Financial Considerations: Rate Setting for Medicaid Managed Long Term Services and Supports (MLTSS) in Integrated Care Programs

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Workshop on Effectively Integrating Care for Dual Eligibles
World Congress 7th Annual Leadership Summit on Medicaid Managed Care

February 25, 2014

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Introduction and Overview

- **In the CMS financial alignment demonstrations (dual demos), capitated rates for Medicare-Medicaid Plans (MMPs) are set by CMS for Medicare services and by states (with CMS review) for Medicaid services**
  - **Almost all Medicaid services for Medicare-Medicaid enrollees (dual eligibles) are long-term services and supports (LTSS)**
- **CMS gives states substantial discretion in how they structure capitated rates for Medicaid services in the dual demos**
- **Many states have extensive experience in setting Medicaid managed LTSS rates that other states can learn from**
- **Presentation today reviews main options**
  - **Based on 1/9/13 Integrated Care Resource Center (ICRC) Study Hall Call presentation by Maria Dominiak[1] and forthcoming ICRC issue brief on MLTSS rate setting**

[1] For the ICRC Study Hall, see http://www.chcs.org/usr_doc/Study_Hall_Call_-_MLTSS_Ratesetting2.pdf

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Rate Setting in the Dual Demos

- **CMS updated 8/9/13 guidance for joint rate setting in the dual demos provides that Medicaid risk categories should:**
  - **Be risk adjusted or distributed into rating categories (age, sex, nursing home level of care, care setting, etc.)**
  - **Provide incentives for HCBS over institutional placement**
  - **Have clear operational rules/processes for assigning beneficiaries to rate categories**
  - **Be budget neutral across Medicaid program as a whole after application of dual demo savings percentages**
    - Total amount paid through risk-adjusted or multiple rating categories should the same in the aggregate as would be paid using just one unadjusted category
- **A number of states have Medicaid managed LTSS rate-setting systems that generally meet these criteria**
- **CMS joint rate-setting guidance and FAQs are at:** **http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf**

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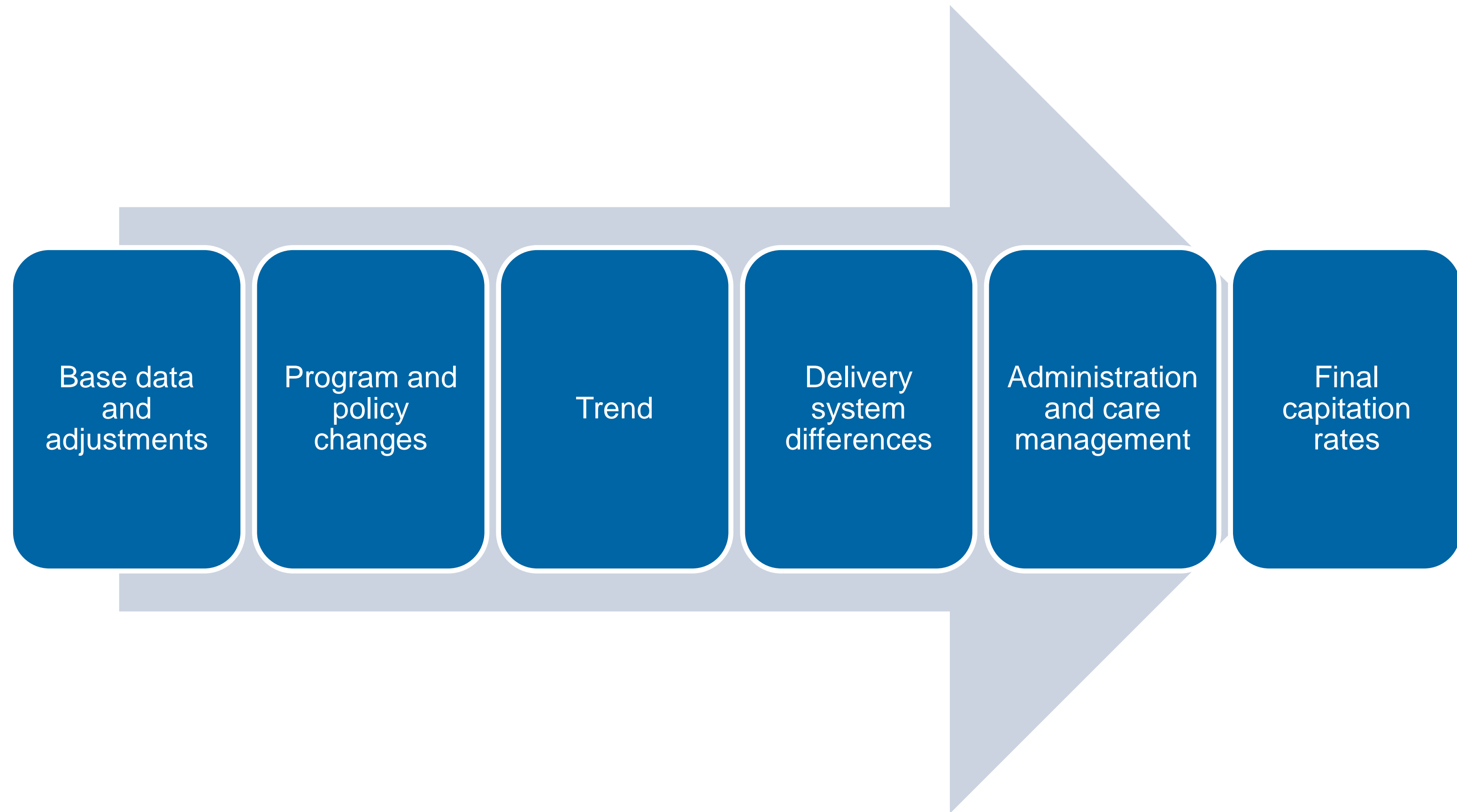
Medicaid Managed LTSS Rate Structure

