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# Payment Reform Under The Medicare-Medicaid Financial Alignment Demonstrations

By Shelly Brandel and Michael Cook

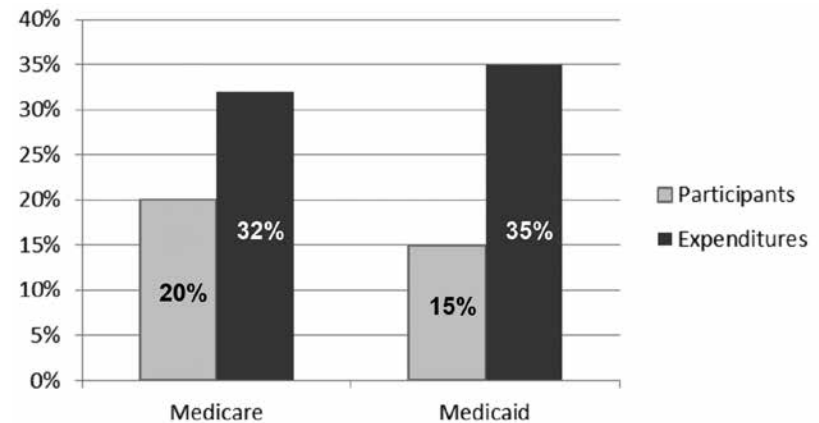
Nationwide, there are about 9 million people eligible for both Medicare and Medicaid benefits, whom we will refer to as “dual eligibles” in this article. These dual eligibles represent \$229 billion in medical spending in 2007.<sup>1</sup> Although dual eligibles represent a relatively small percentage of the combined Medicare and Medicaid population, they represent a significantly larger percentage of expenditures because they have more intense health care needs as a group than other Medicare or Medicaid populations. Figure 1 shows the proportion of individuals and expenditures represented by dual eligibles for Medicare and Medicaid.

Figure 1 shows that, nationally, in 2007 dual eligibles comprised 20 percent of the Medicare population and 32 percent of Medicare expenditures. They comprised 15 percent of the Medicaid population and 35 percent of Medicaid expenditures.<sup>2</sup>

Because Medicare and Medicaid largely operate as separate programs, it is difficult to coordinate care for dual eligibles using existing delivery systems that typically focus on only one set of covered services or are otherwise limited in scope. In addition, there is often a lack of financial incentive to actively manage care when only the Medicaid funding stream is capitated. However, some limited examples of such programs do exist:

- Some states include dual eligibles in their Medicaid managed care programs. These programs typically coordinate Medicaid services for dual eligibles but not their Medicare services. However, several states have designed programs that coordinate delivery of both sets of services.
- Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) have the potential to provide a coordinated provider network and schedule of covered benefits across Medicare and Medicaid for dual eligibles. The degree of Medicare-Medicaid integration varies significantly across states, and health plans may

**Figure 1:**  
Dual Eligibles as Share of Program Participants Vs. Share of Expenditures, 2007



or may not also be at risk for Medicaid-covered services under separate Medicaid contracts with the state. In all these cases, the Medicaid and Medicare revenue streams remain separate.

- The Program of All-Inclusive Care for the Elderly (PACE) provides fully coordinated, site-based care and funding for individuals over the age of 55 who are eligible for nursing home care. However, these programs are typically limited in the number of beneficiaries they can serve and are restricted to the subset of the dual-eligible population eligible for nursing home care.

The Affordable Care Act (ACA) created the Medicare-Medicaid Coordination Office (MMCO) with the goal of improving access to high-quality, fully integrated and cost-effective care for dual eligibles. In coordination with the Centers for Medicare and Medicaid Services (CMS) Center for Medicare and Medicaid Innovation, the MMCO is working with states to establish the Financial Alignment Demonstration, which will test delivery models that integrate care for dual eligibles. The authors of this article and their colleagues are assisting MMCO staff with various financial and policy-related analyses and review related to the demonstration.

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## Financial Alignment Demonstrations

CMS originally provided design contracts to 15 states to design programs to provide fully coordinated care for dual eligibles. CMS then invited all states to submit proposals to test structures that align Medicare and Medicaid benefits under two different models. Both models are designed to achieve improved quality and financial savings associated with delivery system and payment reform:

- **Capitated Model:** This model includes a three-way contract between the state, CMS and participating health plans. The health plan receives prospective capitation payments that reflect anticipated program savings achieved through coverage of Medicare and Medicaid services, allowing the state and CMS to share in anticipated program savings up front. The health plan is responsible for providing fully integrated care for Medicare and Medicaid benefits for its members.
- **Managed Fee-For-Service (FFS) Model:** Under this model, the state is responsible for establishing programs to coordinate care for dual eligibles. In return, the state will be eligible to share in overall federal savings measured on a retrospective basis, as long as certain quality thresholds are met.

