CHAPTER 5

Issues in Setting Medicaid Capitation Rates for Integrated Care Plans

Key Points

Issues in Setting Medicaid Capitation Rates for Integrated Care Plans

- Many states serve persons dually eligible for Medicare and Medicaid through risk-based managed care plans that integrate Medicare and Medicaid services, and several more states have proposed new capitated models under the Centers for Medicare & Medicaid Services (CMS) financial alignment demonstrations. How CMS and the states approach setting Medicaid capitation rates for plans participating in these programs will be a key factor in determining whether these programs move forward, can be sustained over time, and meet expectations for financial savings.
- Challenges for states in setting Medicaid capitation payment rates for integrated care plans include accounting for the wide variability in enrollee use of long-term services and supports (LTSS) and balancing financial incentives with acceptable plan risk. Ideally, the capitation rates should be set at levels that are neither so low that plans avoid enrolling individuals with the greatest needs or limit access to services, nor so high that there are no incentives for plans to be efficient.
- States have experience with two existing integrated care programs for dual eligibles: (1) state arrangements with Medicare Advantage dual-eligible special needs plans (D-SNPs) and (2) Program of All-inclusive Care for the Elderly (PACE) plans. These states use a range of rate-setting tools to create financial incentives while accounting for population differences and financial risk to the plans.
- Voluntary enrollment can make rate setting more challenging because the average health and functional status of the population that ultimately enrolls in the program may be significantly different from the population characteristics assumed in the rate-setting process. Rate-setting mechanisms that adjust for population differences can help account for voluntary enrollment.
- Only a few states have implemented a Medicaid risk adjustment process for dual eligibles because the commonly used risk adjustment models are limited in their ability to predict LTSS costs. Risk adjustment models that are more predictive of Medicaid LTSS costs will likely be needed as more states serve dual eligibles through risk-based managed care programs. Given the differences in LTSS benefits in each state, a single risk adjustment model may not accurately predict LTSS costs across states, and some states may need to develop their own models.

CHAPTER 5

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Individuals over age 65 and younger persons with disabilities who are dually eligible for both Medicare and Medicaid (dual eligibles) are among the highest-need and highest-cost individuals in both programs. As a result, they have become the focus of efforts to develop more effective integrated care delivery models. The goal of these programs is to provide better coordination of Medicare and Medicaid services, lower costs, and improve health and functional outcomes for this population.

Several states are serving dual eligibles through risk-based managed care models, and more have proposed to do so. Under these models, the state pays participating managed care plans a capitated payment—a fixed amount for a defined package of benefits, usually paid on a per member per month basis. The managed care plan assumes financial risk for the cost of covered services and plan administration. The combination of a fixed payment amount and financial risk is intended to create incentives for the managed care plan to coordinate care so that needed services are provided in the most cost-effective manner.

Among the states that have moved to capitated managed care for dual eligibles, some have created arrangements with Medicare Advantage dual-eligible special needs plans (D-SNPs) and developed Program of All-inclusive Care for the Elderly (PACE) programs to coordinate Medicaid and Medicare benefits. The Centers for Medicare & Medicaid Services (CMS) is working with states on initiatives to create new integrated care plan options and further coordinate services for dual eligibles.

The largest initiatives in this effort are the financial alignment demonstrations, in which 15 states are working with CMS to enroll dual eligibles into risk-based managed care.[1] Estimates are that up to 2 million individuals could be enrolled in the financial alignment demonstrations in the future (Bella 2012). Under these managed care models, CMS and the states will collaborate to develop care delivery approaches that encourage more coordination across Medicare and Medicaid services. Both Medicare and Medicaid

will share in the savings achieved through the demonstrations.

Much of the public attention to the financial alignment demonstrations has focused on how care management, enrollment, and appeals processes will be approached, and how savings resulting from the demonstrations will be allocated and used. Another important issue is how the capitation rates will be set. The approach to setting capitation rates for plans participating in these programs will be a key factor in determining whether the demonstrations move forward, are sustained over time, and meet expectations for financial savings.

This chapter focuses on several policy and technical issues related to setting appropriate Medicaid capitation rates for integrated care programs serving dual eligibles. It begins with an overview of the general Medicaid capitation rate-setting process for dual eligibles and highlights the significance of enrollees' use of long-term services and supports (LTSS) in developing these rates. The chapter then describes various components of rate-setting methodologies that states have used to develop capitation rates in existing integrated dual-eligible managed care programs and provides state-specific examples of the joint rate-setting process being used for CMS's financial alignment demonstrations. The chapter concludes by raising additional policy issues for consideration.

Overview of Rate Setting for Medicaid Managed Care

Today, several states have plans that serve dual eligibles through Medicaid capitated arrangements. Many of these plans also participate in the Medicare Advantage program and receive capitated payments from CMS to provide Medicare benefits for beneficiaries who have chosen to enroll. Typically, when a beneficiary is enrolled in the same plan for both Medicare and Medicaid, the plan receives separately developed Medicare and Medicaid capitation rates.

Medicaid capitation rate-setting methods vary from state to state. This section describes some of the key concepts in developing capitation rates for Medicaid enrollees and some of the challenges in setting rates for dual eligibles. Later sections address how states have implemented these concepts in developing capitation rates for integrated care models, such as D-SNPs, PACE, and the financial alignment demonstrations.

