SFY 2021 Health Home Care Coordination Rate Development

Washington State Health Care Authority

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I. EXECUTIVE SUMMARY

Milliman, Inc. (Milliman) has been retained by the State of Washington, Health Care Authority (HCA) to provide actuarial consulting services related to the development of rates for the fee-for-service (FFS) Health Home Care Coordination program effective during state fiscal year 2021 (July 2020 through June 2021). We have prepared this report to outline the development of those rates under the current three-tier structure.

The Health Home rate structure includes payments for three stages of care coordination (CC), which are billed as follows:

1. Tier 1: Outreach, Engagement and Health Action Plan (HCPCS G9148). This includes outreach, assessments and development of a health action plan (HAP). This code is billed upon submission of the HAP.

2. Tier 2: Intensive Health Home Care Coordination (G9149). This includes active engagement in the HAP, with at least one face-to-face visit every month. This code is billed once per month following the qualifying face-to-face visit.

3. Tier 3: Low-Level Health Home Care Coordination (G9150). This includes periodic review of the HAP at least once every four months. This code is billed once per month following performance of a qualifying Tier 3 (low-level) service.

Table 1a illustrates the proposed payment rates under the tier structure described above as well as an estimated composite rate using estimated encounters based on historical FFS utilization. Each tier includes an 8.5% administrative load for the SFY 2021 proposed rates consistent with the SFY 2019 proposed rate, but lower than the 10% administrative load assumed in SFY 2017 rates. Note that as the program has matured, HCA has been working to improve the rate adequacy by tier. As such, both the overall rate change and individual tiered rate changes reflect an improvement in cost coverage as opposed to trends in historical cost.

Table 1a
State of Washington
Health Care Authority
FFS Health Home Care Coordination Program
SFY 2021 Proposed FFS Health Home Rates

HCPCS	Description	Projected Units	Proposed Rates	Prior Rates	Rate Change	Estimated Expenditures
G9148	Outreach, Engagement, HAP	1,130	$ 870.38	$281.28	209%	$ 984,000
G9149	Intensive HH CC	47,465	244.60	208.36	17%	11,610,000
G9150	Low-Level HH CC	2,611	200.94	83.34	141%	525,000
	Composite	**51,206**	**$ 256.18**	**$203.59**	**26%**	**$ 13,119,000**

Table 1b shows estimated Federal and State expenditures by tier (HCPCS) under the proposed SFY 2021 rate structure, assuming a 50% federal match. Note that values have been rounded.

Table 1b
State of Washington
Health Care Authority
FFS Health Home Care Coordination Program
Federal and State Projected Expenditures

HCPCS	Federal	State
G9148	$ 492,000	$ 492,000
G9149	5,805,000	5,805,000
G9150	262,000	262,000
Total	**$ 6,559,000**	**$ 6,559,000**

Note that Table 1b illustrates the projected costs of the health home coordination services. It does not include the impact of shared savings attributable to the health home program.[1]

II. DATA

We reviewed multiple sources of data and information to update assumptions and understand actual experience relative to previously projected experience. The following identifies the data received and relied upon for the rate update. We relied upon data provided by participating Care Coordination Organizations (CCOs) via their Lead Organizations and HCA, as well as historical fee-for-service experience from the state's ProviderOne data warehouse. We have not audited or verified this data and other information. We reviewed the data and found sufficient completeness and accuracy for the purposes of this work.

CCO Templates

We created a simple data request template which was distributed to all Lead Organizations serving FFS members in the Health Home program. The template requested calendar year (CY) 2018 and CY 2019 summary CCO information for the following metrics:

- Revenue
- Expenditures
- Service units by care coordination (CC) tier
- Estimated expenditures allocated by CC tier
- Estimated professional hours allocated by CC tier

We received completed data templates from 24 CCOs and 6 lead organizations containing Health Home data and information pertaining to their Health Home populations.

We reviewed the reasonableness of each data component reported for each CCO individually and compiled all data that we assessed to be reliable. Upon review, several of the completed CCO templates reported data for specific metrics that appeared incomplete, or unreasonable. For these less reliable CCOs, our use of reported data was limited to metrics that we were able to validate.

Based on aggregated information from the reliable CCO templates, we analyzed historical revenues, expenditures, and gains/losses related to the FFS Health Home program. We reviewed the information individually and in aggregate to inform our assumptions driving the overall rate increase.

