

Getting the Mix Right

Pricing, Benefits, and Risk Adjustment for Dual Eligibles

Dual Eligibles Program Leadership Forum
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Introduction and Overview

- **Brief overview of Dual Eligible Special Needs Plan (D-SNP) and Medicare-Medicaid Plan (MMP) enrollment**
- **Challenges and opportunities for health plans in coordinating Medicare and Medicaid benefits for dual eligibles**
 - **Understanding Medicaid long-term supports and services (LTSS) and behavioral health benefits in specific states**
 - **Understanding the tools available to manage those benefits in specific states**
 - **Assessing how the LTSS and behavioral health portions of capitated rates have been set**
 - **Assessing opportunities for savings and improved care when Medicare and Medicaid benefits are combined**

D-SNP and MMP Enrollment Growth

- **D-SNP growth***
 - **October 2014**
 - 1,705,849 enrollees in 353 plans in 38 states, DC, and PR
 - **October 2015**
 - 1,732,200 enrollees in 336 plans in 38 states, DC, and PR
 - Two-thirds of enrollment is in 11 states (FL, NY, CA, TX, PA, AZ, TN, AL, GA, MA, and MN)
- **MMP growth****
 - **October 2014**
 - 166,580 enrollees in 27 plans in 5 states (CA, IL, MA, OH, and VA)
 - **October 2015**
 - 383,895 enrollees in 66 plans in 9 states (CA, IL, MA, MI, NY, OH, SC, TX, and VA)
 - NY, SC, MI, and TX began enrollment in 2015
 - RI will begin enrollment in 2016
- **No additional dual demos planned, but D-SNP contracting remains an option for states and plans**
 - **Current statutory authorization for D-SNPs extends through December 31, 2018**

*From monthly CMS SNP Comprehensive Reports, available at: <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDENrolData/Special-Needs-Plan-SNP-Data.html>

** ICRC analysis of CMS Monthly Enrollment by Contract reports, available at: <http://www.chcs.org/media/ICRC-MMP-Enroll-by-State-October-2015.pdf>

Preview of D-SNP New Entries and Departures in 2016

- **In CY 2016:**
 - 21 new Medicare Advantage contracts will include D-SNPs
 - D-SNPs in 16 existing contracts will be departing
 - 19 existing contracts with D-SNPs will be consolidated into other contracts operated by the same company
 - Large (affecting more than 50 enrollees) D-SNP service area reductions will occur in 12 contracts
- **3 percent of 1.7 million September 2015 D-SNP enrollees will be affected by 2016 departures, and another 1 percent by service area reductions**
 - Impacts will be concentrated in CO, CT, IA, MI, MO, PR, and WA
- **Details by state and by plan are in an Integrated Care Resource Center (ICRC) table at this link:**
<http://www.chcs.org/media/ICRC-D-SNP-Entries-and-Exits-by-State-November-2015.pdf>