- Remainder of presentation focuses on current rate-setting in Medicaid managed LTSS rate-setting
  - Can provide models/examples for Medicaid rate-setting in the dual demos
- Medicaid managed LTSS rate structure should provide for variations in cost/risk of the population covered by the managed care plans
  - Improves predictability of risk
  - Reduces opportunities for gaming and adverse selection
- Rates required to be actuarially sound
- Should generally reflect variations by
  - Age
  - Geography
  - Medicare status
  - Diagnosis
  - Degree of frailty (nursing home level of care)
  - Setting of care (institutionalized and community)

Overview of Basic Rate Setting Approach



Rate Structure – Rating Categories (Cells)

- Rate cells structure costs for similar populations or services
  - An individual's rate category should be updated to reflect a change in expected service utilization
- States can adjust timing of the rate category change
  - At a minimum, should change in a new care setting
- The Massachusetts dual demo uses 4 rating categories, which vary by region
  1. Facility-based care ($$$$)
  2. High needs & community-based care ($$$)
  3. High behavioral health needs & community based care ($$)
  4. Other community-based needs ($)

Rate Structure – NF and HCBS Rates (1)

- **Blended Nursing Facility (NF) and HCBS rate**
  - **Pay a single blended rate for those members who meet that state's nursing home level of care criteria regardless of setting**
    - Blend generally reflects current institutional vs. community mix, but can be adjusted each year to encourage more community care
  - **Provides a strong financial incentive to serve members in the community rather than in an institution**
  - **Mix of members can be difficult to predict**
  - **Plans may target HCBS members over institutionalized members**
- **State examples**
  - **Arizona and Tennessee use this approach in MLTSS**
  - **New York and Virginia use this approach in their dual demos**

Rate Structure – NF and HCBS Rates (2)

- Separate NF and HCBS rates - modified blended approach
  - Pay separate rate cells based on setting but limit the availability of the NF rate cell to encourage the use of HCBS over NF
  - Encourages transition of institutionalized members to the community, but incentives may not be as strong as blended rate
  - Reduces risk of under/overpayment
  - Separate rates may encourage plans to target particular beneficiaries over others (e.g., nursing home residents or HCBS)
- State examples
  - Illinois and Ohio use this approach in their dual demos