Fewer CCOs were able to reliably report allocations of cost and utilization among tiers. For the CCOs that reported reasonable allocations of expenditures and units by service tier, we reviewed the information individually and in aggregate to inform our assumptions for the relative cost of each tier and distribution of costs between tiers.

Provider One Fee-for-Service Claims

We used historical encounter experience for the three CC service tier codes from ProviderOne (P1) encounter data for the FFS population, as well as membership data received from HCA, to inform projected utilization rates and program engagement assumptions. This data was reviewed for reasonableness and completeness in prior analyses conducted for HCA. We relied on eligibility and encounter data from January 2017 through February 2020 in order to:

- assess CCO-reported revenues and utilization
- establish historical engagement rates
- determine patterns of service use for the intensive and low-level HH tiers

[1] Washington State Medicaid is eligible to share up to half the gross Medicare Parts A & B savings from the integrated program. For more information, please refer to the Health Home webpage, available here: https://www.dshs.wa.gov/altsa/washington-health-home-program

All experience was reviewed separately for King and Snohomish counties versus the rest of the state because the Health Home program was not implemented in these counties until April 2017, while the program has been operational elsewhere since 2014.

Other Health Home Program Information

We relied on two additional documents containing additional Health Home program information:

- HCA provided a Health Home network document containing an exhaustive list of Health Home CCOs, the leads they work with, location and service area information, and beneficiary totals for each. This was used to validate the data received from the CCOs.
- HCA published a report on March 11, 2020 entitled "Washington State's Fee-For-Service Dual Eligible Demonstration Monthly Report,"[2] which summarizes various metrics from the FFS Health Home program. We used this report to validate our analysis, and to pull summary information on Health Home eligible membership by month.

[2] Available at https://www.hca.wa.gov/assets/billers-and-providers/HH-duals-demonstration-summary.pdf

III. METHODOLOGY AND ASSUMPTIONS

This section illustrates the calculations applied in the development of the SFY 2021 Health Home payment rates.

Validation of CCO Templates

In reviewing the CCO-reported data, we reviewed several sources of comparative information in addition to comparing data among CCOs. First, we analyzed reported utilization by CCO for CY 2018 and CY 2019 and compared this to utilization in the P1 encounters. Because not all CCOs completed the data templates, we were not able to compare aggregate utilization between the sources, but we were able to assess specific CCO experience as well as distributions of utilization among tiers for all CCOs in aggregate. Note that there are separate payment HCPCS for each tier, therefore tiers are presented by these HCPCS codes in this report.

We also reviewed reported revenue, expenditures, and distributions by tiers for reasonableness and reliability. CCOs with limited, duplicative, volatile, or unreasonable experience were excluded from our analysis. We identified outliers separately for each reported metric for each CCO. Reported revenue and expenditures were compared to distributions by tiers to check for internal consistency within CCO templates, and multiple methods of allocating expenses among tiers were evaluated.

Table 2 gives a brief summary of the data received from CCOs.

Table 2
State of Washington
Health Care Authority
FFS Health Home Care Coordination Program
Data Request Summary

Number of CCOs Reporting	24
Date Data Received	6/8/2020
Time Periods Covered	CY 2018 - CY 2019
CCOs With Reliable Revenue & Expenditures	23
Average Annual Revenue Amounts	$ 600,000
CCOs With Reliable Expense Allocation	12

Review of CCO Financial Performance

Of the CCOs that completed the templates, 23 reported reliable revenue and expenditures. We used these reported values in aggregate to assess financial performance of the Health Home program and to inform our assumption for increasing payment rates.

On average across reliable CCOs, reported expenditures for the FFS population exceeded reported revenue by approximately 24 to 29% in CY 2018 and 15% to 24% in CY 2019. However, the CY 2018 data included a midyear rate

increase which explains the improvement from CY 2018 to CY 2019. Table 3 shows statistical metrics for the ratio of expenditures to revenue for these CCOs.