D-SNP Enrollment by State, October 2015

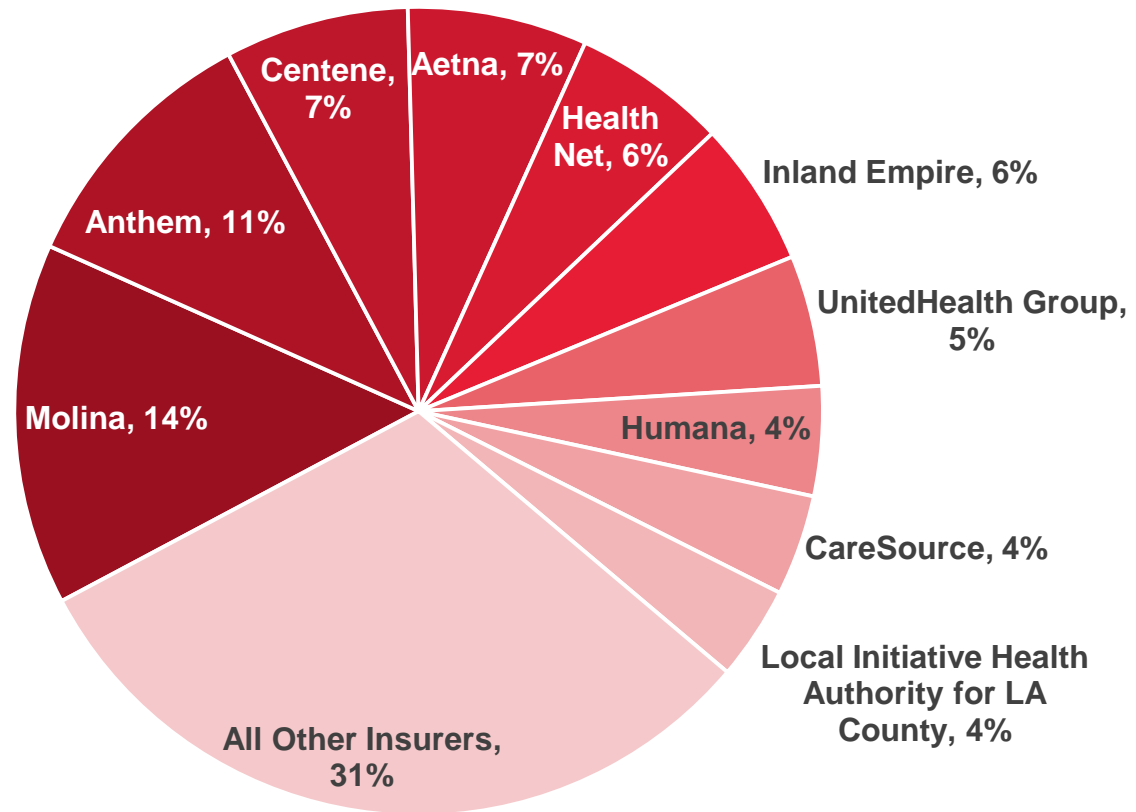
State	Number of D-SNP Plans	Total D-SNP Enrollment
Puerto Rico	12	278,556
Florida	45	224,637
New York	41	190,049
California	30	166,073
Texas	21	123,082
Pennsylvania	10	109,207
Arizona	22	79,712
Tennessee	6	76,309
Alabama	4	51,002
Georgia	10	46,889
Massachusetts	6	36,591
Minnesota	9	36,416
Louisiana	10	29,249
Washington	5	25,145
South Carolina	3	23,622
Oregon	7	22,311
Wisconsin	15	20,662
Hawaii	4	19,842
North Carolina	6	18,733
Ohio	11	14,544
Mississippi	6	13,769
Arkansas	5	13,547

D-SNP Enrollment by State, October 2015

State	Number of D-SNP Plans	Total D-SNP Enrollment
Michigan	7	12,485
Missouri	4	12,326
New Mexico	4	12,243
New Jersey	2	12,077
Connecticut	2	11,544
Colorado	4	10,908
Illinois	6	10,727
Utah	2	8,330
Washington DC	3	5,393
Kentucky	6	4,887
Maryland	2	2,339
Maine	3	2,164
Delaware	1	2,027
Idaho	1	1,676
Virginia	2	1,618
Indiana	3	1,119
West Virginia	1	215
Iowa	1	145
TOTAL¹	342	1,732,169

¹ 5 Plans spanned across multiple states. In this table, we divided the number of enrollees in those plans evenly across the states and added the plan to each state's total number of D-SNP Plans. The total excludes 31 enrollees in plans with fewer than 11 enrollees.

