

HEALTH MANAGEMENT ASSOCIATES

Dual Eligible Financial Alignment
Demonstrations:
Rate Setting for Plans and Providers

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Presentation Overview

- Overview of Medicare and Medicaid Payment and Rate-Setting
- Financial Alignment (“duals demonstrations”) Models
- Rate-Setting for Duals Capitated Model
- Baselines, Adjustments, Plan Variation, etc.
- How Payments Flow to Providers
- Implementation Challenges / Rate Impact

Medicare Payment Options

- Fee-for-service Medicare – “Traditional”
 - Administered by CMS
 - Covers Part A (inpatient), Part B (outpatient) services, and Part D prescription drug plan
 - Government pays providers (through intermediaries) for services
- Medicare Advantage (MA) – Part C
 - Medicare Part A and B from a private insurance company that contracts with the government (HMOs and PPOs)
 - Plans are paid a certain amount per enrollee by Medicare (PMPM)
 - Plans contract with and pay providers
 - Can include Part D drug coverage and other benefits (such as dental and vision)

State Medicaid Rate Setting

- States set Medicaid rates, with CMS approval
 - Traditionally set for state plan benefits using fee schedule
 - Medicaid managed care has grown across states
 - Each state's method is unique & reflects policy objectives
 - State receives federal match for approved spending
- Payment rates may be negotiated, competitively bid, or administratively set
- Standard of “reasonableness” with sufficient documentation, actuarially sound, and appropriate for populations covered and services provided
- Capitation rate development for plans
 - Blended rates provide a single rate for all Medicaid services
 - Separate capitation rates cells for each category of service

Goal of the Financial Alignment Initiative/“Duals Demonstrations”

The goal of the Financial Alignment Initiative is to increase access to seamless, quality programs that integrate primary, acute, behavioral, prescription drugs and LTSS for the beneficiary

Financial Alignment Models

- Two demonstration models:
 - **Capitated Model:** A State, CMS, and a health plan enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care (9/12 states)
 - **Managed Fee-for-Service (MFFS) Model:** A State and CMS enter into an agreement by which the state would be eligible to benefit from a portion of savings from initiatives designed to improve quality and reduce costs for both Medicare and Medicaid (2/12 states, CO and WA)
- Minnesota is doing neither – participating in the demonstration, but is only doing administrative alignment not financial alignment

Principles of Managed Care Rate Setting for the Duals Demonstrations

- States have discretion regarding structure of capitation for Medicaid services: blended or individual rate cell methodology
- Duals Demonstration rate setting principles:
 - Rates are risk adjusted
 - Rates designed to provide incentives for using HCBS to reduce institutionalization
 - Rules established for assigning beneficiaries to various plans
 - Rates must be budget neutral, in total, for Medicare and Medicaid dollars paid
 - Managed care plans must be Medicare Advantage plans with at least a 3 star rating
 - Rates must be actuarially sound
 - Rates must reflect geographic variations

Capitated Model: Basic Methodology

(1.) Determine baseline

CMS calculates baseline Medicare payment and states calculates baseline Medicaid payment

(2.) Apply savings

CMS applies pre-determined savings percentage to both the Medicare and Medicaid baselines to determine the rates

(3.) Make adjustment

Adjustments are made to both Medicare and Medicaid rates (e.g. risk adjustments, certain amount withheld as a quality incentive)

(4.) Make payment to plan

Plan receives separate Medicare and Medicaid capitated payments (a prospective “blended” rate)

Capitated Model: Joint Rate-Setting Process

Baseline spending is determined for the target population in the demonstration area

- Baseline spending: An estimate of what *would* have been spent in the payment year (for Medicare and Medicaid) in absence of the demonstration
- Established prospectively, annually
- Medicare methodology to determine baseline is consistent across all states participating in the Duals Demos
- Medicaid methodology to determine baseline varies by state

1. Determine
baseline

2. Apply
savings

3. Make
adjustments

4. Payment

How Medicare Baseline is Determined

- CMS develops baseline cost estimates for Part A and B at county level
- Spending assumptions are calculated for Medicare Advantage (MA) and FFS Medicare, then a weighted average is determined based on expected enrollment
- **For beneficiaries coming from FFS Medicare:** The baseline is based on Medicare standardized FFS county rates (reflecting *historical* Medicare FFS expenditures)
 - Adjusted by wage and practice cost indices, DHS payments (where applicable)
- **For beneficiaries coming from MA:** The baseline is based on estimated amounts that would have been paid to MA plans (including Part C rebates)
- Baselines also include plan-specific assumptions about bids, quality bonus payment-adjusted benchmarks, and rebate amounts for each county

