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Financial Challenges in New Integrated Care Programs

Deconstructing Rate-Setting Issues in Search of Solutions

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Introduction and Overview

- Rate setting and financial pressure points in the capitated financial alignment demonstrations and other integrated care programs
  - Medicare
  - Medicaid
  - Combined
- How Medicare and Medicaid capitated rates are set
- Some potential sources of funding in Medicare for improved care for dually eligible beneficiaries
- State and health plan options to improve alignment of financing and care needs

Medicare Financial Pressure Points

- **Limited behavioral health coverage in fee-for-service (FFS) and Medicare Advantage (MA) managed care**
  - **Covers medically necessary inpatient and outpatient care**
    - More limited than Medicaid
      - No non-medical support services, case management, residential care, etc.
  - **190-day lifetime limit for inpatient care in a freestanding psychiatric hospital**
    - But no IMD exclusion for those ages 22 to 65, so Medicare can fill this Medicaid gap
- **Medicare capitated payments for Part D Rx drugs are more than adequate over time, but retroactive settle-ups can result in significant cash flow problems**
  - **LIS subsidy, risk adjustment, risk corridors, and reinsurance ultimately cover Part D costs**
  - **But up-front capitated payment may not adequately reflect costs of dually eligible beneficiaries, especially those under age 65 who are heavy users of costly behavioral health drugs**
- **Star Ratings bonuses are only available to plans with a rating of 4 or higher on a scale of 1-5**
  - **CMS is considering adjustments to the Star Ratings system to avoid disadvantaging MA plans with significant enrollment of dually eligible beneficiaries**

Medicaid Financial Pressure Points

- **A number of states have Medicaid capitated payment systems for LTSS that provide incentives to make greater use of community-based LTSS**
  - AZ, MA, MN, NY, TN
- **But few states have risk adjustment systems that fully account for variation in risk within nursing facility (NF) and community-based LTSS populations**
  - NY and WI Medicaid LTSS risk adjustment systems focus on community-based LTSS
  - States with case-mix/acuity-based FFS reimbursement systems for NFs have a form of risk adjustment that health plans can build on when making payments to NFs
  - CHCS and Mathematica are partnering in a project for the West Health Policy Center to help states improve Medicaid MLTSS risk adjustment
    - See next slide for details
- **While Medicaid's behavioral health coverage is broader than Medicare's, low provider payments, limited provider participation, carve-outs, communication gaps, and multi-agency funding may limit FFS expenditures that provide the basis for capitated payments**
  - Biggest gap is that Medicaid does not pay for services in freestanding inpatient psych hospitals for those ages 22 to 65 (IMD exclusion)

Overview of MLTSS Rate-Setting Initiative

- **Project goal**
  - Examine, refine, and/or develop states' rate setting methodologies for MLTSS or Medicare-Medicaid integrated care programs
- **Approach**
  - Convene and connect with state and federal government, industry, and research experts to examine current challenges in setting and risk adjusting rates for these programs
  - Work with eight project states to test new rate setting, risk adjustment, and data collection approaches with a particular focus on using functional assessment
  - Examine best practices and develop technical guidelines for states and other key stakeholders to improve rate-setting methodologies
- **Participants**
  - INSIDE States: AZ, MA, MN, TX, VA
  - Other States: KS, TN, WI
- **Funder**
  - West Health Policy Center

Pressure Points in Combined Medicare-Medicaid Programs

- **Savings targets and quality withholds in financial alignment demonstrations**
  - **Savings targets are typically 1% in year 1, 2-3% in year 2, and 3-5% in year three**
    - See Table 4 in September 2015 MACPAC report for state-by-state details
    - Initial targets have been adjusted downward in some states (MA, for example)
  - **Quality withholds are typically an additional 1-3% and are returned to plans each year if quality measures are met**
    - Withhold measures in first year are mostly process-based (HRA completion, for example)
    - See p. 14 in September 2015 MACPAC report for details
- **Financing up-front investments**
  - **Medicare-Medicaid Plans (MMPs) and other integrated plans often have to make substantial up-front investments in staff, organization, and IT infrastructure to develop capacity to integrate/coordinate care for dually eligible beneficiaries**
    - Plans with limited Medicare or Medicaid experience have the greatest challenges
    - Learning curve can be steep
- **Addressing unmet enrollee needs**
  - Required up-front health risk assessments (HRAs) and initial clinical visits will likely identify needs that were unmet in the FFS system
  - Addressing these needs can reduce future ER and inpatient hospital use, but those savings will likely not offset upfront costs in the first year or two