Rate Structure – Risk Adjustment

- Pay using a sophisticated classification algorithm based on a member's functional, cognitive and behavioral needs and medical condition
  - Requires screening questionnaire and/or medical record review for individual enrollees
  - More accurately predicts risk of the enrolled population
  - Provides more equitable payments between health plans with strong financial incentive to provide care in the most cost effective setting
  - Minimizes selection bias
- No national model exists, so sophisticated data modeling is required to develop model and refine over time
- Data-intensive – requires collection of electronic assessment information that can be linked to paid claims or encounter data
- New York uses this approach in its dual demo

Risk Mitigation Strategies – Risk Sharing

- **Risk sharing using "risk corridors"**
  - **State retains full or partial responsibility for cost above the aggregate capitation payments that exceed a predetermined corridor**
  - **Provides both upside and downside protections**
    - Protects the health plan from excess losses and protects the state from excessive overpayments
  - **Often used in initial years of program, or at time of significant program change when risk is less predictable**
  - **Can be burdensome for state to administer**
  - **Important to include detailed specifications in the contract to avoid misunderstandings**
- **Massachusetts has multi-tier risk corridors for first year of its dual demo (more on this below)**

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Risk Mitigation – Medical Loss Ratio (MLR)

- MLR represents the share of total health plan premium revenue that is spent on medical care
  - A higher proportion of the premium spent on medical care brings more value for the payer
- Minimum MLR requirement is a one-sided risk sharing arrangement
  - Protects the state from paying excessive health plan administrative expenses or profits
  - Does not protect the health plan from adverse claims experience
- Most dual demo states (except CA) use an 85% minimum MLR
  - Non-medical expenses exceeding 15% of total premiums paid must be returned to Medicare and Medicaid in proportion to their contributions

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Risk Mitigation Strategies – Risk Pools

- Risk pools
  - Include a withhold through which the health plans contribute to a pool in exchange for coverage against additional risk uncertainty
  - Used to cover unanticipated costs for low-frequency, high-risk, high-cost individuals
  - Budget neutral to the state
- Massachusetts has high-cost risk pools in its dual demo

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Risk Mitigation Strategies - Reinsurance

- Reinsurance
  - Protects health plan from high-cost, low-frequency claims incurred by an individual beneficiary
  - Plans can seek private reinsurance (often very expensive) or state can act as the reinsurer
  - Does not protect plans from overall adverse experience
  - Generally targeted to certain high-cost conditions or services
- State example
  - Arizona provides reinsurance for transplants; members receiving certain biotech drugs; members with Von Willebrand's disease, Gaucher's disease, or hemophilia; and certain high cost behavioral health members

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Pay for Performance/Quality Incentives

- **Provides additional opportunities to encourage health plans to meet policy goals and achieve quality targets**
- **Funded either as additional incentive payments (up to 5% of the cap rate) or as a withhold**
- **Need to be specific, actionable, and measurable and defined upfront**
- **Financial Alignment Demonstrations use a quality withhold**
  - **A portion of the Medicaid and Medicare (Parts A and B) capitation payment is withheld**
    - 1% in Year 1, 2% in Year 2, and 3% in Year 3
  - **MMPs can earn back this amount if they meet expectations on standard (core) and state-specific quality measures**
    - Core measures include quality of life and experience of care, changes in LTSS and behavioral health services use, and coordination of care
    - State-specific measures include physical accessibility of buildings and equipment, language, accommodations, and care planning

Other Incentives

- Money Follows the Person (MFP) incentives
  - MFP provides grants and enhanced federal match to support community transitions
  - Tennessee pays an incentive payment to health plans out of MFP funds for members who are discharged from a long term nursing facility stay to the community and another incentive payment after the same member has remained in the community for one year
  - Tennessee also allows plans to provide a one-time $2,000 allowance to members transitioning from the nursing facility to the community to cover transition expenses
- Auto assignment algorithm
  - Texas plans to favor health plans that perform better on certain performance measures through improved placement in its auto assignment algorithm for its MLTSS program, STAR+PLUS

State Examples

- Arizona Long Term Care System (ALTCS)
- Tennessee CHOICES
- Massachusetts One Care Demonstration
- Illinois Medicare-Medicaid Alignment Initiative

