Rate Setting for Capitated Medicaid Managed Long Term Supports and Services (MLTSS)

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The Integrated Care Resource Center is a joint technical assistance initiative of the Centers for Medicare & Medicaid Services’ Medicare-Medicaid Coordination Office and the Center for Medicaid and CHIP Services. Technical assistance is coordinated by Mathematica Policy Research and the Center for Health Care Strategies.
Rate Setting Methodology Overview

- Rate Setting Objectives
- Basic MLTSS Rate Setting Approach
- Rate Structure
  - Financing strategies
  - Risk adjustment
- Risk Mitigation Strategies
  - Risk sharing
  - Risk pools
  - Reinsurance
- Pay for Performance/Quality Incentives
- State Examples
Rate Setting Objectives

- Develop a rate structure that:
  - Matches payment to the risk of the enrolled population
  - Meets CMS requirements per 42 CFR 438.6(c) and actuarial rate setting checklist
  - Promotes policy goals of MLTSS program
  - Can be administered and operationalized
Rate Setting Objectives

- CMS Medicaid actuarial soundness requirements
  - Capitation rates have been developed in accordance with generally accepted actuarial principles and practices
  - Rates are appropriate for the populations to be covered and the services to be furnished under the contract
  - Rates are developed by actuaries that meet the qualifications standards established by the American Academy of Actuaries (AAA)
  - Rates follow the practice standards established by the Actuarial Standards Board (ASB)
Basic Rate Setting Approach – Overview

- Base data and adjustments
- Program and policy changes
- Trend
- Delivery system differences
- Administration and care management
- Final capitation rates
Base Data

- Detailed claims and eligibility data
- Medicaid-covered services only
- Includes only those services covered by the capitation rate
- Reflects only those populations eligible to enroll in the MLTSS program
- Modeled to reflect MLTSS payment structure
Base Data - Sources

- Fee-For-Service (FFS) Experience
  - Best for new MLTSS programs and smaller, voluntary MLTSS programs
  - Generally complete, comprehensive and high quality
  - May not reflect risk of managed care population if MLTSS program is voluntary

- Encounter Data From Health Plans
  - Best for more mature and larger MLTSS programs
  - Data quality and completeness vary by health plan
Base Data - Adjustments

- Completion factors
  - Lags in provider claim submission
  - Missing encounter data
- Costs outside of the MMIS system
  - Pharmacy rebates
  - Disproportionate Share Hospital (DSH)/Graduate Medical Education (GME) payments
- Retroactive eligibility
- Third party liability
- Member cost sharing and patient liability
- Effects of voluntary selection if enrollment is not mandatory
Program and Policy Changes

- Generally reflect one-time changes outside of normal trend
  - State fee schedule adjustments
  - Benefit changes
  - Eligibility changes
  - Federal mandates
  - State legislative actions

- Historical changes
  - Differences in benefits, eligibility or fee schedule between the base data and the contract period

- Prospective changes
  - Changes in the program that were not captured in the base data but will be implemented prior to or during the contract period
Trend

- Estimates change in service cost over time due to differences in practice patterns, technology, utilization, inflation and cost shifting
- Used to project costs from the base period to the contract period
- Applied to Utilization and Unit Cost separately or to total per member per month (PMPM) costs
- Generally varies by major category of service
- Excludes changes in program/policy or managed care efficiency adjustments, which are applied separately
Delivery System Differences

- Reflects expected changes in service delivery for the projected MLTSS program compared to the base data period
  - Change in mix of Home and Community Based Services (HCBS) and Nursing Facility (NF) users
  - More effective use of personal care/home health services
  - Reductions in unnecessary hospitalizations and readmissions
  - Reductions in unnecessary emergency room visits
  - Increased access to HCBS services

- Adjustments vary depending on whether data source is FFS or Encounter data
  - Encounter data reflect managed care effects
Administration and Care Management

