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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 -- original
  - Traditional Medicare, administered by the federal government (CMS)
  - Covers Part A (inpatient), Part B (outpatient) services, and Part D prescription drug plan
  - Government pays providers for services (e.g. DRGs, physician fee schedules, etc.)
- Medicare Advantage (MA) – voluntary 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
  - Plans contract with and pay providers
  - Can include Part D drug coverage and other benefits (such as dental and vision)

State Medicaid Rate Setting

- It is a State's responsibility to set Medicaid rates, with CMS approval
  - Traditionally set for hospitals, physicians, nursing facilities, group homes, etc. (fee schedules), now managed care
  - 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 rates for all Medicaid services
  - Separate capitation rates cells for each category of service

Goal of the Financial Alignment / 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 long-term care supports and services for the beneficiary

Financial Alignment / Duals Demonstration Models

- Now 13 demonstrations in 12 states, aimed at improving care coordination and lowering healthcare costs for duals, eligible for Medicare and Medicaid
- 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 (10/12 states)
  - **Managed Fee-for-Service (FFS) 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)
- Washington is implementing both (a hybrid model) -- capitated model in two urban counties and managed FFS in the rest of the state
- Minnesota is doing neither -- participating in the demonstration, but is only doing administrative alignment not financial alignment

Source. Kaiser Family Foundation. *Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS,* July 2014.

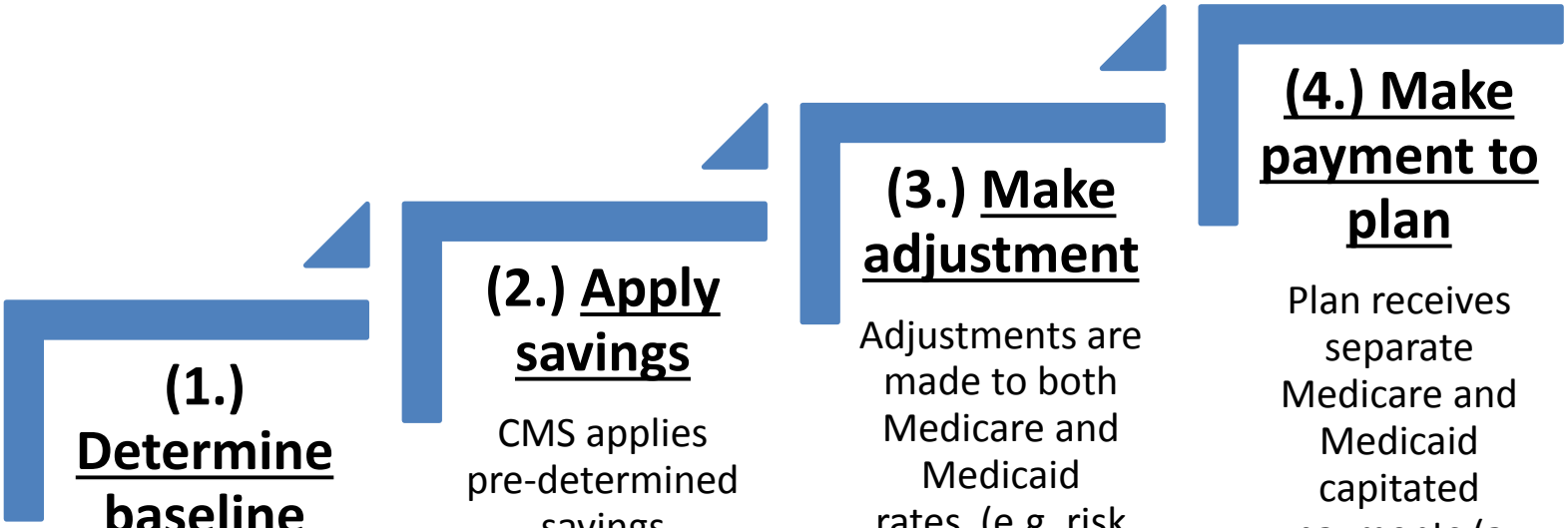
Principles of Managed Care Rate Setting for the Dual Demonstrations

- CMS and a State enter into a three-way contract with health plans participating in the Dual Demonstration
- States have discretion regarding the structure of capitation for Medicaid services
  - States can use a blended rate methodology
  - Individual rate cell methodology
- CMS has adopted the same approach generally it uses to set Medicare Advance health plan rates
- Dual demonstration rate setting principles
  - Rates are risk adjusted
  - Rate provide incentives for using home- and community-based services 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 3 star rating
  - Rates must be actuarially sound
  - Rates must reflect geographic variations