Medicare capitation rates for D-SNP and PACE plans are developed as part of the national Medicare Advantage and Part D rate-setting and bid processes and are not discussed in this chapter.[2]

Capitation rate development

In determining Medicaid capitation rates, states begin with a baseline of historical claims and eligibility data for the relevant population and make adjustments to reflect expected costs during the payment period (typically one year). Using the adjusted baseline, capitation rates are set for groups of enrollees to reflect differences in predicted service use for each group. States may further refine their payment methodologies with various approaches to mitigate some of the plans' financial risk and to create incentives related to plan performance and quality of care. Ideally, the capitation rates should be set at levels that are neither so low that plans avoid enrolling individuals with the greatest needs or limit access to services, nor so high that there are no incentives for plans to be efficient.

Establishing and adjusting the baseline. The rate-setting process starts by establishing a baseline of historical spending for the relevant population. The baseline data are typically one to two years of recent experience for the eligible population and are based on either fee-for-service (FFS) claims or

managed care plan encounter data. The services included in the baseline data reflect those included in the managed care contract; any services carved out of the contract would be excluded from the baseline.

The baseline data are then adjusted for several factors, including:

- claims completion (i.e., services provided for which a claim has not yet been paid);
- state or federal policy and programmatic changes (e.g., fee schedule and benefit package changes);
- price and utilization trends;
- anticipated managed care efficiency (e.g., if the baseline uses FFS data, expected differences in service price and utilization realized through managed care); and
- administrative costs (including care management activities not routinely conducted under FFS).

Determining rate cells. Rather than paying the same rate for every enrollee, states develop Medicaid capitation rates for subgroups of the enrolled population who have similar cost characteristics. These subpopulation-specific rates are called rate cells. The rate cells may be based on enrollee characteristics such as basis of eligibility, age, gender, and geographic region.

Risk adjustment. Risk adjustment may be used in Medicaid managed care programs to further refine payments to plans based on enrollee health status and service needs. Risk adjustment approaches typically use diagnostic information and other enrollee characteristics to calculate a risk score that represents an individual enrollee's expected costs relative to the average cost of the overall population.

The risk score is applied to the capitation rate so that a plan is paid more for enrollees with higher-acuity conditions and less for enrollees with lower-acuity conditions. Risk adjustment can protect against unintended incentives for adverse selection or "cherry picking" healthier enrollees among health plans. The use of rate cells and risk adjustment allows for payment to vary based on enrollee characteristics when there is a different enrollment mix across participating plans.

Risk sharing. States may use risk-sharing arrangements such as risk corridors or stop-loss provisions to mitigate some of the plan's financial risk. Under risk corridors, the state limits a plan's gains and losses by sharing in the costs or savings beyond a certain threshold. The state will reimburse the plan for a certain percentage of losses if aggregate spending for services exceeds the plan's capitation payments and will share in a portion of the savings should payments for services be less than the capitation payments.

Stop-loss or reinsurance provisions protect plans from losses beyond predetermined thresholds on an individual basis (e.g., $100,000 in annual payments for a single enrollee). Beyond the specified threshold, the state will assume some or all of the enrollee's cost of care. If stop-loss or reinsurance provisions are used to limit the amount of loss a plan may experience, the capitation rates are adjusted to account for the reduced risk that the plans bear.

Incentive and withhold payments. States may include incentive payments in the rate-setting process that give plans a bonus for achieving high ratings on performance or quality measures. Alternatively, the state may withhold a small percentage of the capitation payment and allow the plan to earn it back by meeting certain performance standards.

Challenges in Medicaid rate setting for dual eligibles

There are several challenges for states in setting capitation payment rates for dual eligibles under Medicaid, including accounting for enrollee use of LTSS and balancing a state's desire for savings with acceptable plan risk.

Accounting for LTSS. Spending on LTSS accounts for approximately 70 percent of Medicaid benefit spending for full-benefit dual eligibles (see Chapter 3 of this report), so a key element of the Medicaid rate-setting process for this population is how the state calculates the portion of the rate that covers LTSS. Theoretically, putting plans at risk for LTSS should create incentives for plans to provide services in the most cost-effective setting, for example, assisting certain individuals in the community, rather than in a nursing facility setting.

Experience with paying plans on a capitated basis for LTSS varies across the states. In the majority of states, LTSS users and services have typically been carved out of the managed care program and claims have been paid on a FFS basis. In 2012, 16 states operated capitated LTSS programs that covered nearly 400,000 LTSS users (Saucier et al. 2012). Additionally, capitated LTSS may be delivered through PACE plans. There were about 25,000 PACE enrollees across 29 states in 2012 (National PACE Association 2012).

Balancing savings and plan risk. Another challenge in developing capitation rates for Medicaid managed care plans for dual eligibles is balancing the desire a state may have for savings through managed care with the financial risk plans face in delivering services for this diverse population. Some dual eligibles are relatively healthy and require very few services, while others have multiple chronic health conditions and functional limitations that require a nursing facility stay or other institutional care. Consequently, the financial risks to plans are considerable should the needs of its enrolled population not match the cost and savings assumptions built into the capitation rates. Yet if states go too far in constraining the risks that plans face, they might also reduce the incentives for plans to seek out cost-effective ways to deliver services.