How Medicare and Medicaid Capitated Rates Are Set

- **Medicare**
  - **Financial Alignment Initiative Capitated Model**
    - Maria Dominiak. *Financial Alignment Demonstration Capitated Model Medicare Rate Methodology.* Integrated Care Resource Center Webinar, November 1, 2013.
      - http://www.chcs.org/media/ICRC_Medicare_Rate_Setting_for_Duals_Demo_11-01-13.pdf
  - **Medicare Advantage**
    - MedPAC. *Medicare Advantage program payment system.* Payment Basics, October 2014.
      - http://www.medpac.gov/documents/payment-basics/medicare-advantage-program-payment-system-14.pdf?sfvrsn=0
- **Medicaid**
  - **Managed LTSS**
    - Jenna Libersky and James Verdier. *Financial Considerations: Rate Setting for Medicaid Managed Long Term Services and Supports (MLTSS) in Integrated Care Programs.* Conference Presentation, February 25, 2014.
      - http://www.mathematica-mpr.com/~/media/publications/PDFs/health/dual_eligibles_ML_TSS_rate_setting.pdf
- **Combined**
  - CMS/MMCO. *Joint Rate-Setting Process for the Capitated Financial Alignment Model*. FAQs updated August 9, 2013.
    - https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf

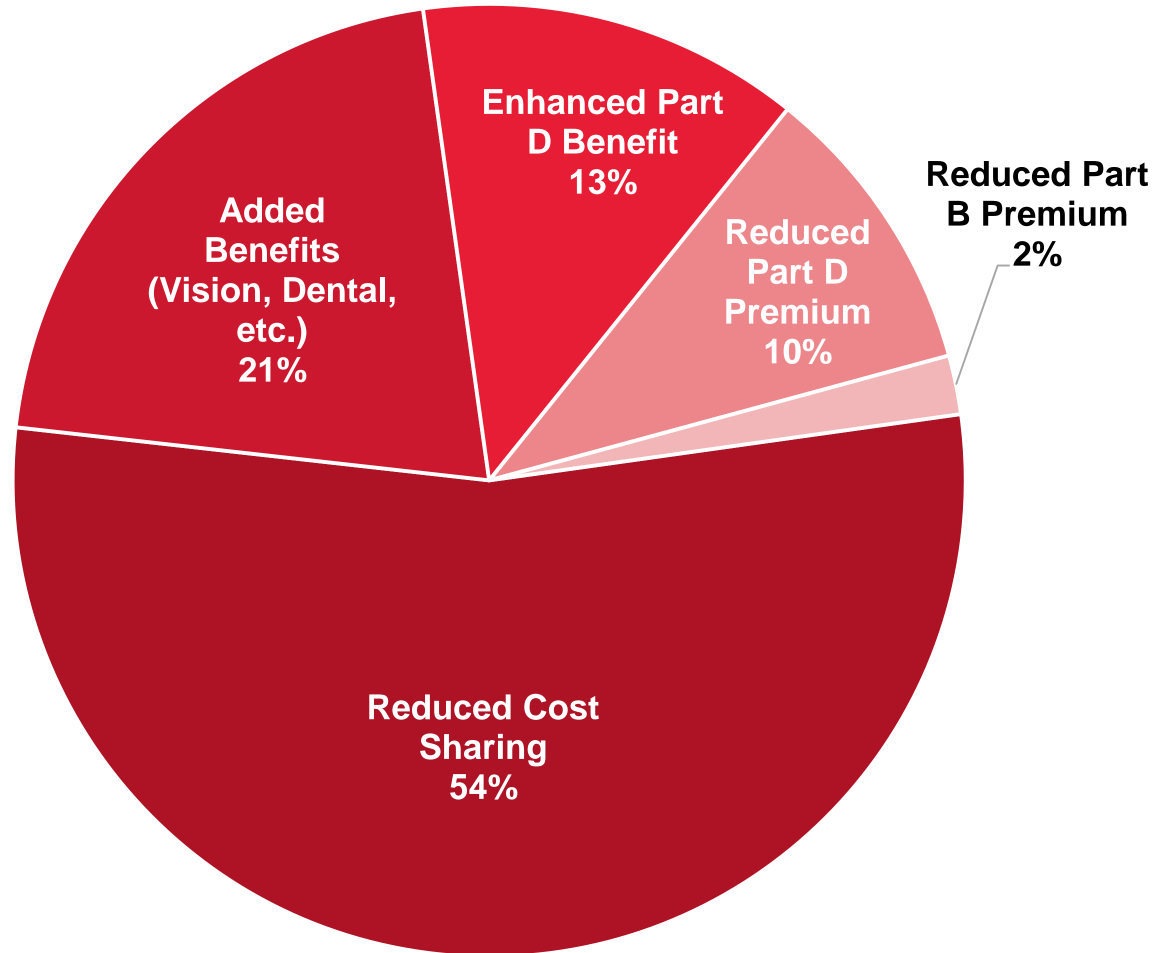
Major Rate-setting Dials in Combined Medicare-Medicaid Programs