Medicare Part D Baseline

- The Part D projected baseline is set at the Part D national average monthly bid amount for the payment year (set every August)
- CMS also estimates the average monthly payment for LIS (Low-Income Subsidy) cost-sharing and Federal reinsurance subsidy amounts and these payments are 100% reconciled after the payment year has ended

How Medicaid Baseline is Determined

- Medicaid baseline methodology varies from state to state
- All states must provide data to support their baseline projections to CMS actuaries – who validate the data and projected baseline costs
- Medicaid baseline takes into account historic costs and must consider:
 - FFS Medicaid, and
 - Medicaid managed care plan payment (if the state currently serves duals through capitated managed care)
- Historic spending is used to reflect costs for services to be included in capitation rates for the target population, incorporating data for the most recent years available

How Expected Savings Are Estimated

- CMS determines an aggregate savings percentage based on modeling of expected changes in utilization
- Savings percentages vary by state and by year (specified in each state's MOU)
- Savings are prospectively applied to baseline amounts to determine rates paid to plans
- The savings % is then applied to the Medicare A/B and Medicaid components of the rate

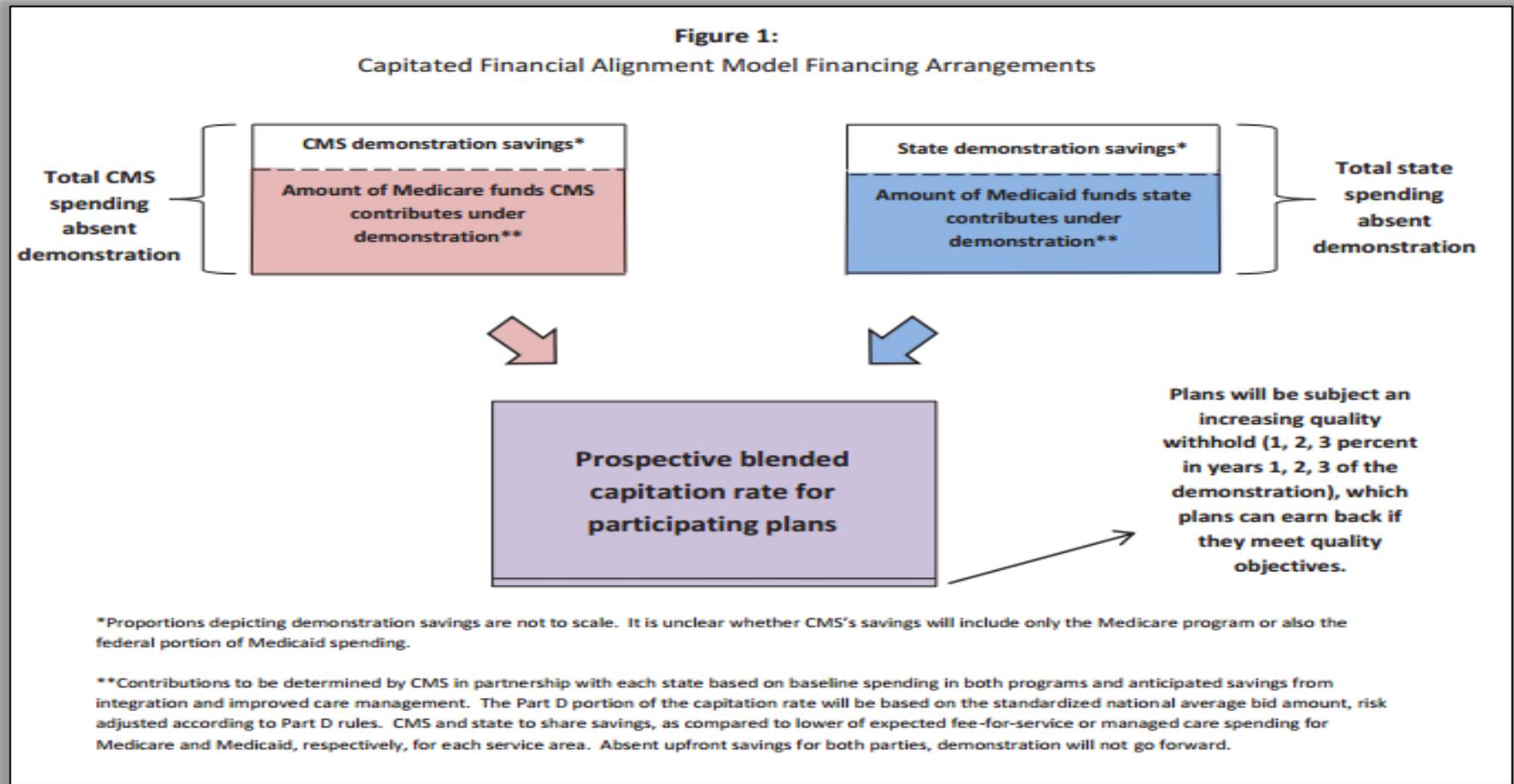
1. Determine
baseline

2. Apply
savings

3. Make
adjustments

4. Payment

Blending Payment Rates for Savings



Rate Adjustments

- Rates are **risk adjusted** by both Medicare and Medicaid
 - Accounting for differences in expected costs based on individual enrollee health status and demographics
 - CMS risk adjusts county MA rates at the enrollee level
 - Rates are also adjusted for coding intensity
- There is also a **quality incentive** withhold
 - CMS and the state withhold a % of the capitated payments that health plans can earn back if they meet quality targets
 - Aims to ensure that cost savings are not at the expense of quality
 - 1% in Year 1: Based on encounter reporting and process measures
 - 2% in Year 2 and 3% in Year 3: Based on performance

1. Determine
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2. Apply
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Medicaid Risk Adjustment Parameters

- The Medicaid component of the rate is adjusted according to methodologies proposed by the states, subject to CMS approval