The wide variability in LTSS use and spending is the key driver of financial risk to the plans. Even among enrollees who have been certified to need a nursing facility level of care, the LTSS needs of frail persons age 65 and over may be very different from the LTSS needs of individuals with physical or intellectual disabilities. The average Medicaid cost per all-year, full-benefit dual-eligible enrollee who does not use any LTSS was about $2,800 in 2007, compared to approximately $32,000 for those who use home and community-based (HCBS) wavier services and approximately $44,000 for enrollees who use institutional LTSS services (see Chapter 3 of this report).

Current Experience with Managed Care for Dual-Eligible Enrollees

For states that enroll dual eligibles in a Medicaid managed care plan, the level of coordination with the Medicare program and with Medicare Advantage plans can vary. While states may make enrollment into a managed care plan mandatory or voluntary for Medicaid benefits, beneficiary enrollment into a Medicare Advantage plan is voluntary.[3] In some states, individuals may be enrolled in separate managed care plans for their Medicare and Medicaid benefits or they may receive their Medicare benefits through FFS while being enrolled in a managed care plan for Medicaid. Other states have made a push to voluntarily enroll dual eligibles in one plan for both programs, to create an integrated care program.

States' experiences with Medicare Advantage D-SNP and PACE plans shed light on some of the key design issues in setting capitation rates for integrated care plans serving dual eligibles. This section provides an overview of the Medicaid rate-setting processes for these plans. Key rate-setting design issues are highlighted, particularly regarding how states determine the right balance between nursing facility services and HCBS in setting the capitation rates and the use of risk mitigation strategies. In the following section, we touch upon rate setting under the financial alignment demonstrations that are expected to begin soon in a few states.

State arrangements with dual-eligible special needs plans

Many Medicaid managed care plans serving dual eligibles participate in the Medicare Advantage program as D-SNPs—Medicare Advantage plans designed to provide targeted care to individuals dually eligible for Medicare and Medicaid. State Medicaid contracts with D-SNPs vary in the types of Medicaid services covered, with some states carving out one or more services, such as behavioral health or nursing facility services, from the contract.

Fully integrated dual-eligible (FIDE) SNPs. D-SNPs that have risk-based contracts with state Medicaid agencies to provide specified acute care services, LTSS, and coordination of Medicare and Medicaid services are considered to be fully integrated plans (42 CFR 422.2). Five states require Medicaid managed care plans serving dual eligibles to be FIDE SNPs, and require enrollees that wish to voluntarily enroll in the integrated program to choose the same managed care entity for both sets of benefits (Saucier et al. 2012). Only a small number of Medicare Advantage D-SNP plans have contracted with states to become FIDE SNPs. In 2008, an estimated 120,000 dual eligibles were enrolled in D-SNPs that also had Medicaid contracts (Bella and Palmer 2009).

For Medicaid, there are no requirements regarding the categories of dual eligibles that may enroll in a FIDE SNP. States may choose to include only a certain subset of dual eligibles in a FIDE SNP plan, such as those who receive full Medicaid benefits or those who meet nursing facility level of care criteria.

Capitation payments. Medicaid capitation payments to FIDE SNPs must comply with the same statutory requirement for actuarial soundness that applies to other Medicaid managed care programs (MACPAC 2011).[4] States have used a variety of rate-setting design options to create incentives for providing LTSS in the most cost-effective setting while mitigating some of the risk to the plans in providing these services.

Use of rate cells. For FIDE SNP plans, typical Medicaid capitation rate cells might include age (under 65 and over 65 years), geography, and frailty level or institutional status. Creating separate rate cells based on institutional status may help mitigate risk for the plan, but it does not create strong incentives to maintain an individual in the community as the plan will get a payment increase once the enrollee is institutionalized. If states use separate rates for institutional status, they may include other payment structures to create stronger incentives to keep the enrollee in the community.

For example, the Massachusetts Senior Care Options (SCO) program utilizes separate rate cells for institutional versus community enrollees, but includes a transition policy to create incentives to maintain an individual in a community setting. For the first three months after an enrollee switches from the community to an institutional setting, or vice versa, the plan will be paid according to the prior level of care. Thus, for a person transitioning from the community to an institutional setting,

the plan is paid at the community capitation rate for the first three months. Likewise, for a person transitioning from an institutional setting to the community, the plan is paid at the higher institutional capitation rate for three months (Massachusetts DHHS 2010).

Partial risk arrangements for LTSS. Because LTSS can be so expensive, some states limit the amount of risk that plans must take on in this area. These states typically put plans at full risk for HCBS but lessen the amount of risk plans have for nursing facility services. Alternatively, they may create a separate add-on component for nursing facility care. For example, Texas has carved out nursing facility services from its STAR+PLUS program, while the Minnesota Senior Health Options (MSHO) program has put plans at limited risk for nursing facility services.

States sometimes pair limited risk arrangements with other design features to provide an incentive to keep enrollees in the community. For example, Texas withholds 5 percent of the premium from STAR+PLUS plans, which the managed care organizations can earn back if they meet performance standards on several measures, including no statistically significant increase in the nursing facility admission rate (Texas HHSC 2012).

In Minnesota, MSHO plans are at risk only for the first 180 days of nursing facility care. The plans are paid a separate add-on payment intended to cover potential nursing facility placements, which is paid to the plan for all enrollees living in the community. Once a person is admitted to a nursing facility, the add-on payment is stopped and the plan covers up to 180 days of nursing facility care out of the previously paid add-on revenues (Minnesota DHS 2012).

