all beneficiaries
Risk Scores Components by PACE Site: August 2015
% of Enrollees with 0 and 4+ HCCs by PACE Site: August 2015

Average Risk Score for this PACE Site = 3.33

Average Risk Score for this PACE Site = 1.53
Distribution of Most Prevalent HCCs for the Top 20% Most Costly PACE Participants: August 2015
Looking Ahead: What Changes in 2016?

- **Normalization Factor for PACE**: will increase from 1.028 to 1.042
- **MA Coding Intensity Adjustment**: will increase from 5.16% to 5.41%
- **MA Growth Rate**: will increase from -4.07% to 5.04%
Looking Ahead: What Doesn’t Change in 2016

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

2) Frailty Adjuster Factors will be the same as in 2015:

<table>
<thead>
<tr>
<th>ADL Count</th>
<th>Non-Medicaid</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>-0.062</td>
<td>-0.189</td>
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<tr>
<td>1-2</td>
<td>0.152</td>
<td>0.000</td>
</tr>
<tr>
<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>

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>
<tr>
<td>Frailty Adjuster</td>
<td>.00918</td>
<td>.151694</td>
<td>0.161</td>
</tr>
</tbody>
</table>

* Percentages in each cell are the results of the HOS-M Survey
Relationship 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?

- An Increase in Normalization Factor *Will Decrease Risk Scores
- An Increase in MA Coding Intensity Adjuster* Decreases Payment
  * If coding held constant

Net Estimate: Approximately 3% increase in Payments to PACE

- An Increase in MA Growth Rate Will Increase County Risk Rates

HCC Model v21 and Frailty Factors are unchanged
Estimated Impact of 2016 Payment Changes

- PACE organizations’ average county benchmark payment amount increased by 3.45%
  \[2015 = 857.95 \quad 2016 \text{ interim} = 901.19\]

- PACE participants’ average total risk scores decreased by approximately 1.6%
  \[2015 = 2.43 \quad 2016 \text{ interim} = 2.39\]

- In general, PACE organizations’ interim PMPM payments will increase due to a higher MA Growth Factor
  \[2015 = 2,266.79 \quad 2016 \text{ interim} = 2,344.95\]
Impact of Sequestration

• Sequestration continues into 2016
  – 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
Looking Ahead: Coding Intensity

• CMS is reviewing the Medicare Advantage coding intensity adjustment methodology
• MedPAC recently analyzed the impact of home assessments on Medicare Advantage risk scores
• CMS concerned the methodology and the use of home assessments overstates the acuity of MA relative to FFS
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.
Overview of ESRD Program

- CMS ESRD Payment Options

- 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.
Overview of ESRD Payment Model

• 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
Risk Adjustment Model for Dialysis Patients

- 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).
Risk Adjustment Model for Transplant Patients

• 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 Model for Functioning Graft Beneficiaries

- 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 Post-Graph Model only
CMS-HCC ESRD Risk Score and 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 CY2016

• Payment rates vary significantly across states, e.g., in 2016 (rounded):
  – New Jersey: $8269
  – Pennsylvania: $7210
  – Texas: $6980
  – Oklahoma: $6482
  – Iowa: $6014
  – North Dakota: $5472
Example CMS-HCC ESRD Risk Score Calculation (Dialysis)

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: 1.028

Adjusted Risk Score = (2.35/1.028) = **2.285**
Example of Payment Calculation for Community Enrollee (Dialysis)

- HCC Adjusted Risk Score* = 2.285
- State Payment Rate = $8269 (New Jersey)
- Payment = 2.285 * $8269 = $18,895

*After normalization
CMS-HCC ESRD Risk Score and Payment Calculation (Post-Graph)

• **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
Example CMS-HCC ESRD Risk Score Calculation (Post-Graph)

Community Resident
• 82 year-old woman: .517
• Medicaid eligible: .213
• CHF (HCC85): .361
• COPD (HCC111): .388
• Dementia (HCC 51): .616
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Unadjusted Risk Score = 2.35
• Normalization Factor: 1.028
Normalized Risk Score = (2.35/1.028) = 2.285
• MA Coding Intensity Adjustment: 5.16%
Adjusted Risk Score = 2.285 \times (1-.0516) = 2.17
Example of Payment Calculation for Community Enrollee (Post-Graph)

- HCC Adjusted Risk Score* = 2.17
- County Payment Rate = $971 (Camden Co. NJ)
- Payment = 2.17 * $971 = $2107

* After normalization and coding intensity adjustment
ESRD Payment in CY 2016

- No change in CMS-HCC ESRD models (dialysis, transplant, functioning graft)
- Normalization factors for the CMS-HCC ESRD models in 2016:
  - Dialysis model: 0.990
  - Functioning graft model: 1.042
- In PACE states, ESRD rates increased an average 3.5%
Summary of ESRD Groups in PACE

- 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 July MMRs for the period 2011-2015, 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 during this five-year period, NPA staff are not aware of this having occurred.
ESRD Groups/Population in PACE