- CMS allow states to use different methods, as long as they **incentivize community alternatives to institutional placement, have clear operational rules and processes for assigning beneficiaries into a rate category that are compatible with an individual's risk level/profile, and are budget neutral** across the Medicaid program, as a whole, after the application of savings percentages

How Payment Rates Vary by Plan

- For the Medicare component of the payment, base rates are developed at a county level using standardized FFS county rates and MA benchmarks
- Medicare base rates don't vary from plan to plan – the same county baseline applies to all plans operating in that county
- But Medicare rates are risk-adjusted by enrollee. Thus, actual payment may differ
- States have discretion, subject to CMS approval, to develop the Medicaid component of the payment and may choose to develop rates on a county, regional, or statewide basis, and customize risk adjustment methods

1. Determine
baseline

2. Apply
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3. Make
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4. Payment

Payment to Plans Under Duals Demo

- When payment is made to plans, Medicare and Medicaid funds are not co-mingled
- **CMS** makes separate payments to participating health plans for (1) Medicare A/B and (2) Part D components of the rate
- The **state** makes a payment to participating health plans for (3) the Medicaid component of the rate
- Medicare and Medicaid coordinate in rate setting
 - Both prospectively share in achievable demonstration savings
- Unlike Medicare Advantage, plans do not submit bids. Demonstration rates are jointly set by CMS and the state.

MCOs Negotiate Provider Rates

Medicare Provider Payment Options

Medicare FFS Rates	Part A/B
Partial Risk Based Capitation	Professional Only (Primary Care and Specialty Care)
Full Risk Capitation	Inpatient and Professional
End Stage Renal Dialysis	Case rate
Care Management Fee	Patient centered Medical Home Team
Durable Medical Equipment	Vendor contract rate
Quality Performance Withhold	Pass through to providers
Risk Adjustment	Based on Medicare Risk Adjustment Factor
Risk Pools	To incentivize low acute care and/or ER utilization

Medicaid Provider Payments

Institutional	Per diem for skilled nursing based on acuity level
Home and Community Based Services	Adult Day Care: Day Rate
	Home Health: Per hour plus mileage
	Behavioral health capitation or FFS
	Homemaker services: Per hour plus mileage
	Case management FFS or PMPM
	Group home or Assisted Living
Other Medicaid	Regional center services
	Part A/B Deductible and Co-Pays
	Medicaid Wrap Services