Capitation Rate Setting Components

1. Base rate is determined by claims and encounter data
2. Adjustment for state program policy changes
3. Service utilization and cost trends factors
4. Delivery system differences (e.g. requirements to use of safety net providers, county behavioral health etc.)
5. Health risk adjustments
6. Geographic adjustments
7. Administrative load, care management, risk contingency, or pass through requirements
8. Reinsurance allocation
9. Savings adjustment
10. Quality withhold

Capitated Model: Basic Methodology



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 capitated duals
- Medicaid methodology to determine baseline varies by state

1. Determine baseline → 2. Apply savings → 3. Make adjustment → 4. Payment

How Medicare Baseline is Determined

- CMS develops baseline cost estimates for Part A and B by demonstration county
- 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); these are adjusted for the current hospital wage index and physician geographic practice cost index; and in some states adjusted for DSH payments that would have been received
- **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

Rate Setting Example – California

- Medicaid beneficiaries shall receive Medi-Cal and LTSS through coordinated health care systems offered by Medi-Cal managed care plans
- Such coordinated systems shall promote beneficiary independence and use of home- and community-based services and reduce unnecessary use of emergency and hospital services
- Managed care plans shall develop and expand their care management and coordination practices with nursing facilities and other home- and community-based services
- Medicaid managed care plans shall expand enrollment for the 3 year period of the demonstration
- To the extent possible, for Medicaid beneficiaries enrolled in the federal Medicare program, the state shall work with the federal government to coordinate financing and incentives to allow managed care plans to deliver and coordinate the full scope of Medicare and Medi-Cal benefits, including long-term services and supports
- The state, in a coordinated effort with the federal government, shall ensure continued strong beneficiary protections, choice of providers, and beneficiaries' ability to self-direct their care, as well as robust monitoring and oversight of managed care plans

Dual Eligible Medicare and Medicaid Rate Setting

Medicare Base Rate Distribution

Rate Component	1st Year	2nd Year	3rd Year
Base Rate	97%	96%	94%
Administrative Load	5.5%	5.5%	5.55
Profit Margin	2.0%	2.0%	2.0%
Medical Costs Distributions			
Part A	51.5 %	47.1%	45.3%
Part B	48.5 %	52.9%	54.7%
Part D	2.0%	2.0%	2.0%

Medicaid Blended Rate Setting

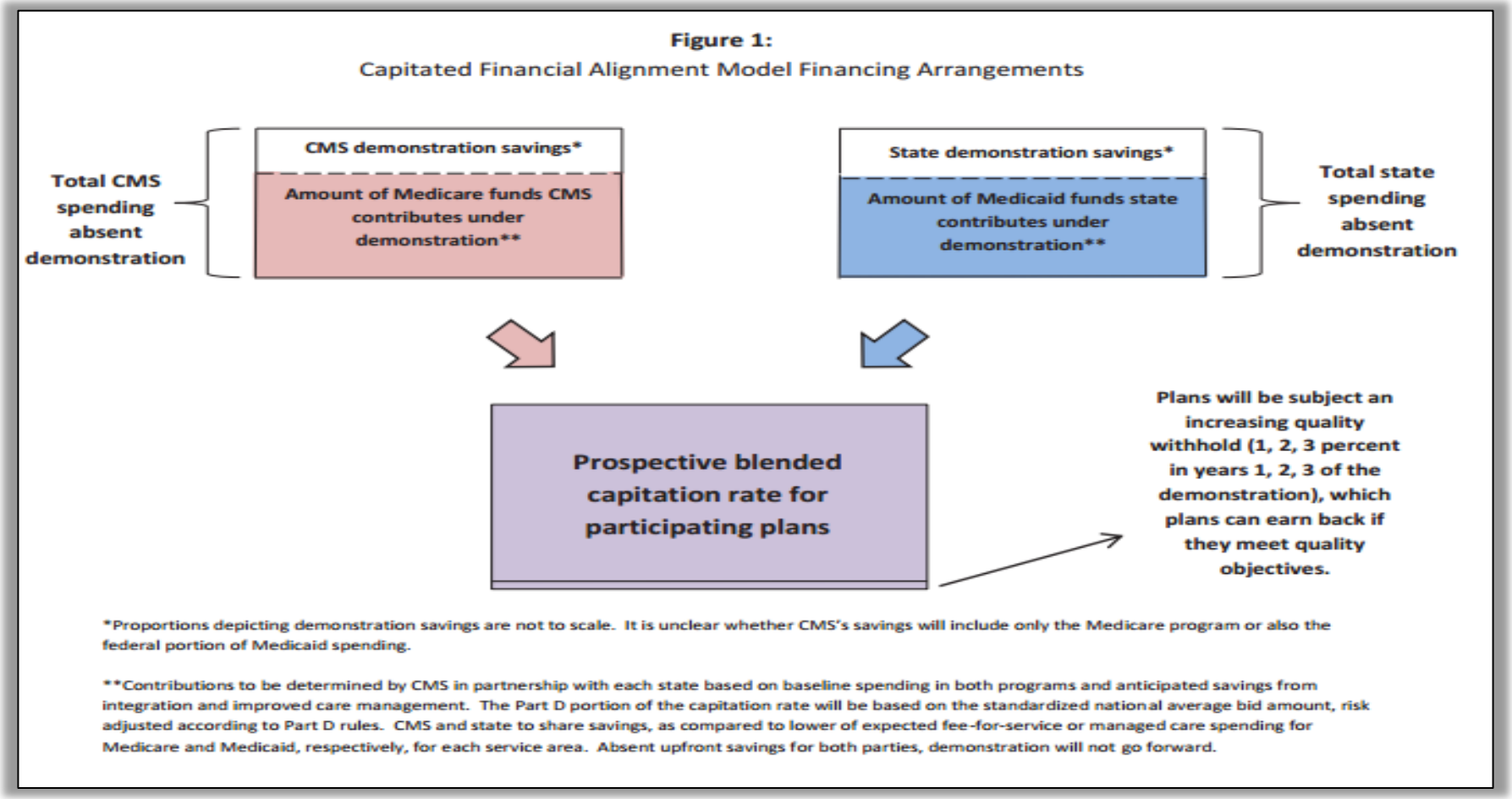
Rate Compon-Ent	1st Year	2cd Year	3rd Year
Institutional	8.8%	7.4%	6.3%
HCBS High	11.2%	12.5%	13.6%
HCBS Low	22.4%	22.6%	23.4%
Healthy	57.4%	57.5%	56.7%