Table 3
State of Washington
Health Care Authority
FFS Health Home Care Coordination Program
Aggregate Ratio of Expenditures to Revenue - Statistics

	CY 2018	CY2019
Number of CCOs Used	23	23
Max	323%	590%
Min	75%	87%
Median	129%	124%
Mean	124%	115%

Even within reliable CCOs, there were still issues with the data, including:

- Two of the twenty three CCOs reported state fiscal year data as opposed to calendar year data. We attempted to adjust the revenue to calendar year levels by applying the known SFY 2018 rate change. However, there are likely to be minor issues associated with this adjustment.
- CCOs were asked to report revenue and expenses only for FFS enrollees, but it appeared that many CCOs reported revenue from both Managed Care and FFS enrollees. We attempted to allocate the data across FFS and MCO enrollees. However, we had to assume that revenue and expenses were distributed equally. Table 3 reports the mean ratio of expenditure to revenue when weighting by estimated FFS revenue. If we instead assumed all CCOs did in fact report only FFS expenditure data, the reported means would be 136% and 128% for CY 2018 and CY 2019, respectively.
- Reported revenue for four CCOs above was suspect. We verified reported revenue by calculating imputed revenue from the known FFS rates multiplied by reported units. Table 3 above uses the imputed revenue as opposed to the reported revenue for the four suspect CCOs. The decision to use the imputed revenue for two CCOs significantly impacts the mean reported above. If we changed two CCOs to use the reported revenue as opposed to our imputed revenue, the mean above changes to 130% and 125% in CY 2018 and CY 2019, respectively.[3]

Because of these issues, we decided to assume an aggregate rate increase of 20% would be required if CY 2019 revenue would be sufficient to cover estimated FFS expenditures. This rate increase is prior to any allocation across services or before trend to SFY 2021.

Review of Rate Distribution

In addition to reviewing overall losses reported by the CCOs, we reviewed reported cost per service by tier, and compared this to the current rates to assess whether the allocation of funding should be distributed differently by tier. Experience varied significantly among the twelve CCOs that reported reliable cost and utilization allocations by tier. The reported cost allocation between tiers suggested a variance from the current rate structure may be appropriate. We used a combination of CCO-reported data, CCO-reported anecdotal estimates, and estimated losses by HH tier relative to previous encounter rates to inform our revised assumptions.

- CCOs reported Tier I outreach and engagement (G9148) costs to be 160% to 270% of current Tier I rates. This includes the cost of outreach efforts for members that do not engage.
- CCOs reported Tier II care coordination efforts (G9149) costs to be 90% to 110% of current Tier II rates.
- CCOs reported Tier III care coordination efforts (G9150) costs to be 170% to 210% of current Tier II rates.

[3] For two of the four CCOs for which we decided to use imputed revenue, reported revenue was not sufficiently populated to allow us to understand the impact of using imputed revenue compared to reported revenue.

Based on this information and the reported allocation of costs between tiers, we determined that Tier I and Tier III rates required a significant increase to sufficiently fund outreach and engagement efforts. Costs were reallocated to shift funding from Tier II, which required a smaller than average increase, to Tiers I and III to align funding with costs.

Table 4 summarizes the historical relativities between rates per tier and proposed rate relativities, developed using reported allocation of costs between tiers.

Table 4
State of Washington
Health Care Authority
FFS Health Home Care Coordination Program
Rate Distribution and Cost Distribution

	G9148	G9149	G9150
Prior Rate Relativity	1.350	1.000	0.400
Proposed SFY21 Rate Relativity	**3.558**	**1.000**	**0.822**

Notes:
(1) Rate Relativity is unit cost compared to G9149, Intensive Support.

Development of SFY 2021 Utilization Estimates

To develop SFY 2021 utilization for estimating projected expenditures and composite rate increases, we used detailed encounter data and Health Home FFS membership to project aggregate encounters by tier into SFY 2021. Projections were developed separately for King and Snohomish counties as the program was not implemented there until April 2017 and is still ramping up to full capacity.

We observed a significant decrease in Health Home enrollment in December 2018, largely a result of the largest Health home lead closing (Optum). As a result of this sudden drop, we based all projections off of data from January 2019 forward.

Outreach and Engagements

To project outreach and engagement utilization, we projected FFS Health Home membership using historical experience. We observed a relatively flat trend in Health Home eligible membership but an upward trend in Health Home participation, resulting in a moderate increase in projected Health Home enrollment. We then calculated historical rates of engagement encounter submissions as a percent of FFS Health Home enrolled members, and used this to project successful engagements in SFY 2021. This projection was done separately for King and Snohomish counties to capture separate trends resulting from duration in the program, but the methodology was consistent statewide.

Intensive and Low-Level Health Home Care Coordination

Utilization for intensive and low-level health home care coordination was estimated based on projected Health Home enrolled members.