- Projecting baseline costs
- Savings percentages
- Risk adjustment and rating categories
- Risk mitigation
  - Medical loss ratio
  - Risk pools
  - Risk corridors
- Quality measures and withholds
- For details, see MACPAC. *Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare.* September 2015, pp. 9-14.
- There are provisions for joint CMS-state rate review “at any point” in MOUs and three-way contracts in all financial alignment capitated model demonstrations
  - Specific rate provisions can be modified if experience warrants and it would meet goals of the demonstrations

Medicare Options for Savings and Care Improvement

- **All MA plans, including D-SNPs, can provide additional benefits not covered by Medicare FFS with "rebate" dollars**
  - **If MA plans bid below the CMS payment area "benchmark," CMS pays the plan 75 percent of the difference, and keeps the other 25 percent**
  - **Plans must use this 75 percent rebate amount to fund benefit enhancements for their enrollees**
    - For details, see MedPAC Medicare Advantage Payment Basics summary at http://www.medpac.gov/documents/payment-basics/medicare-advantage-program-payment-system-14.pdf?sfvrsn=0
  - **Most common enhancements are vision and dental benefits, more generous Part D coverage, and reductions in Medicare premiums and cost sharing**
    - Premiums and cost sharing for dually eligible beneficiaries are already covered by Medicaid, as are vision and dental to varying extents
    - As a result, D-SNPs may be able to use rebate dollars for services not adequately covered in FFS by Medicare or Medicaid (personal care assistance, care coordination)

Allocation of Rebate Dollars to Benefit Enhancements by all MA Plans, 2010



Note: Weighted by projected enrollment in 2010. Part B-only plans excluded.
Source: MedPAC March 2010 Report to the Congress, Chapter 4, The Medicare Advantage Program, Figure 4-2. Available at: http://www.medpac.gov/documents/reports/mar10_ch04.pdf?sfvrsn=0

Medicare Options for Savings and Care Improvement (Cont.)

- **MA capitated payments still exceed FFS levels, but are scheduled to reach FFS levels in 2017**
  - **102% of FFS for all MA plans in 2015, 101% for SNPs**
    - MedPAC. March 2015 Report to Congress, p. 325.
- **SNPs have substantially higher profit margins on partial duals than on full duals**
  - **MedPAC March 2015 Report to Congress, pp. 331-332**
- **Medicare FFS payments to skilled nursing facilities (SNFs), especially for therapies, substantially exceed costs**
  - **FFS SNF overpayments are part of MA rate-setting base**
    - MedPAC reports that MA plans they reviewed paid 22% less than FFS for SNF services (March 2015 Report, pp. 198-200)
  - **For more details, see**
    - MedPAC March 2015 Report to Congress, Chapter 8
    - DHHS Inspector General, September 2015
      - http://oig.hhs.gov/oei/reports/oei-02-13-00610.pdf

Medicare Options for Savings and Care Improvement *(Cont.)*

- Part D Rx drug payments to health plans for dually eligible beneficiaries are high overall because of the low-income subsidy (LIS) and reinsurance
  - LIS covers premiums and cost sharing for dually eligible beneficiaries
  - Reinsurance covers 80 percent of individual Rx drug costs above $4,700
- MedPAC reports substantial health plan competition for LIS enrollees (March 2015 Report, pp. 362-363)
  - But built-in delays in Part D settle-ups can lead to financial uncertainty and cash flow problems, especially for smaller non-profit plans
- MA-PD plans (including MMPs and D-SNPs) have limited tools to influence use of Rx drugs
  - Dually eligible beneficiary copays limited to $1.20 to $7.40
  - Plans can use prior authorization, step therapy, and quantity limits
  - Can also use Part D Medication Therapy Management Program
  - Limited oversight and management of Part D drug use in Medicaid NFs and HCBS waivers