How Expected Savings Are Estimated

- CMS determines an aggregate savings percentage for the demonstration 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
  - In other words, CMS and the state reduce the amount they pay to plans to realize these savings
  - Both payers proportionally share in savings regardless of underlying utilization patterns
  - Savings are not applied to Part D component

1. Determine baseline
2. Apply savings
3. Make adjustments
4. Payment

Blending Payment Rates for Savings



Source. Kaiser Commission on Medicaid and the Uninsured, *Policy Brief: An Update on CMS's Capitated Financial Alignment Demonstration Model for Medicare-Medicaid Enrollees,* April 2012. Link: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8290.pdf

Rate Adjustments

1. Rates are **risk adjusted** by both Medicare and Medicaid
   - Intended to account for differences in expected costs based on individual enrollee health status and demographics
   - CMS risk adjusts the standardized county rates at the enrollee level

2. 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 baseline | 2. Apply savings | 3. Make adjustments | 4. Payment

Additional Adjustments

3. CMS applies a **coding intensity** adjustment
   - Accounts for differences in diagnosis coding patterns between MA and FFS Medicare
   - Already applied to MA plans – in 2014, it's 4.91%
   - At the start of the demo, CMS applied a coding intensity adjustment based on the proportion of enrollees with prior MA experience, on a county-specific basis
   - After Year 1, CMS applies the prevailing MA coding intensity adjustment for all enrollees

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

Impact of Reducing Service Utilization

Reduction in Acute Care Utilization				
Service Utilization	**1st Year**	**2nd Year**	**3rd Year**	**4th Year**
Inpatient Hospital	-15%	-20%	-20%	-20%
Skilled Nursing Facility	-5%	-5%	-5%	-5%
Physician	+4%	+5%	+5%	+5%
Pharmaceutical	+2%	+2%	+2%	+2%

Summary -- Dual Demo Adjustments

Medicare Dual Adjustments	
Adjustment Components	
Sequester	Applied to the total capitation
Savings Adjustment	Required saving reduction go up annually
Risk Adjustment Factor	A percent increase of decrease based on enrollment of high risk individuals
Coding Intensity Adjustment	
Quality Withhold	Reduction for quality performance
ACA Tax	Payment ACA Tax
State Fees (if applied)	Payment of state applied tax

State Medicaid Rate Adjustments	
Adjustment Components	
Savings Adjustment	Applied to total Medicaid capitation
Program or Policy Adjustments	State specific Medicaid program changes
Reinsurance	State reinsurance charge (if applicable)
Geographic Factors	State geographic adjustment factors
Pass Through	Adjustment for state required pass through
Quality Withhold	Reduction for quality performance
ACA Tax/State MCO Fee	Payment of federal ACA and any state MCO tax

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 savings
3. Make adjustments
4. Payment

Payment to Plans Under Dual 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
- For the capitated model, 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.