Risk sharing. States may use risk-sharing arrangements such as risk corridors to limit a plan's gains and losses by sharing in the costs or savings beyond a certain threshold. For example, the Massachusetts SCO program established four risk corridors for the first few years of the program.[5] For gains or losses between 0 and 5 percent of the plan's capitation revenue, the plan bore all of the losses or kept all of the gains. Massachusetts was responsible for 50 percent of the losses or kept 50 percent of the gains between 5 and 15 percent of the plan's capitation revenue, and 75 percent of losses or gains between 15 and 25 percent of revenue. The plan bore all of the losses or kept all of the gains greater than 25 percent.

Some states have created specialized risk-sharing arrangements around a specific benefit or assumptions used in the rate-setting process. In Arizona's Long Term Care System program, the LTSS portion of the capitation rate is based in part on an assumed ratio of HCBS and nursing facility months for each plan. If a plan's HCBS nursing facility mix is 1 percent over or under this assumed mix percentage, the plan bears all of the costs or retains all of the savings. If the difference is greater than 1 percent over or under the assumed mix, the state and plan share the costs or savings equally (AHCCCS 2012).

Risk adjustment. Risk adjustment is commonly used for high-cost populations in Medicaid managed care to account for differences in the enrollment mix between plans. However, few states have implemented risk adjustment for the Medicaid benefits covered by FIDE SNPs due to the limitations of existing risk adjustment models for LTSS costs. The commonly used risk adjustment models have been designed to predict the cost of acute care services. These models are based largely on demographic factors (e.g., age and sex), health status, and diagnostic information, and their predictive capabilities do not correlate well with LTSS costs.

This limitation of existing risk adjustment models is problematic for determining appropriate

Medicaid payments to FIDE SNP plans, because the most significant risk for plans is for LTSS. In order to have meaningful risk adjustment for the Medicaid capitation rate, the state must implement a risk adjustment model that takes into account functional status and other enrollee characteristics that are more predictive of LTSS needs, such as measures of level of care, activities of daily living (ADLs), and cognition. However, developing and implementing an LTSS risk adjustment process can be resource intensive. If a state is not collecting the same measures of frailty as other states, it may not be able to leverage an existing model and would need to develop its own model to predict LTSS costs. The level of effort required to develop and implement an LTSS risk adjustment process has been a factor in states not putting LTSS services fully at risk in their capitated arrangements with FIDE SNP programs.

One state that has developed an LTSS risk adjustment model is Wisconsin. In the Wisconsin Family Care Partnership program, the state currently puts plans at full risk for nursing facility services and uses risk adjustment to account for a plan's relative risk based on the characteristics of the enrolled population. The state separately risk adjusts the acute care and LTSS components of the Medicaid capitation rate.

For the acute care component of the Medicaid capitation rates, Wisconsin uses the hierarchical condition category (HCC) model used by Medicare to risk adjust plan payments for Medicare Advantage plans. For the LTSS component of the Medicaid capitation rate, a separate regression model takes into account the enrollee's functional status as well as certain health-related conditions. In addition, the state has developed three separate LTSS regression models for persons with developmental disabilities, persons with physical disabilities, and persons age 65 and over because the average costs and the most predictive measures are different for each of these populations (Wisconsin DHS 2012).

Program of All-Inclusive Care for the Elderly

PACE provides another integrated service delivery model that involves risk-based capitated payments from both Medicare and Medicaid. PACE is a covered Medicare service and is available as a Medicaid service as a state plan option. It provides comprehensive medical care, behavioral health services, and LTSS to individuals age 55 and older who meet the state's nursing facility level of care criteria. PACE programs generally enroll dual eligibles; however, Medicare or Medicaid eligibility is not required.[6] Enrollment into a PACE plan is voluntary. There were about 25,000 PACE enrollees across 29 states in 2012 (National PACE Association 2012).

Upper payment limit and capitation payments. PACE Medicaid capitation rates are subject to different regulations and guidelines than those that govern rate setting for other Medicaid managed care programs. They are not subject to the actuarial soundness requirement but are instead subject to an upper payment limit (UPL).[7] The UPL is defined as the amount that would otherwise have been paid under the state plan if the participants had not been enrolled in the PACE program (42 CFR 460.182). Even though not required to do so, many states have actuaries set the PACE UPL and capitation rates and follow similar principles and methodologies that would be used to set actuarially sound rates.

The process for determining the UPL is similar to the process used for setting the baseline for other Medicaid capitation rates: historical experience for the PACE-eligible population is adjusted for claims completion and policy and programmatic changes, and then trended forward to the payment period to estimate what expected costs would

be for the population if not enrolled in PACE. Most states calculate the UPL first and then set the capitation rate as a fixed percentage of the UPL (e.g., 95 percent of the UPL). This is similar to the adjustment states make to account for the efficiency of managed care compared to a FFS-based baseline. Administrative costs are also included in the PACE capitation rates.

PACE UPL and capitation rates must be based on the costs of comparable populations similar in health and functional status to PACE enrollees. Because most dual eligibles and LTSS services are not covered under managed care programs, the UPL is typically based on the FFS experience of the nursing facility-certifiable population that is using either HCBS waiver or nursing facility services. Unlike many state arrangements with D-SNPs, PACE plans are required to cover all Medicaid state plan approved services, so no services are carved out of the capitation rate and the plans are at full risk for LTSS, including the nursing facility benefit.