Arizona Long Term Care System (ALTCS)

- ALTCS established in 1989
- Mandatory enrollment of elderly and beneficiaries with physically disabilities who are nursing home level of care
- Comprehensive benefit package - including acute, behavioral and long term services and supports
- Rebalanced from 95% NF in 1989 to 30% NF in 2011
- Pays a blended HCBS/NF rate with an annual reconciliation process
  - If actual mix percentage is within 1 percentage point of expected, no change in payment
  - If actual mix percentage is above or below 1 percentage point of expected, the underpayment/overpayment is shared 50/50 between the State and the health plan
- Provides state-sponsored reinsurance

Tennessee - CHOICES

- CHOICES established in 2010
- Mandatory enrollment of elderly and physically disabled beneficiaries who meet nursing home level of care (CHOICES 1&2), or at risk for nursing home level of care (CHOICES 3)
- Comprehensive benefit package
  - Including acute, behavioral and long term services and supports (more moderate package of HCBS for CHOICES 3)
- Rebalanced from 83% NF prior to CHOICES implementation in 2010 to 63% NF as of December, 2012
- Pays a blended HCBS/NF rate for CHOICES 1&2 enrollees and a separate rate for CHOICES 3 enrollees
- Uses blended capitation payment and Money Follows the Person funding to encourage and support nursing home transitions

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Massachusetts One Care

- Passive enrollment began January 1, 2014, following three months of voluntary opt-in enrollment
- Enrolls non-elderly adult duals in ~8 counties
- Adds new services (supplemental diversionary behavioral health, community support services, and expanded Medicaid state plan benefits)
  - Excludes DD targeted case management and mental health rehabilitation option services
- Rate categories based on a needs assessment or length of stay in a facility:
  - (1) facility based care, (2) high community need, (3) community high behavioral health, and (4) community other
  - Rate categories can update each month

Massachusetts One Care (continued)

- High risk cost pools offset the impact of specific disproportionate LTSS costs
  - For enrollees in facility and high community need rating categories only
  - Pool makes payments to plans in proportion to the amount of total costs they make above a per-enrollee threshold
  - Used until additional risk adjustment is in place
- Symmetrical risk corridors also used in Year 1

Share\Corridor	<80%	80-97%	97-99%	99-100%	100-101%	101-103%	103-120%	>120%
State and CMS	0	50	90	0	0	90	50	0
Health Plan	100	50	10	100	100	10	50	100

Illinois Medicare-Medicaid Alignment Initiative

- **Enrollment begins March 1, 2014**
  - **Opt-in first, followed by passive starting June 1, 2014**
- **Will enroll adult dual eligibles in 21 counties (2 regions)**
  - **Excludes beneficiaries with developmental disabilities**
  - **Excludes ICF/MR services**
- **Modified blended NF/HCBS rate**
  - **Five rate cells, which also vary by age band and region**
    - (1) nursing facility, (2) waiver, (3) waiver plus, (4) community, and (5) community plus
  - **Waiver plus and community plus are "transitional" rates**
    - Paid for 90 days following NF admission or discharge
- **Minimum MLR of 85%**

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Additional Links

- Arizona
  - AHCCCS Notice of Request for Proposal released January 31, 2011 http://www.azahcccs.gov/commercial/Purchasing/bidderslibrary/YH12-0001.aspx
  - AHCCCS Strategic Plan State Fiscal Years 2013-2017 http://www.azahcccs.gov/reporting/Downloads/StrategicPlans/StrategicPlan_13-17.pdf
  - AHCCCS Medical Policy Manual http://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/Chap300.pdf
- Illinois
  - Financial Alignment Demonstrations Three-way contract: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/IllinoisContract.pdf.
- Massachusetts
  - Updated CY 2013 Demonstration Rate Report, revised August 30, 2013 http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/duals-demo-payment-rates.pdf
  - Financial Alignment Demonstration Three-way contract: http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MassachusettsContract.pdf
- Tennessee
  - TennCare Choices Contract: www.medicaid.gov/mltss/contractsfull.html
- Other
  - The Growth of MLTSS Programs: A 2012 Update", Truven Health Analytics, July, 2012 http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf