

Medicaid Rate-Setting Strategies to Promote Home- and Community-Based Services

By Suzanne Gore and Julie Klebonis, Center for Health Care Strategies, Inc.

MAY 2012

Most individuals prefer to receive long-term services and supports (LTSS) in their own homes and other community settings instead of nursing facilities.¹ States, in turn, have strong financial incentives to provide Medicaid-covered LTSS through home- and community-based services (HCBS) because on average per person, one year of HCBS is half the cost of a year in a nursing facility.^{2,3} However, less than half of Medicaid LTSS dollars nationally are spent on HCBS.⁴ This imbalance is largely because nursing facility care is an entitlement, whereas in many states HCBS are only offered through waiver programs, which often have budget and enrollment caps. Budget constraints make expanding access to HCBS difficult, and a number of states have waiting lists for people to access HCBS.

In addition to the need to better balance HCBS and nursing facility care, states face issues around better coordinating LTSS. Ninety-four percent of Medicaid beneficiaries who need LTSS services receive care within fee-for-service reimbursement arrangements.⁵ As a result, service delivery between LTSS and medical care is fragmented, with little assistance to help beneficiaries coordinate services or smoothly transition between care settings. Thus, states are seeking to improve coordination of services and ensure that beneficiaries receive the right services in the right setting at the right time.

Several states have created managed long-term services and supports (MLTS) programs to improve access to HCBS and coordination of care. In doing so, states have developed various rate-setting strategies to help achieve these goals. This brief discusses strategies for structuring MLTS rates to encourage HCBS and details state experiences in MLTS rate-setting.

Development of Managed Long-Term Services and Supports Programs

Over the last two decades, states have increasingly sought MLTS approaches for Medicaid beneficiaries in need of

IN BRIEF

States are pursuing a variety of innovative managed long-term services and supports (MLTS) delivery models to improve care for Medicaid beneficiaries. In particular, offering long-term services and supports in home- and community-based settings can provide high-quality care for beneficiaries and is cost effective for state Medicaid programs. This brief describes rate development strategies that states can use to promote home- and community-based services (HCBS) in MLTS programs, the role of integrated care programs to help expand HCBS, and other considerations for developing rates for MLTS programs.

LTSS. Arizona, Minnesota, and Wisconsin have operated MLTS programs since the 1990s; Hawaii, Massachusetts, New Mexico, and Texas introduced managed LTSS models in the 2000s; and Tennessee launched its CHOICES program in 2010. Most states have developed MLTS in conjunction with a larger integrated care effort that coordinates with Medicare; however, to date no program has financially integrated Medicare and Medicaid services. Moreover, some states view MLTS as a significant delivery system improvement in and of itself. New Jersey and Florida are not pursuing a financial alignment model at this time, but are currently developing MLTS programs. Of note, states developing MLTS programs for Medicaid-only beneficiaries (i.e., beneficiaries who are not also enrolled in Medicare) can request waiver authority to require mandatory program enrollment. States working on MLTS as part of a broader integrated care initiative for Medicare-Medicaid enrollees may only require mandatory enrollment for Medicaid-covered services. Enrollment must be voluntary when managed care also includes services traditionally covered by Medicare.

Whether states are developing MLTS for Medicaid-only beneficiaries or for those who are dually eligible for Medicare and Medicaid, the state typically contracts with a health plan or similar entity to provide Medicaid-covered

medical services, care management, and LTSS. A capitated per member, per month (PMPM) rate is typically set based on historical utilization and costs. Most often the contracted entity is a health plan.

Structure of Reimbursement Rates

Developing reimbursement rates for MLTS programs is still relatively new terrain, especially in the area of how to best structure rates to support care in the community. States can strategically design financial incentives to help MLTS programs foster community-based care, including supporting transitions from nursing facilities to community-based settings and promoting discharges to the community from acute care settings. The following discussion outlines four strategies that states have used to structure MLTS rates to promote the use of HCBS, including examples from pioneering states as well as lessons from the Program of All-Inclusive Care for the Elderly (PACE).

1. Pay the Same Reimbursement Rate Regardless of Setting

Paying health plans the same rate regardless of setting creates the strongest financial incentives to keep people in the community. The cost of nursing facility care is much higher, on average, than the cost of community-based care. When MLTS programs keep more people in the community and transition more people from nursing homes to the community than initially projected during rate setting, the MLTS contractor achieves savings.

New Mexico

One of New Mexico's primary goals in developing its Coordination of Long-Term Services (CoLTS) program was to create opportunities for beneficiaries to move from facilities to community-based settings. To meet this objective, CoLTS health plans are fully responsible for nursing facility care and do not receive a payment adjustment when a beneficiary enters a nursing facility. For all individuals who meet the nursing facility level of care criteria, the CoLTS program uses a reimbursement rate that is a blend of nursing facility and community costs; the rate is the same whether an individual resides in a facility or the community. Not paying a higher rate for individuals in a facility encourages CoLTS plans to provide extra supports to keep people in the community and out of more expensive facility care. The state renegotiates the CoLTS rates annually based on service patterns.⁶

Arizona

The Arizona Long Term Care Services System (ALTCS) also requires plans to be responsible for the full spectrum of a beneficiary's care, whether provided in home or community settings or nursing facilities. When a beneficiary moves from a home- or community-based setting to a nursing facility, there is no impact on the reimbursement rate paid to the plan. As in New Mexico, capitation rates are set on a yearly basis and the same capitation rate is paid whether the beneficiary is in a nursing facility or an HCBS setting. Capitation payments to ALTCS plans are based on the mix of beneficiaries residing in home and community settings and nursing facilities.

When developing the capitation rates, the state projects the future HCBS mix and builds that into the rates, which should reflect member movement from HCBS to a nursing facility setting and vice versa. If a plan is able to provide more services in a community setting than is assumed in the rates, it benefits financially, but if facility use is higher than expected, the rates may not fully cover the plan's facility costs. The state uses various sources of information for rate setting including encounter data, audited and quarterly financial statements, fee-for-service rate adjustments, home-based services fee schedule rebase, and changes in placement in HCBS.⁷ The rates are adjusted each year based on updated experience.

PACE

States considering an MLTS program should also examine the way in which rates are set for PACE. Although PACE is not considered an MLTS program, it has the same goal of providing comprehensive care in community-based settings. PACE Medicaid rates are regulated by the Centers for Medicare & Medicaid Services (CMS) and must: (1) be budget neutral; (2) account for the frailty of participants; (3) be set at a fixed amount, regardless of changes to the participant's health status; and (4) be renegotiated on an annual basis. PACE rates can be determined by using one of three methods: (1) an upper payment limit (UPL); (2) an actuarially-based rate; or (3) a competitive procurement. At present only the first two methods are used by any state.⁸

The Pennsylvania PACE program uses the UPL approach. The UPL is developed using a comparison group of individuals who are currently receiving HCBS and nursing home services in the fee-for-service setting.

These costs are then blended together and are considered the UPL. The PACE rate is set as a percentage of the corresponding UPL. If the PACE rate was set at 90 percent of the UPL, the state could report that the PACE organization saves an average of 10 percent on every person they enroll in PACE. Once an individual enrolls in PACE, the PACE program is responsible for paying for care even if the individual transitions to the more costly nursing facility setting. This approach allows the state to simplify the rate-setting process and financially motivate PACE organizations to provide care focused on keeping beneficiaries in the community.

2. Use Partial Capitation for Nursing Facility Care

If states and plans are not comfortable placing plans at full risk for nursing facility days, they can look to partially capitated options to ameliorate the risk. Minnesota offers an example of how to use the rate structure to promote HCBS without putting plans fully at financial risk for extended nursing facility stays.

Minnesota

Minnesota Senior Health Options (MSHO) provides both Medicare and Medicaid-covered services including LTSS for beneficiaries over age 65. Contracted plans are paid a PMPM capitation payment to provide care for beneficiaries and are at risk for 180 days of nursing home costs for anyone who transitions from the community to a nursing facility. After 180 days of nursing facility placement, the nursing facility per diem is paid directly by the state at fee-for-service rates, but the beneficiary remains enrolled in the program for other services.

To encourage plans to keep beneficiaries in the community, the state pays an actuarially-determined “nursing facility add on” for all members residing in the community to cover potential nursing facility placements.⁹ The add-on payment is based on the state’s projections of nursing home admissions, length of stay, and per diem payments and is not plan-specific. When a beneficiary moves to a nursing facility, the add-on payment to the plan ceases, and the plan must cover the higher facility cost out of previously paid revenues. Days are counted cumulatively for each enrollee so it may take several years for the 180-day facility liability to be satisfied. In addition, liability may recur at a later point if the individual returns to the community.¹⁰ States considering this option will want to ensure that they have a mechanism in place to easily track the cumulative number of nursing facility days.

3. Reward Plans for Appropriate Transitions to the Community

Several states have found that financially rewarding MLTS plans for efforts to help beneficiaries move back into the community provides the extra incentive needed make these transitions happen. Some states also offer incentives for plans that keep a certain number of beneficiaries in community settings and out of nursing facilities.

Arizona

In addition to placing plans at full risk for nursing facility utilization, Arizona’s ALTCS program uses an HCBS reconciliation process to encourage plans to transition beneficiaries from nursing facilities to HCBS, when appropriate. The state establishes an assumed ratio of beneficiaries residing in home and community settings versus those in a nursing facility by geographical service area and plan. When a health plan’s percentage of members in HCBS exceeds the assumed ratio that was set by the Arizona Health Care Cost Containment System, the reconciliation process allows the state to reimburse the plan for a portion of the difference in the amount of the nursing facility rate versus the HCBS rate. If the plan falls below the target ratio, the state may recoup some portion of the difference in the rates.¹¹

Massachusetts

The Massachusetts Senior Care Options (SCO) program serves MassHealth members age 65 and over. Senior Care Options is a voluntary program and most participants are Medicare-Medicaid enrollees. As a disincentive to serving people in nursing facilities, the state pays SCO plans a rate that is lower than the standard nursing facility rate for 90 days after an enrollee moves from the community to a nursing facility. Yet to incent plans to transition individuals to the community, the state pays the nursing facility rate (a rate that is higher than the community rate) for the 90 days after an enrollee moves from a nursing facility into the community.¹²

4. Provide Incentives for HCBS Even When Services are Carved Out of the Program

Some states developing MLTS programs are faced with the obstacle of trying to promote HCBS even though certain services are carved out, meaning they are not included in the program’s capitation payment. Carve outs typically result from political concern raised by provider groups—

most frequently about reimbursement rates for those providers.

Texas

The Texas STAR+PLUS program, covering both Medicaid-only people with disabilities as well as Medicare-Medicaid enrollees, completely excludes nursing facilities from its plan capitation rates. The state made the decision to carve out nursing facility care due to facility concerns that their payments from the STAR+PLUS plans would not be as timely as the payments they receive directly from the state. The state, therefore, pays the nursing facilities on a fee-for-service basis. Texas, however, is still able to promote HCBS by awarding quality-based performance bonuses.