Rate cells. Federal statute and regulations require Medicaid PACE capitation rates to be a fixed amount regardless of changes in the enrollee's health status during the contract period. Under this requirement, CMS has prohibited states from developing different capitation rates depending on the site of care. As a result, states cannot use separate institutional and community rate cells as found in some Medicaid payments to D-SNPs, and they have fewer options in the capitation rate structure. PACE capitation rates generally use only a few rate cells, with eligibility (Medicaid only versus dual eligible), geography, and age being the primary rate cell determinants.

Frailty adjustment in PACE. Federal statute and regulations also require that PACE Medicaid capitation rates take into account the comparative frailty of PACE enrollees. Most states use the average cost of enrollees using HCBS and nursing facility services as a proxy for frailty (National PACE Association 2009). States typically create a blended capitation rate based on the existing proportion of Medicaid FFS enrollees who use HCBS waiver and nursing facility services, using the average costs for each group. States may adjust the weighting between the two populations to meet their expectations of the PACE plan's ability to maintain persons in the community or to adjust for the increasing frailty of a plan's enrollees over time. Because the HCBS population is typically less costly than the nursing facility population, this weighting between HCBS waiver enrollees and nursing facility enrollees is typically the key driver in determining the overall level of payment and whether the payment is sufficient to cover the risk of the enrolled population.

Risk adjustment and risk sharing in PACE. PACE plans can face significant risk in the capitation rates because the plans are at full risk for the nursing facility benefit and separate rate cells cannot be used for enrollees in institutions and those living in the community. As mentioned above, the weighting between the nursing facility and the HCBS populations used in the blended capitation rate is the main way states adjust for the frailty of the population. As PACE is voluntary, a state may over- or underpay plans if the population that actually enrolls in the PACE program does not reflect the assumptions used to set the rates. States do not have the flexibility to use partial risk arrangements, nursing facility add-ons, or other rate-setting design options to help mitigate this risk.

Few states use risk adjustment in PACE due to the same difficulties they face in risk adjusting rates for D-SNPs. Wisconsin and New York risk adjust for LTSS services in PACE by combining the PACE and D-SNP rate-setting efforts and using the LTSS risk adjustment process for both programs.

Medicaid Payment in the Financial Alignment Demonstrations

The CMS financial alignment demonstrations are testing the concept of coordinating the rate-setting processes between Medicaid and Medicare. Currently, while FIDE SNPs and PACE plans receive payments from both Medicare and Medicaid, the financing is still not fully coordinated: the capitation rates for each program are developed independently without full consideration of how a fully integrated, coordinated care program may impact the overall cost of care under the plan. For example, an increase in LTSS services could lead to a decrease in spending on acute care services and overall cost savings; however, states have been reluctant to make this investment as the costs of LTSS are incurred by Medicaid while the initial savings for acute care accrue primarily to Medicare. The financial alignment demonstrations under CMS seek to coordinate the Medicare and Medicaid rate-setting processes to take into account these cross-program interactions and share overall cost savings across both programs.

Joint rate-setting process

CMS has released general guidelines as to how the capitation rates will be set for the financial alignment demonstrations. CMS will make two separate payments, one reflecting coverage of Medicare Part A and B (Medicare A/B) services and one reflecting coverage of Part D services, to the participating health plans for Medicare benefits.[8] The Medicare rate-setting methodology will be consistent across all participating states and will be based on the existing Medicare Advantage and Medicare Part D rate development processes.

The state will make a separate payment to each participating health plan for the Medicaid component of the rate. States and their actuaries, with review from CMS, will develop the Medicaid payment rates (CMS 2013).

Establishing the baseline. CMS will develop Medicare baseline spending estimates, while the states and their actuaries, with review by CMS, will develop the Medicaid baseline spending estimates (CMS 2013). The estimates project what both programs would have spent in the payment year if the demonstration did not exist; this baseline is similar in concept to the UPL used in PACE programs.

The Medicare A/B baseline will be established on a year-by-year basis for each demonstration county. The baseline will be calculated as a weighted average of FFS and Medicare Advantage spending based on the expected proportion of enrollment of beneficiaries who would have previously been in FFS and Medicare Advantage. FFS baseline spending will be based on the published Medicare standardized FFS county rates developed annually as part of the Medicare Advantage rate development process, and the Medicare Advantage spending will reflect the estimated amounts that would have been paid to Medicare Advantage plans in which beneficiaries could enroll. The Part D component will equal the Part D national average monthly bid amount for the payment year (CMS 2013).

The Medicaid baseline will vary by state, based on each state's program design and the historical experience of the target population. The historic spending will use data for the most recent years of prior experience available and will include consideration of Medicaid managed care plan payment (if a state currently serves dual eligibles through capitated managed care) as well as FFS costs (CMS 2013).

Savings targets. An aggregate savings target will be developed and applied to both the Medicaid and

Medicare A/B baseline estimates to determine the capitation payment rates. No savings target will be applied to the Part D component. Medicaid and Medicare will thus share in the savings achieved through the demonstrations.

Based on financial modeling and other analytic work and input from states and others, CMS and the state will establish an aggregate savings target for each year of the demonstration (e.g., 1 percent in year one, 2 percent in year two, and 4 percent in year three). This savings percentage will then be applied prospectively to the Medicare A/B and Medicaid components of the rate. Savings targets may differ among states based on factors such as historic Medicare spending, utilization of institutional LTSS, and penetration of Medicaid managed care. By applying the savings target to the Medicare A/B and Medicaid components, CMS intends to allow both payers to share proportionally in the savings achieved, regardless of whether savings accrue from changes in utilization of acute care services (for which Medicare is the primary payer) or changes in utilization of LTSS services such as nursing facility placements (for which Medicaid is primary) (CMS 2013).