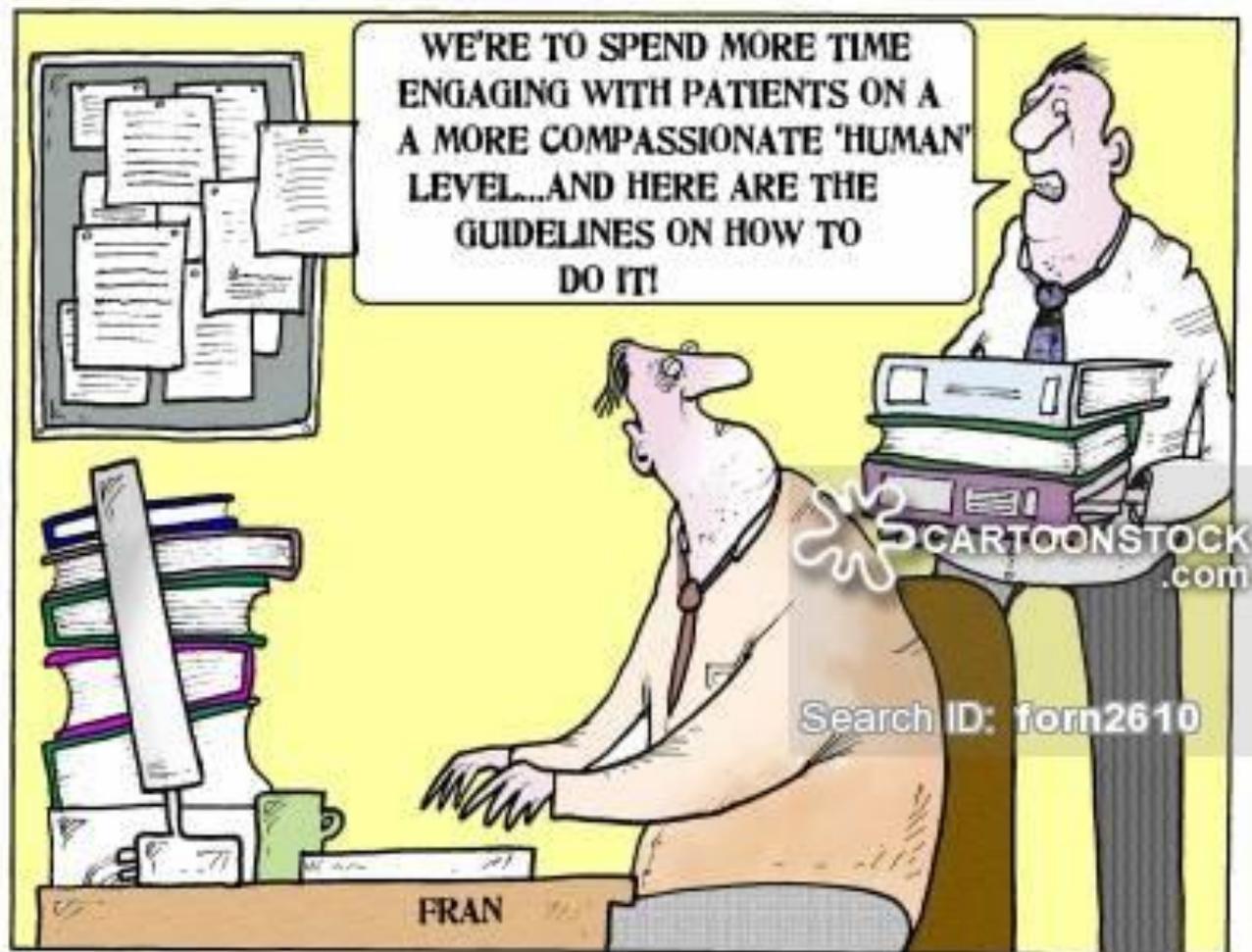
Community-based Support Services (LTSS) Examples

- Functional and home assessments
- Chore and personal care assistance
- Housing assistance
- Protective supervision
- Case management
- Respite
- Transportation
- Meal services
- Social services and recreation services
- Social service support
- Communication services

Unique Issues with the Duals Demo and Impact on Future Rate Setting

- High opt-out rates for beneficiaries
- Low enrollment and membership up-take
- Poor adherence to providing health risk assessment
- Beneficiary confusion
- Lower level of medical risk than expected higher risk opting to stay in FFS
- MA Star Rating issues for some health plans

Conclusion



Resources

Jenna Libersky and James Verdier. *Medicare Basics: An Overview for States Seeking to Integrate Care for Medicare-Medicaid Enrollees*. Washington, DC: Integrated Care Resource Center Technical Assistance Brief. July 2013.

Centers for Medicare and Medicaid Services (CMS). Joint Rate-Setting Process for the Capitated Financial Alignment Model (FAQs). Updated August 9, 2013

<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/JointRateSettingProcess.pdf>

CMS Financial Alignment Incentive resources and guidance (Medicare-Medicaid Coordination Office):

<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsInCareCoordination.html>