One percent of a plan's reimbursement is at risk based on its performance on several measures, including the nursing facility admission rate of enrolled members.¹³ Texas used a comparable approach during the period from 2006 to 2011 when the state excluded inpatient hospital services from the STAR+PLUS capitation. In 2008, the state required health plans to achieve a 22 percent reduction in projected fee-for-service hospital inpatient stay costs for the Medicaid-only population and placed part of the health plans' administrative fee at risk if that standard was not met. Health plans that exceeded the 22 percent reduction standard were eligible for a shared savings award.^{14,15}

New Opportunities to Invest in HCBS Through Medicare-Medicaid Integrated Models

Passage of the Affordable Care Act (ACA) and establishment of CMS' Medicare-Medicaid Coordination Office (MMCO) bolstered states' ability to improve and streamline the delivery of LTSS. The MMCO, in coordination with the Center for Medicare and Medicaid Innovation, provided two new financial alignment models for states to support development of fully-integrated systems of primary and acute care, LTSS, and behavioral health services to Medicare-Medicaid enrollees.

MLTS programs currently do not have the benefit of being financially integrated with Medicare. Before the ACA, the primary way for states to expand HCBS services without exceeding "budget neutrality" (i.e., without spending more on the MLTS program than the state spent on fee-for-service LTSS) was by rewarding plans for diverting or avoiding the use of nursing

facilities. The financial alignment models proposed by the MMCO offer states the opportunity to promote the use of HCBS for Medicare-Medicaid enrollees through savings achieved from decreasing the use of *Medicare* services. For example, if a state's integrated care program resulted in fewer emergency department visits and hospital readmissions, the state could then use savings from that avoided service use to expand HCBS. For example, expanding personal care services to help a beneficiary with bathing could potentially prevent a fall, thus possibly avoiding an emergency department visit, hospital stay, hip replacement surgery, and rehabilitation services.

Further Considerations for Rate Development

In addition to the above-described strategies to promote HCBS and opportunities in integrated care, there are a few other points that states should consider when developing rates for MLTS.

- **Consider the resource demands of transitioning individuals to the community.** When developing rates, states should recognize how resource intensive it is for a health plan to transition an individual from a facility to the community, especially if that individual has been in the facility for a long period of time. States may want to consider ways to help health plans partner with existing state initiatives such as Money Follows the Person or nursing home diversion programs to give plans access to the additional resources needed to support transitions. If states pay a higher reimbursement rate for beneficiaries in nursing facilities, such as the Massachusetts SCO program,¹⁶ they may want to consider continuing that rate for several months after transition to support the plans' higher costs during and immediately after transition.
- **Give plans flexibility to develop a high-performing provider network.** In some states certain provider groups have resisted MLTS initiatives. To "warm up" providers to MLTS, some states require plans to contract with all willing providers in these groups. While this may be necessary to initially launch a program, this does not enable the plan to improve the quality of care by eliminating under-performing providers. Requiring plans to contract with any willing provider limits the program's ability to optimally ensure quality of care and most cost-effectively deliver services.

- **Allow rate-setting strategies adequate time to achieve savings.** States with newer MLTS programs, such as New Mexico and Tennessee, have indicated that it takes time to generate savings from an MLTS program. The level of unmet need identified during initial assessments often results in higher expenditures during the first few years. Nevertheless, a high quality, well-functioning care coordination system can identify needs and address them in an efficient and cost-effective manner.

Conclusion

Beneficiaries want the freedom to choose how and where they obtain LTSS and most would prefer to live

in their own homes or a community-based setting. At the same time, an increasing number of states are seeking to better coordinate LTSS services and provide access to HCBS options through MLTS programs. Ensuring that rates are structured in a way that does not inadvertently reward health plans for nursing facility-based care is imperative for ensuring that beneficiaries have the broadest options for LTSS. States developing reimbursement rates for MLTS programs can look to experienced states such as Arizona, Massachusetts, Minnesota, New Mexico, Tennessee, and Texas, and even to the PACE program as a starting point to develop rates that best ensure beneficiaries' access to services and supports in the setting of their choice.