MMP Enrollment, by Firm or Affiliate, Oct 2015



Total MMP Enrollment, Oct 2015 = 383,895

Medicare and Medicaid LTSS Benefits

- **Medicare covers only post-acute care**
 - Skilled nursing facility (SNF) services for up to 100 days after a three-day hospital stay
 - Short-term medically necessary home health care
 - No long-term nursing facility (NF) services or home-and community-based services (HCBS) and related services
- **Medicaid covers long-term NF, home health, HCBS, personal care assistance, and other LTSS**
 - Service definitions, coverage limitations, payment rates and systems, providers, beneficiary advocates, political support, history, and context are different in every state
 - This underlying FFS complexity is the starting point for setting capitated rates
 - For details on Medicaid LTSS, see MACPAC, *Medicaid's Role in Providing Assistance with Long-Term Services and Supports*, Report to the Congress, Chapter 2, June 2014
 - <https://www.macpac.gov/publication/ch-2-medicaids-role-in-providing-assistance-with-long-term-services-and-supports/>
 - See also MACPAC, *State Medicaid Payment Policies for Nursing Facility Services* (October 2014)
 - <https://www.macpac.gov/publication/nursing-facility-payment-policies/>

Medicare and Medicaid Behavioral Health Benefits

- **Limited behavioral health (mental health and substance use disorder) coverage in Medicare FFS**
 - **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 Institutions for Mental Diseases (IMD) coverage exclusion for those ages 22 to 65, as in Medicaid, so Medicare can fill this Medicaid gap
- **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)**
- **For more details, see Integrated Care Resource Center, *Coordination of Medicare and Medicaid Behavioral Health Benefits* (August 26, 2015 webinar)**
 - <http://www.integratedcareresourcecenter.com/PDFs/WWM%20BH%20Slides%20FINAL.pdf>

Medicaid LTSS Capitated Payments

- **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
 - The Center for Health Care Strategies (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

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**
 - AZ, MA, MN, KS, TN, TX, VA, WI
- **Funder**
 - West Health Policy Center

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.
 - <https://www.macpac.gov/publication/financial-alignment-initiative-for-beneficiaries-dually-eligible-for-medicaid-and-medicare/>
- 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

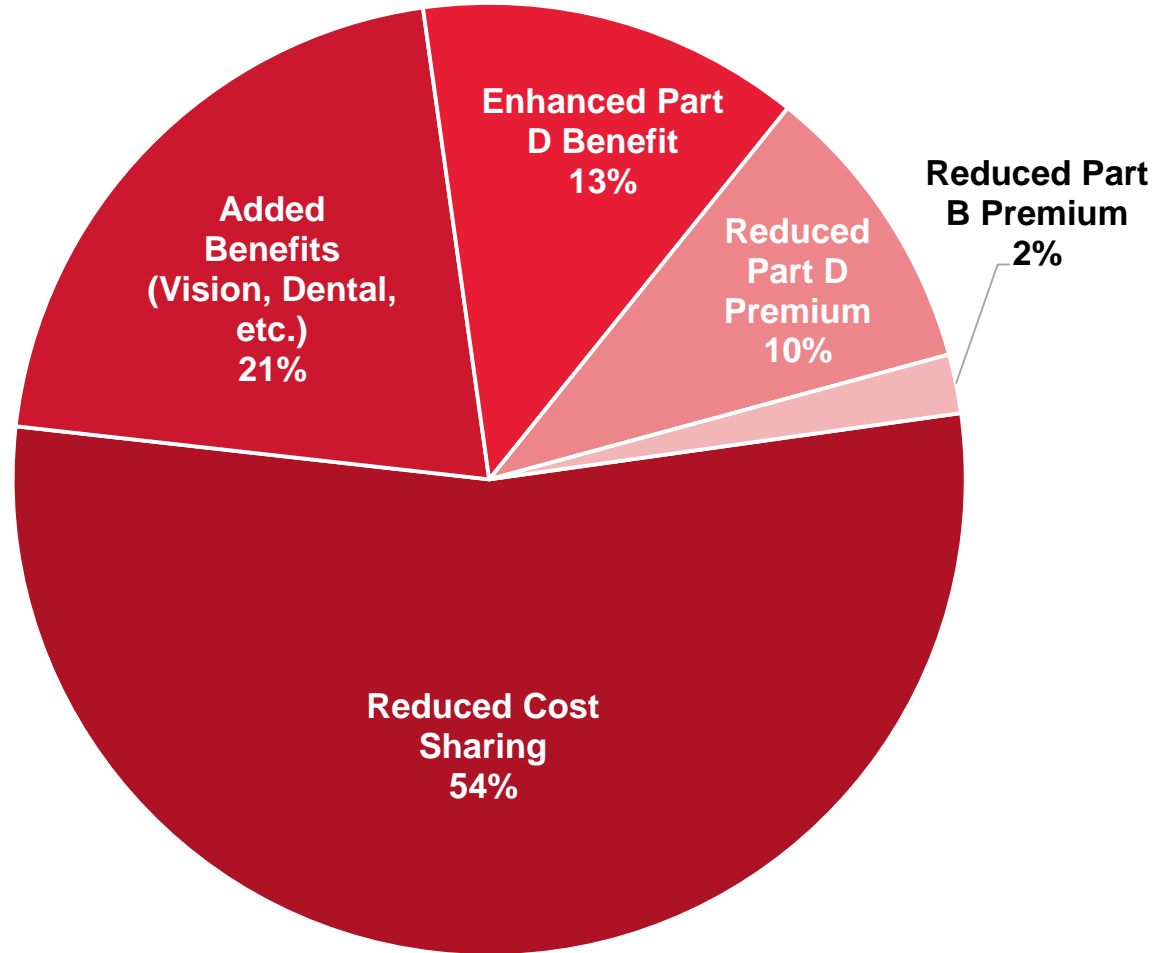
Financial Pressure Points in Combined Medicare-Medicaid Programs