### Dialysis Participants
- 2011: 392
- 2012: 460
- 2013: 508
- 2014: 634
- 2015: 713

### Functioning Graft Participants
- 2011: 16
- 2012: 20
- 2013: 20
- 2014: 26
- 2015: 32

### MSP-Transplant/Dialysis Participants
- 2011: 3
- 2012: 4
- 2013: 2
- 2014: 2
- 2015: 0
Average ESRD PMPM in PACE

- Dialysis
- Functioning Graft
- MSP-Transplant/Dialysis

<table>
<thead>
<tr>
<th>Year</th>
<th>Dialysis</th>
<th>Functioning Graft</th>
<th>MSP-Transplant/Dialysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>$8,174</td>
<td>$3,365</td>
<td>$0</td>
</tr>
<tr>
<td>2012</td>
<td>$9,254</td>
<td>$3,121</td>
<td>$1,568</td>
</tr>
<tr>
<td>2013</td>
<td>$8,638</td>
<td>$3,227</td>
<td>$1,602</td>
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<tr>
<td>2014</td>
<td>$8,562</td>
<td>$3,391</td>
<td>$1,391</td>
</tr>
<tr>
<td>2015</td>
<td>$8,682</td>
<td>$3,708</td>
<td>$0</td>
</tr>
</tbody>
</table>
Average ESRD Risk Scores in PACE
All Type ESRD vs Total PACE Enrollment 2011-2015

All ESRD Types

2011: 411
2012: 484
2013: 530
2014: 662
2015: 745

Total PACE population

2011: 22788
2012: 25443
2013: 28255
2014: 31654
2015: 34413
Flow Chart of ESRD Payments

1. PACE Center Participant
   - Reduced kidney function? Yes → Dialysis Model
   - Reduced kidney function? No → CMS-HCC Model

2. Dialysis Model
   - Yes
   - No

   - 3 months – 50%; 25%; 25%
   - Transplant Successful? Yes → Functioning Graph Model
   - 4th month
   - No → Dialysis Model

4. Transplant Successful? Yes
   - Transplant Successful? No

5. Functioning Graph Model
On June 26, 2015, CMS issued a proposed rule that will update payment policies and rates under the ESRD PPS for dialysis services furnished on or after January 1, 2016.

This rule also proposes new quality and performance measures to improve the quality of care by dialysis facilities treating patients with ESRD.

This proposed rule also includes changes to the ESRD Quality Incentive Program for payment years 2017-2019 under which payment incentives are applied to dialysis facilities to improve the quality of dialysis care.

Under the ESRD QIP, facilities that do not achieve a minimum total performance score with respect to quality measures established in regulation receive a reduction in their payment rates under the ESRD PPS.

Final rule should be published in late October/early November.
Encounter Reporting Update

• 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.
Encounter Reporting Update

- PACE organizations are currently only required to submit encounter data for services in which they have claims.

- There are currently **NO** requirements for encounter reporting for internal services for PACE. CMS has stated to NPA that there would be **NO** requirement for internal encounter reporting before **1/1/2017**.

- In the interim, NPA 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

• From the 2016 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 2015 payment year, which is to use diagnoses from the following sources in equal measure (with no weighting): (1) Encounter Data System (EDS) data valid for risk adjustment with 2015 dates of service; (2) Risk Adjustment Processing System (RAPS) data valid for risk adjustment with 2015 dates of service; and (3) Diagnoses from FFS claims valid for risk adjustment.”

• Confirmed in the 2016 Final Notice of Payment:

“Encounter Data as a Diagnosis Source for 2016: As proposed in the 2016 Advance Notice, CMS will blend the risk scores, weighting the risk score from Risk Adjustment Processing System (RAPS) and FFS by 90% and the risk score from the Encounter Data System (EDS) and FFS by 10%.” This statement confirms the proposal made in the Advance Notice. There will be **NO** blending/weighting of risk scores for PACE in 2016.
Looking Ahead -
Encounter Data Reporting

- Encounter Data Reporting and PACE
  - Federal: CMS continues its push to fully utilize EDR for risk adjustment
  - States: Effort continues towards the Managed Care Model in the absence of
    FFS data in establishing Medicaid rates; increasingly reliant on EDS
  - Medicaid Managed Care proposed rule heavily influenced by the
    Transformed-Medicaid Statistical Information System (T-MSIS)

- NPA is developing a Medicaid rate-setting workgroup
  that will assemble a series of inter-related issues that
  should be considered by state policy makers and PACE
  organization when negotiating rates.
• PACE organizations are not subject to the sections of the code modified in the Medicaid Managed Care Proposed Rule. Nonetheless, as PACE organizations function alongside, compete with, and serve many of the same populations as the managed care organizations subject to this rule, PACE organizations are directly and indirectly affected by these changes.

• NPA believes it is important for the Medicaid Managed Care Proposed Rule to support the alignment of Medicaid managed care plans with PACE. With this goal in mind, NPA offered comments and recommendations on the issues that most directly impact PACE and its ability to serve frail, vulnerable populations.

• NPA provided comments on the following issues and are awaiting a response from CMS:
  – Actuarial Soundness, Rate Setting and Medical Loss Ratio
  – Options Counseling
  – Enrollment and Disenrollment
  – Marketing
  – Appeals and Grievances
  – Quality Measurement and Improvement, External Quality Review
  – Enrollee Encounter Data
Additional Resources

• 2016 Final Notice of Payment

• ESRD
Contact Information

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