MCO 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
	Home maker services: Per hour plus mileage
	Case management FFS or PMPM
	Group home or Assisted Living
	Regional center services
Other Medicaid	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

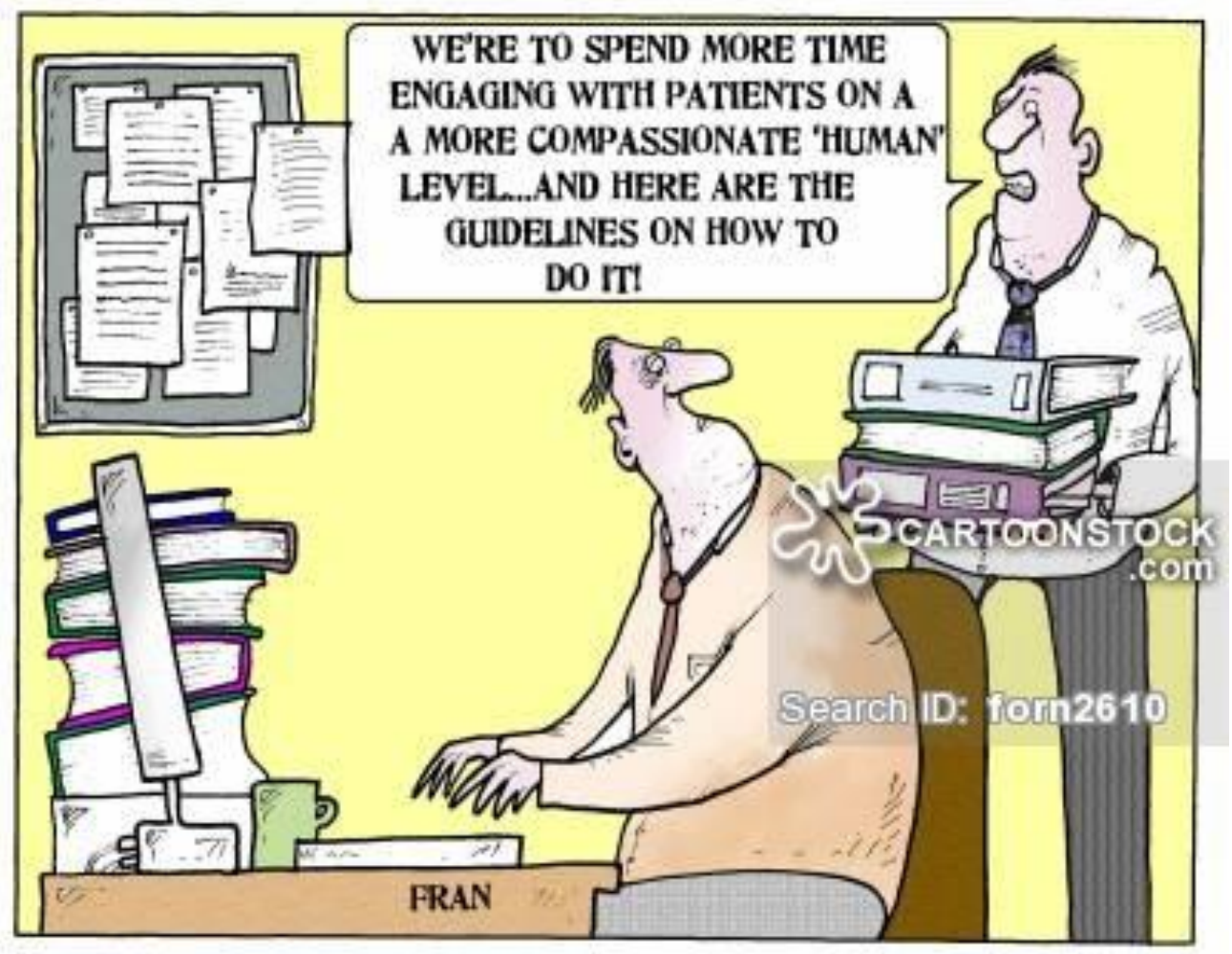
Provider Negotiation

Medicare Negotiation Considerations	Medicaid Negotiation Consideration
Capitation Split (Inpatient vs. Professional)	Beneficiary Assignment: Service Distribution and Workload
Quality Withhold Payment Reconciliation Delay	Case Management workload: Payment Approach PMPM or Case Rate
Risk Adjustment	Payment for other HCBS all inclusive or service rates
Risk Pools	Reporting Requirements
Tax or Fee Pass Through	Care Team Coordination
Care Management Fee	Transportation
Care Coordination with other Services	Community Care Transition
Health Information Exchange	Commination Requirement
	Health Information Exchange

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
- Star rating issues for some health plans

Conclusion


WE'RE TO SPEND MORE TIME ENGAGING WITH PATIENTS ON A A MORE COMPASSIONATE 'HUMAN' LEVEL...AND HERE ARE THE GUIDELINES ON HOW TO DO IT!
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CARTOONSTOCK .com
Search ID: forn2610

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):
ttp://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html