State Options to Improve Alignment of Financing and Care Needs

- **Require MMPs and D-SNPs to share MA bid information with the state**
  - Can help state determine whether and where Medicare savings are achievable
  - Can help identify gaps in coverage that Medicaid can fill
- **If state has capacity to effectively analyze MA encounter data, require MMPs and D-SNPs to submit that data directly to the state**
  - Another way of identifying potential savings and gaps in care
- **Make sure that Medicaid LTSS capitation payments provide appropriate incentives for community-based LTSS and adjust appropriately for risk in NF and community LTSS settings**
- **Make sure that Medicaid coverage of behavioral health, LTSS, and other "wrap-around" Medicaid services meshes effectively with Medicare coverage to fill gaps in care for dually eligibles beneficiaries**

Health Plan Options to Improve Alignment

- **Take advantage of fungible Medicare and Medicaid funding**
  - Use savings from reduced Medicare hospital and ER use to provide incentives to improve primary and preventive care and care transitions
  - Reduce avoidable hospitalizations for NF residents by paying NFs more for higher-acuity care
  - Reduce overpayments to Medicare SNFs to fund more community-based care
  - Treat overlapping benefits like home health and DME as a single unified benefit with a single payer, eliminating administratively burdensome attempts to shift costs that exist in FFS
- **Manage services more effectively**
  - Limit Medicaid NF use only to those who cannot be served in the community
  - Review Part D Rx drug use in NFs and HCBS waivers to identify opportunities for more effective use
- **Make sure that health plan organization, management, staffing, training, care coordination, financial, and IT systems are set up to maximize opportunities to improve care and reduce costs**
  - Eliminate or reduce Medicare-Medicaid organizational silos
  - Increase communication and cross-fertilization

Conclusion

- Medicare and Medicaid were not designed to work together
- The FFS financing that provides the starting point for capitated payments to MMPs and D-SNPs reflects all the gaps, disconnects, and historical rigidities and anomalies built into the two systems
- Joining the Medicare and Medicaid funding streams in a single accountable entity provides an opportunity to rethink how care should be provided for Medicare-Medicaid enrollees
  - States, CMS, and health plans can work together to identify opportunities and clear away obstacles

References

- ICRC. *Coordination of Medicare and Medicaid Behavior Health Benefits.* Webinar, August 26, 2015.
  - http://www.integratedcareresourcecenter.com/PDFs/WWM%20BH%20Slides%20FINAL.pdf
- ICRC. *Reducing Avoidable Hospitalizations for Medicare-Medicaid Enrollees in Nursing Facilities: Issues and Options.* TA Brief, April 2015.
  - http://www.integratedcareresourcecenter.com/PDFs/ICRCReducingAvoidableHospitalizations%20508%20complete.pdf
- ICRC. *Improving Coordination of Home Health Services and Durable Medical Equipment for Medicare-Medicaid Enrollees in the Financial Alignment Initiative.* TA Brief, April 2014.
  - http://www.integratedcareresourcecenter.com/PDFs/ICRC%20-%20Improving%20Coordination%20of%20HH%20and%20DME%20-%204-29-14%20(2).pdf
- ICRC. *Medicare Part D Prescription Drug Coverage for Medicare-Medicaid Enrollees in the Capitated Financial Alignment Demonstration.* TA Brief, March 2013.
  - http://www.integratedcareresourcecenter.com/PDFs/ICRC%20-%20Part%20D%20Brief%20for%20States%20FINAL%20(2-22-13).pdf
- MACPAC. *Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare.* Issue Brief, September 2015.
  - https://www.macpac.gov/publication/financial-alignment-initiative-for-beneficiaries-dually-eligible-for-medicaid-and-medicare/
- MedPAC. Report to the Congress. *Medicare Payment Policy.* March 2015.
  - http://www.medpac.gov/documents/reports/mar2015_entirereport_revised.pdf?sfvrsn=0
- MedPAC. *Part D Payment System.* Payment Basics, October 2014.
  - http://www.medpac.gov/documents/payment-basics/part-d-payment-system-14.pdf?sfvrsn=0