Endnotes

- ¹ T. Keenan. *Home and Community Preferences of the 45+ Population*. AARP, November 2010. Available at: <http://assets.aarp.org/rgcenter/general/home-community-services-10.pdf>.
- ² *Medicaid's Long-Term Care Users: Spending Patterns Across Institutional and Community-Based Settings*. Kaiser Commission on Medicaid and the Uninsured, October 2011. Available at: <http://www.kff.org/medicaid/7576.cfm>.
- ³ The costs of Medicaid nursing facilities and HCBS vary by geographic region; however, in 2007 nursing facility care cost an average of \$62,750, whereas community-based care cost an average of \$31,341 per year. Note though that the cost for HCBS can vary significantly depending on a beneficiary's level of frailty or need. Source: *Medicaid's Long-Term Care Users: Spending Patterns Across Institutional and Community-based Settings*. Kaiser Commission on Medicaid and the Uninsured, October 2011. Available at: <http://www.kff.org/medicaid/7576.cfm>.
- ⁴ V. Smith, K. Gifford, E. Ellis, R. Rudnowitz, M. O'Malley Watts, and C. Marks. *The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession. Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2009 and 2010*. Kaiser Commission on Medicaid and the Uninsured, September 2009. Available at: <http://www.kff.org/medicaid/7985.cfm>.
- ⁵ P. Saucier. "Overview of Medicaid Managed Long-Term Care." Presented at the National Health Policy Forum on Medicaid Managed Long-Term Care, April 25, 2008.
- ⁶ Personal communication with former New Mexico CoLTS staff on March 29, 2012.
- ⁷ Personal communication with ALTCS staff on March 27, 2012. For further information on current ALTCS rates, including the Actuarial Certification please visit: <http://www.azahcccs.gov/commercial/ContractorResources/capitation/capitationrates.aspx>.
- ⁸ *PACE Medicaid Rate-Setting: Issues and Considerations for States and PACE Organizations*. National PACE Association, May 2009. Available at: <http://www.npaonline.org/website/navdispatch.asp?id=2871>.
- ⁹ R. Kronick and K. Llanos. *Rate Setting for Managed Long-Term Supports and Services*. Center for Health Care Strategies, March 2008. Available at: http://www.chcs.org/usr_doc/Rate_Setting_for_Medicaid_MLTS.pdf.
- ¹⁰ Personal communication with Minnesota staff on March 28, 2012.
- ¹¹ Personal communication with Arizona staff on April 27, 2012. For more information, see "Home and Community Based Services (HCBS) Reconciliation – ALTCS." Arizona Health Care Cost Containment System Contractor Operations Manual, November 2011. Available at: http://www.azahcccs.gov/shared/Downloads/ACOM/4_17_12ACOM.pdf.
- ¹² J. Verdier, M. Au, and J. Gillooly *Managing the Care of Dual Eligible Beneficiaries: A Review of Selected State Programs and Special Needs Plans*. Medicare Payment Advisory Commission, June 2011. Available at: http://medpac.gov/documents/Jun11_ManagingDualEligibles_CONTRACTOR.pdf.
- ¹³ Texas Health and Human Services Commission. *Uniform Managed Care Manual*, Chapter 6.2.1 and 6.2.2. Accessed January 13, 2012. Available at: <http://www.hhsc.state.tx.us/medicaid/umcm/>.
- ¹⁴ Uniform Managed Care Contract Terms & Conditions, Sections 6.3.2.5 to 6.3.2.5.2. [Note that this version of the contract is no longer on the Texas Health and Human Services commission web site.] According to Pam Coleman, former administrator of Texas' STAR+PLUS program, all the MCOs met the 22 percent reduction requirement for 2008, and inpatient costs have remained at essentially that level since then.
- ¹⁵ Texas Health and Human Services Commission, op. cit.
- ¹⁶ Verdier et al., op. cit.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs.

This policy brief is a product of CHCS' Implementing the Roadmaps: Innovations in Long-Term Supports and Services program, made possible through The SCAN Foundation. Through this program, CHCS is helping participating states to rebalance and better manage an array of long-term services and supports for Medicaid populations. For more information, visit www.chcs.org.