- Statewide, excluding King and Snohomish Counties: Using historical experience, monthly intensive service encounters were submitted for approximately 36% of enrolled members, and low-level services make up approximately 1.6% of enrolled members. These numbers were relatively flat throughout recent years for counties other than King and Snohomish, so we projected utilization without any assumed trend in these assumptions.
- King and Snohomish Counties: For King and Snohomish counties, we observed a slow ramp-up of monthly intensive encounters as a percent of enrolled members, similar to the ramp up seen in the first several years of the program in other counties. We assumed a continued ramp-up of monthly intensive service to a SFY 2021 projected assumption of 14.7%, compared to the January 2020 value of 14.2%. Low-level services as a percent of enrolled members were relatively flat throughout recent experience at 1.7% of enrolled members, and no additional trend was applied to this assumption.

Normalized Cost Projection

Using the CCO financial information, we established a 26% aggregate rate increase will be required to adequately fund the continuation of the Health Home program for FFS members. The increase includes two main components:

1. 20% increase required to align rates with CY 2019 expenditures.
2. 3.5% annual unit cost trend used to trend rates 1.5 years from CY 2019 to SFY 2021, based on a review of inflation indicators, historical and projected Medicare trends, and trends in per capita GDP.

In addition to the aggregate 26% rate increase, we redistributed rates among tiers to realign payment rates with estimated cost allocations.

Using the P1 data, we calculated the projected utilization by tier for SFY 2021 and used this distribution to calculate the weighted-average composite rate across all health home encounters for SFY 2021. We applied the 26% increase to the composite rate and applied the proposed rate relativity assumptions presented in Table 4 to calculate new payment rates by tier.

Table 5 shows the development of the SY 2021 rates and change in rate relativities, as described above.

Table 5
State of Washington
Health Care Authority
FFS Health Home Care Coordination Program
SFY 2021 Rate Relativities

HCPCS	Estimated Units	Prior Rates	Prior Relativities	Proposed Rates	Proposed Relativities	Rate Change
G9148	1,130	$ 281.28	1.350	$ 870.38	3.558	209%
G9149	47,465	208.36	1.000	244.60	1.000	17%
G9150	2,611	83.34	0.400	200.94	0.822	141%
Composite	**51,206**	**$ 203.59**		**$ 256.18**		**26%**

Administrative Cost

We asked CCOs to report administrative costs separate from other expenditures. We reviewed reported administrative costs both as a percentage and on a per-encounter basis by tier. Proposed SFY 2021 rates leave admin at 8.5% of unit cost, however the aggregate per-encounter administrative load is increased by 26% due to the rate change. Table 6 summarizes administrative cost assumptions by tier for previous and proposed encounter rates.

Table 6
State of Washington
Health Care Authority
FFS Health Home Care Coordination Program
Administrative Cost By Tier

HCPCS	Prior	Proposed
G9148	$ 23.91	$ 73.98
G9149	17.71	20.79
G9150	7.08	17.08
Total	**$ 17.31**	**$ 21.78**

Table 7 shows the resulting effective rate increase to the CCOs for provision of care coordination services.

Table 7
State of Washington
Health Care Authority
FFS Health Home Care Coordination Program
Effective CCO Increase by Service Tier – Net of Administrative Cost

HCPCS	Estimated Units	Prior Rates	Proposed Rates	Rate Change
G9148	1,130	$ 257.37	$ 796.40	209%
G9149	47,465	190.65	223.81	17%
G9150	2,611	76.26	183.86	141%
Composite	**51,206**	**$ 186.29**	**$ 234.41**	**26%**

IV. LIMITATIONS AND QUALIFICATIONS

The services provided for this project were performed under the contract between Milliman and HCA dated December 15, 2017.

This analysis is intended for the use of the Washington Health Care Authority in support of rate development of the Health Home Care Coordination program. We understand that this information may be shared with HCA's contracted CCOs and Leads, and the Centers for Medicaid and Medicare Services (CMS). This report may not be distributed to other third parties without the prior consent of Milliman. To the extent that the information contained in this letter is provided to third parties, the document should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this report to third parties. Similarly, third parties are instructed that they are to place no reliance upon this report prepared for HCA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. It is the responsibility of any CCO to make an independent determination as to the adequacy of the proposed rates for their organization.

Actual costs for the program will vary from our projections for many reasons, including the actual cost to obtain necessary care coordination staff. Experience should continue to be monitored on a regular basis, with modifications to rates or to the program as necessary.

This analysis has relied extensively on data provided by HCA and its vendors. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries and meet the qualification standards for performing the analysis documented herein.