Quality withholds. CMS and the state will withhold a portion of the capitation payments that the participating plans may earn back if they meet certain quality standards. Quality withholds of 1 percent, 2 percent, and 3 percent will be applied to the Medicaid and Medicare A/B components of payment for years one, two, and three respectively; no withhold is applied to the Medicare Part D component (CMS 2013).

Rate cells and risk adjustment. The Medicare A/B and Part D components of the capitation payment will be risk adjusted for the enrollee's health status using the risk adjustment models currently used in Medicare Advantage and Part D (CMS 2013).[9] For Medicaid, states and their actuaries may propose rate cells and risk adjustment for CMS approval, as long as the rate structure creates an incentive for HCBS over institutional placement (CMS 2013). Similar to Medicaid rate setting for FIDE SNPs, Medicaid payment rates under the demonstration may vary at the individual level based on enrollee characteristics such as age, health status, and functional status.

State examples

Massachusetts and Ohio are the first states to have completed memoranda of understanding (MOUs) with CMS for the financial alignment demonstrations that describe the capitation rate structure for the Medicaid component of the rates. Both states have similarities in how the Medicaid capitation rate will be calculated, but each has a unique approach to developing rate cells, implementing risk adjustment, and mitigating financial risk through risk-sharing arrangements (Table 5-1).

Baselines. In Massachusetts and Ohio, the Medicaid baseline spending amounts for each demonstration year will be set up front and will be applied to future years of the demonstration. The baseline estimates will only be revisited to use more recent data or to include an update that results in a substantial change to the baseline (CMS 2012a, CMS 2012b).

Savings targets. The shared savings percentages for Massachusetts and Ohio are set at 1 percent, 2 percent, and 4 percent for years one, two, and three, respectively, and will only be applied to the Medicaid and Medicare A/B components of payment (CMS 2012a, CMS 2012b).

Quality withholds. Both states will apply quality withholds of 1 percent, 2 percent, and 3 percent to the Medicaid and Medicare A/B components of

payment for years one, two, and three, respectively (CMS 2012a, CMS 2012b).

Rate cells and risk adjustment. Massachusetts and Ohio have developed different rate structures for rate cells and risk mitigation strategies (CMS 2012a, CMS 2012b). To mitigate risk for the Medicaid component of the rate, Massachusetts will use four rate cells—one facility-based care rate cell for individuals having a long-term facility stay of more than 90 days, and three community rate cells based on LTSS service needs, selected behavioral health conditions, and all other community individuals. Massachusetts will use a high-cost risk pool (HCRP) for select LTSS above a defined threshold within the facility-based and high community needs rate cells to mitigate plan risk and variability across plans for higher than anticipated LTSS costs. The HCRP will be used until an additional LTSS risk adjustment methodology is developed.

In Ohio, the state will segment the population into nursing facility level of care (NFLOC) and "community well" rate cells. Ohio will risk adjust the NFLOC rate cell by using a member enrollment mix adjustment to account for the relative risk and cost differences of major and objectively identifiable subpopulations. This mix adjustment utilizes the particular waiver enrollment and nursing facility placement to provide higher rates to those plans that have a greater proportion of high-risk individuals and lower rates to plans with a lower proportion of high-risk individuals. Additionally, once an enrollee is determined to no longer need NFLOC services, the plan continues to receive the higher NFLOC capitation rate for three months before receiving the lower community well capitation rate in the fourth month.

Risk sharing. Massachusetts will use a risk corridor for the first demonstration year. CMS and Massachusetts only share risk with plans between 5 and 10 percent savings or loss, with a maximum Medicare payment or recoupment equaling 1 percent of the risk-adjusted Medicare baseline and the remaining payments or recoupments treated as Medicaid expenditures eligible for the federal medical assistance percentage. The plans will bear full risk between 0 and 5 percent savings or loss, and for greater than 10 percent savings or loss (CMS 2012a).

In Ohio, CMS and the state will use a minimum medical loss ratio (MMLR) to regulate the minimum amount (as a percentage of the gross joint Medicare and Medicaid payments) that must be used for medical services or expenses related to quality and the care of enrollees. If a plan has a MMLR below 85 percent, the plan must pay back the difference between the 85 percent threshold and the plan's actual MMLR multiplied by the total applicable revenue. The remittance would be distributed back to Medicaid and Medicare based on the proportion each program contributes to the plan's revenue. If the plan's MMLR is between 85 and 90 percent, CMS and the state could require a corrective action plan or levy a fine (CMS 2012b).

Issues for Consideration

States and CMS have shown interest in using integrated care models such as risk-based managed care to provide Medicare and Medicaid services. Through the financial alignment demonstrations, the number of dual eligibles in fully integrated care models could expand greatly: up to 2 million dual eligibles will be eligible to enroll in the demonstration plans. How CMS and the states develop the capitation rates for these plans will be a major factor in determining whether these demonstrations can be successful. Policymakers need to consider several issues when developing the capitation rates, including accounting for voluntary enrollment, the need for LTSS risk

TABLE 5-1. Comparison of Massachusetts and Ohio Medicaid Capitation Rate Elements in Memoranda of Understanding (MOUs) for the Financial Alignment Demonstrations

Rate Element	Massachusetts MOU	Ohio MOU
Baseline costs	Historical state data; trend factors developed by state actuaries with oversight from CMS.	Medicaid capitation rates through the 1915(b) waiver program that would apply for enrollees in the target population but not enrolled in the demo.
Savings percentages	Demo Year 1: 1 percent Demo Year 2: 2 percent Demo Year 3: 4 percent	Demo Year 1: 1 percent Demo Year 2: 2 percent Demo Year 3: 4 percent
Quality withhold	Demo Year 1: 1 percent Demo Year 2: 2 percent Demo Year 3: 3 percent	Demo Year 1: 1 percent Demo Year 2: 2 percent Demo Year 3: 3 percent
Rate cells	Facility-based care: have a long-term facility stay of more than 90 days High community needs: have a skilled need to be met seven days a week; or two or more activities of daily living (ADL) limitations and skilled nursing need three or more days a week; or four or more ADL limitations Community behavioral health: have ongoing, chronic behavioral health condition such as schizophrenia Community other: all other enrollees	Nursing facility level of care (NFLOC): meets a NFLOC as determined through waiver enrollment or 100 or more consecutive days in a nursing facility; single rate cell for each of the seven contracting regions Community well: does not meet a NFLOC standard; three age group (18 to 44, 45 to 64, 65+) rate cells for each of the seven contracting regions Transitional policy: plan receives higher NFLOC rate for three months when enrollee transitions from NFLOC to community well category
Risk adjustment	Rate cells plus a high-cost risk pool (HCRP) for select long-term services and supports spending above a defined threshold. The HCRP will apply to the facility-based care and high community needs rate cells. HCRP will be used until an enhanced risk adjustment methodology is developed.	A member enrollment mix adjustment will be used for the NFLOC rate cell. The relative risk differences of identifiable subpopulations are measured based on particular waiver enrollment and nursing facility placement. Plans with a greater proportion of high-risk individuals get more revenue than plans with lower-risk individuals; adjustments will be budget neutral.

TABLE 5-1, Continued

Rate Element	Massachusetts MOU	Ohio MOU
Risk sharing	Risk corridor established for Demo Year 1. Medicare and Medicaid responsibility is in proportion to contribution to the capitated rate, not including Part D. Maximum Medicare payment or recoupment limited to 1 percent of the risk-adjusted Medicare baseline. Between 0 and 5 percent savings/loss: plans at risk for 100 percent Between 5 and 10 percent savings/loss: plans at risk for 50 percent, CMS and state share other 50 percent (after applying 0 to 5 percent category) Greater than 10 percent savings/loss: plans at risk for 100 percent (after applying other categories)	Each plan must meet Minimum Medical Loss Ratio (MMLR) threshold (as a percentage of the gross combined Medicare and Medicaid payments) beginning in calendar year 2014. If a plan's MMLR is between 85 and 90 percent, state and CMS may require a corrective action plan or levy a fine. Medicaid and Medicare split amount based on each program's percent of revenue to plans. If a plan's MMLR is below 85 percent, the plan must remit the difference between the plan's actual MMLR and the 85 percent threshold multiplied by the total applicable revenue. Medicaid and Medicare split amount based on each program's percent of revenue to plans.

Sources: CMS 2012a, CMS 2012b

adjustment models and appropriate measures of functional status, and the treatment of supplemental payments.

Accounting for voluntary enrollment

A complicating factor in rate setting for dual-eligible managed care programs is the fact that many of these programs have voluntary enrollment, which may lead to an enrolled population that differs in composition from the population experience used in setting the capitation rates. While states are allowed to make enrollment into Medicaid managed care mandatory for dual eligibles, the Medicare program does not allow mandatory enrollment into managed care for Medicare benefits.

Under mandatory managed care enrollment, which is common for other populations in Medicaid, the enrollee characteristics and spending in the baseline experience are likely to be similar to the population that ultimately enrolls, as almost all individuals enroll in the program. Additionally, mandatory-enrollment groups are often large, so that average costs in the past are an actuarially credible predictor of future costs.

In a voluntary program, the average health and functional status of the population that ultimately enrolls in the program may be significantly different from the population used as the baseline

experience in the rate-setting process. As a result, there is a chance that the state may over- or underpay, and the plan also faces significant risk of losses. The state must try to adjust the base period experience to account for any differences between the base and the enrolled population. In addition, some programs may only enroll a small number of dual eligibles, making individual enrollees with particularly high costs (i.e., outliers) a significant concern. Effective rate-setting design, such as appropriate rate cells and a good LTSS risk adjustment model, are needed to maintain the positive incentives of risk-based managed care while accurately reflecting the differences in the population enrolled in the program.

Plans participating in the financial alignment demonstrations will all have passive voluntary enrollment, that is, dual eligibles will be automatically enrolled in a managed care plan, but will have the opportunity to voluntarily disenroll from the plan. While other concerns about passive enrollment still remain, from a rate setting perspective, it may increase enrollment and reduce some of the rate-setting issues with voluntary enrollment and small population size. However, some mechanism that adjusts for population differences will still be needed. Additionally, given the uncertainty of the program's costs in the early years, risk mitigation strategies will also be important.

Need for LTSS risk adjustment models

Policymakers seeking to set capitation payments for LTSS struggle to balance the need to create financial incentives for providing services in the most cost-effective setting with the need to ensure plans are paid adequately for a population with significant functional limitations and LTSS needs. Risk adjustment models that are more predictive of Medicaid LTSS costs will likely be needed to help states meet these goals.