- Assumed costs/savings should be reasonable, appropriate and attainable
- Use a flat percentage across all rate categories or make assumptions about fixed and variable costs
- Other considerations include:
  - Start up costs
  - Care management costs
  - Risk/contingency margin
  - Profit margin
  - Investment income
  - Premium tax
  - Other assessments
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
- Required to be actuarially sound
- Should generally reflect variations by
  - Age
  - Gender
  - Geography
  - Medicare status
  - Diagnosis
  - Degree of frailty (Nursing Home Level of Care)
  - Setting of care (Institutionalized and Community)
Rate Structure - Financing Strategies

- Blended HCBS/NF 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
  - Arizona and Tennessee use this approach
Rate Structure – Financing Strategies

- 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)
  - Massachusetts and Minnesota use this approach
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. 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 and Wisconsin use this approach
Risk Mitigation Strategies – Risk Sharing

- Risk sharing
  - 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
  - New York is currently using a risk sharing model for new enrollees as it expands its MLTSS program from voluntary to mandatory
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
  - NM used risk pool to retroactively adjust HCBS/NF mix percentages assumed in blended rate in initial years of MLTSS program
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
  - 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
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

Texas performance targets include:
- Rate of nursing facility admissions for enrolled members
- Percent of members who return to community following a nursing home admission
- Percent of members using personal assistance or respite services who self-direct these services
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
- Massachusetts
- New York
- Tennessee
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
Massachusetts – Senior Care Options (SCO)

- SCO established in 2004
- Voluntary enrollment of beneficiaries age 65 and older, regardless of frailty
- Comprehensive benefit package - including acute, behavioral and long term services and supports
- Integrated with Medicare
- Pays separate rates for Institutional (3 tiers), Community Nursing Home Certifiable (NHC), Community Alzheimer’s Dementia/Chronic Mental Illness, Community Well
  - State pays higher Institutional rate for 90 days for a beneficiary who transitions to the Community
  - State pays lower Community NHC rate for 90 days for a beneficiary who transitions to the Institution
New York – Managed Long Term Care Program (MLTC)

- MLTC established in 1998
- Voluntary enrollment of elderly and physically disabled beneficiaries who are nursing home level of care
- Expanding to mandatory enrollment in certain regions, including New York City, starting in 2014. Mandatory enrollment will also include individuals who are at risk of becoming NHC
- Benefit package primarily long term services and supports
- Pays blended NF/HCBS rate with risk adjustment
- Risk adjustment reflects variations of plan enrollees based on Activities of Daily Living (ADLs)/Instrumental Activities of Daily Living (IADLs), disruptive behaviors, impaired behaviors, speech limitations, incontinence and specific diagnoses
- Implementing risk sharing for new enrollees
  - Costs between 97% and 103% of premium, no risk sharing
  - Costs between 92% and 97% or 103% and 108% of premium, State and health plan share 50/50
  - Costs above 108% or below 92% of premium, State pays 100%
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
Additional Links

- **Arizona**
  - AHCCCS Notice of Request for Proposal released January 31, 2011
  - AHCCCS Strategic Plan State Fiscal Years 2013-2017
  - AHCCCS Medical Policy Manual

- **Massachusetts**
  - MassHealth SCO: A Guide to the Senior Care Options Program for MassHealth Providers

- **New York**
  - Risk adjustment for Dual Eligibles: New York’s Experience, Presentation February 29, 2012 by Patrick Roohan

- **Tennessee**
  - http://www.tn.gov/tenncare/long_overview.shtml
  - TennCare Choices Contract www.medicaid.gov/mltss/contractsfull.html

- **Other**
State Technical Assistance

- The Integrated Care Resource Center was established by CMS to help states develop and implement integrated care models for Medicaid beneficiaries with high-cost, chronic needs.

- Focus on integrating care for: (1) individuals who are dually eligible for Medicare and Medicaid; and (2) high-need, high-cost Medicaid populations via the Health Homes state plan option as well as other emerging models.

- Individual and group TA coordinated by Mathematica Policy Research and CHCS.

- For more information, visit: www.integratedcareresourcecenter.com