- **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 (health risk assessment 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

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 50 to 70 percent of the difference (depending on the plan’s star rating), and keeps the other 30 to 50 percent**
 - **Plans must use this 50 to 70 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
 - CMS has proposed to address this issue through modifications to the CMS-HCC payment system
 - See October 28, 2015 memo at this link: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/RiskAdj2017ProposedChanges.pdf>
- **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 must cover at least two drugs in each drug category or class and “all or substantially all” drugs in six “protected classes,” including antipsychotics and antidepressants
 - 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
 - See April 2015 ICRC TA brief on *Reducing Avoidable Hospitalizations for Medicare-Medicaid Enrollees in Nursing Facilities: Issues and Options*
 - 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
 - See April 2014 ICRC TA brief on *Improving Coordination of Home Health Services and Durable Medical Equipment for Medicare-Medicaid Enrollees in the Financial Alignment Initiative*
- **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

Fully Integrated Dual Eligible (FIDE) SNPs

- FIDE SNPs are the most integrated Medicare-Medicaid plans outside of the CMS financial alignment demonstrations
- 37 FIDE SNPs in seven states in October 2015 (AZ, CA, ID, MA, MN, NY, and WI)
 - Total enrollment of 112,378
 - 79 percent of total enrollment was in MN (36,416), MA (36,591), and NY (16,141)
- FIDE SNPs must:
 - Have an aligned Medicare and Medicaid care management model
 - Offer a capitated benefit package that includes LTSS benefits (carve outs of benefits are allowed under some circumstances, but must be reviewed and approved by CMS)
 - Employ CMS and state approved policies and procedures to coordinate or integrate enrollment, member materials, communications, grievance and appeals and quality improvement
 - See Chapter 16-B in Medicare Managed Care Manual, Sec. 40.4.3 for more detail on these requirements (<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16b.pdf>)
- FIDE SNPs may be eligible for:
 - The PACE frailty factor payment adjustment to reflect the cost of treating high concentrations of frail individuals if their risk scores indicate a “similar average level of frailty” as the PACE program
 - For details on the frailty factor, see CMS February 2015 Draft Call Letter, pp. 23-24, at this link: <https://www.cms.gov/Medicare/Health-Plans/MedicareAdvgtgSpecRateStats/Downloads/Advance2016.pdf>
 - Additional benefit flexibility
 - See Chapter 16-B, Medicare Managed Care Manual, Secs. 40.4.4 and 40.4.5, for details
 - Applies to FIDE SNPs and other highly integrated D-SNPs that meet criteria in Sec. 40.4.4

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

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