Risk adjustment allows the state to maintain strong incentives for cost efficiency by putting all of the managed care benefits at full risk while appropriately compensating plans that enroll a population with higher acuity. For Medicaid managed care programs that cover acute care services, several states have used diagnosis-based risk adjustment to control for the risk of high-cost populations, even after adjusting for such characteristics as enrollees' basis of Medicaid eligibility (e.g., disability). However, these commonly available risk adjustment models are based on health diagnostic data that are poor predictors of LTSS use (Davidson and Dreyfus 2012).

To address LTSS costs, most states use a variety of rate-setting design options such as defining relevant rate cells, making add-on payments, or allowing partial risk arrangements for the nursing facility benefit. Questions remain as to how well these different methodologies maintain incentives for plans to utilize the most cost-effective setting of care (Kronick and Llanos 2010).

As stated previously, only a few states currently have implemented an LTSS risk adjustment model. The creation of a public or commercial risk adjustment model for LTSS could make it easier for states to adopt capitated managed care approaches for LTSS users, including dual eligibles. There would be several challenges to developing such a model, however. Given the differences in the exact services states may include in their LTSS benefits package, a single model may not be predictive of LTSS costs across states.

Additionally, experience in risk adjustment for LTSS based on frailty and functional status has been limited, and the predictive power of such models has not been widely researched. The

existing models may have limited predictive power in a given state, as that state may not be collecting information on the most predictive measures. Without widespread development and testing of different LTSS risk adjustment models, it will be difficult for a state to identify what additional measures it may want to collect to improve its model.

The financial alignment demonstrations provide an opportunity to review different risk adjustment models that states develop and identify what measures appear to be good predictors of LTSS costs across several states. These key predictors could serve as a foundation upon which other states could develop and enhance their own LTSS risk adjustment methodologies.

Need for measures of functional status

In order to develop and implement an LTSS risk adjustment process, relevant measures of frailty and functional status must be collected on a periodic basis. These measures are not typically found in Medicaid claims data, so they will likely require a separate assessment. In many states, the managed care plan is required to conduct a functional assessment to determine an enrollee's need for services and develop a care management plan when they first enroll. While these data could be used for risk adjustment, plans might have an incentive to "upcode" the frailty of their enrollees to receive higher capitation payments. States may need to validate the assessment data before using it for payment purposes.

Treatment of supplemental payments

As mentioned in MACPAC's June 2011 and March 2012 Reports to the Congress, states may make supplemental payments to institutional providers such as hospitals and nursing facilities, above what they pay for individual services. States make these supplemental payments under the federal UPL regulation.[10] These UPL supplemental payments may be a large source of revenue for institutional providers and have had important implications in states' decisions regarding managed care. Since the UPL supplemental payments are based on FFS days in an institutional setting, transitioning populations from FFS to managed care would lead to lower supplemental payments.

Additionally, these UPL supplemental payments cannot be included in the capitation rate or passed through the managed care plan to contracted providers because CMS considers these options to be inconsistent with the actuarial soundness principle. According to federal regulations, the services covered by Medicaid managed care plans must be considered paid in full through the rate paid to the plan (42 CFR 438.60). Some states have delayed implementation or expansion of Medicaid managed care because of the potential loss in federal matching dollars for supplemental payments. It is unclear whether these supplemental payments will be allowed to be included in the development of the Medicaid baseline for the financial alignment demonstration plans and may be an issue in some states.

Endnotes

1 Twenty states submitted proposals for the financial alignment capitated model; however, five states have recently indicated they will no longer pursue the capitated demonstration.

2 More information regarding the Medicare Advantage and Part D payment process can be found in the Medicare Payment Advisory Commission's *Payment basics* publications (MedPAC 2012a and 2012b).

3 The financial alignment demonstration will allow states to passively enroll dual eligibles into managed care plans, but beneficiaries will have the option to disenroll.

4 42 CFR 438.6(c) specifies that actuarially sound rates must be developed in accordance with generally accepted actuarial principles and practices and be certified by a qualified actuary. Capitation payment rates reflect only those services covered under the Medicaid state plan (or directly related costs such as administrative expenses) that are specified in the contract.

5 Massachusetts phased out the risk corridors in the SCO program in 2008.

6 42 CFR 460.150(d) specifies that eligibility to enroll in a PACE program is not restricted to an individual who is either a Medicare beneficiary or Medicaid enrollee. In practice, about 90 percent of all PACE enrollees are dual eligibles (Mathematica Policy Research analysis for MACPAC, 2012).

7 Actuarial soundness means that the capitation rates are developed in accordance with generally accepted actuarial principles and practices and certified by a qualified actuary.

8 Medicare Part A generally covers inpatient hospital services, skilled nursing facility services, and hospice care. Medicare Part B covers outpatient hospital, physician and other medical services such as laboratory, x-ray, and durable medical equipment. Medicare Part D covers outpatient prescription drugs.

9 CMS-HCC is the hierarchical condition category model currently used to risk adjust Medicare Advantage payments. RxHCC is the model of prescription drug hierarchical condition categories currently used to risk adjust Medicare Part D payments.

10 The UPL regulations governing payment to institutions limit total Medicaid payment to no more than what Medicare would have paid for the same or comparable services delivered by those same institutions. This UPL is different from the UPL established for PACE programs.

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