CMS received proposals from a total of 26 states (including the original 15 states) to participate in the capitated model, managed FFS model, or both. However, CMS does not expect that all proposals will be implemented. The proposed demonstrations are targeted to be effective in early to mid-2013 and 2014 with durations of about three years. Each state's program differs with respect to many factors, including:

- **Target population** (may include all full-benefit dual eligibles or a subset based on age, placement in nursing facilities, or other factors).

- **Geographic area** (can be statewide or limited to specific counties or regions).
- **Capitated model enrollment process** (generally passive enrollment is proposed for use, but the process used to phase in members, assign members to specific plans, etc. may vary).
- **Benefits covered** (generally covers virtually all Medicare and Medicaid covered services; but under the capitated model, states may carve out specific Medicaid services to be provided outside of the demonstration).

CMS is currently reviewing these proposals and working closely with each state whose proposal meets the demonstration standards and conditions to develop memoranda of understanding (MOUs) that outline key aspects of each state's program. As of the end of 2012, three states have established MOUs with CMS for their demonstrations (Massachusetts and Ohio under the capitated model and Washington under the managed FFS model). The remainder of this article focuses on the rate development and potential financial savings associated with the capitated model.

## Overview Of The Capitated Model

Medicaid-Medicare plans participating in the capitated model will need to pass an application process and readiness review addressing the enrollment process, access to care, and many other issues prior to participation in the demonstration. Once the plans are selected and beneficiaries are enrolled, health plans will receive separate capitation payments for Medicare Part A/B, Medicaid and Medicare Part D services. The capitation payments for Medicare Part A/B and Medicaid will be adjusted to reflect anticipated savings associated with care integration. A quality withhold will also be applied to the Medicare Parts A/B and Medicaid components. The Medicare Part D payment will not reflect any quality withholds or anticipated savings.

## CAPITATION DEVELOPMENT

In concept, the capitation rates under the demonstration program (excluding Medicare Part D payments) are calculated using the following process:

1. Project baseline costs in absence of the demonstration.
2. Apply savings percentages.
3. Apply withhold percentages.
4. Apply any prospective risk adjustment mechanisms (for example, HCC Medicare risk adjustment model).
5. Apply any retrospective risk mitigation mechanisms (for example, risk corridors limiting health plan gains and losses or individual high-cost risk pool distributions).

Medicaid-Medicare health plans participating in the capitated model will receive three separate payments: Medicare Part A/B, Medicaid and Medicare Part D. Baseline cost development for each of these is described in more detail below.

### *Medicare Part A/B*

CMS will calculate the Medicare Part A/B capitation rate in each county based on the projected proportion of members enrolled from Medicare FFS versus Medicare Advantage. The component of the rate calculation associated with beneficiaries currently in the Medicare FFS delivery system will be based on the published county-level FFS payment rates, except that the demonstration rates will be increased to reflect any legislation removing the sustainable growth rate (SGR) physician rate reductions.

In addition, CMS may consider not applying the standard Medicare Advantage risk score coding intensity adjustment (3.41 percent downward adjustment to risk scores and revenue in 2013) in the early stages of the demonstration. In states where the majority of members are coming from Medicare FFS, plans may have limited initial ability to impact members' risk scores. In both Massachusetts and Ohio, CMS will not apply the coding intensity adjustment in calendar year 2013. The prevailing coding intensity adjustor will apply after startup.

The component of the rate calculation associated with members currently enrolled in Medicare Advantage will be based on estimated payments to Medicare Advantage plans in which members would have enrolled absent of the demonstration, including plan-specific assumptions regarding bid amounts, quality bonus payment-adjusted benchmarks, and rebate amounts for each county.

The Part A/B baseline projection will be a blend of the projections for individuals moving from Medicare FFS and those moving from Medicare Advantage. No additional adjustments for non-claim expense considerations will be made beyond what is already reflected in the baseline development for the Medicare FFS and Medicare Advantage populations.

### *Medicaid*

Each state, along with their contracted actuaries, will develop a projection of baseline Medicaid costs in absence of the demonstration. For states that currently include (or planned to include in the absence of the demonstration) dual eligibles in their Medicaid managed care programs, the baseline projection represents managed care capitation rates in absence of the demonstration (which may be based on health plan encounter data, Medicaid FFS data or other data sources). For other states, the baseline projection represents historical FFS experience projected to the appropriate time period of the demonstration.

The rate cell structure will vary by state but is generally expected to provide a financial incentive for plans to provide home and community-based services in lieu of institutional placement. For example, all beneficiaries certifiable for nursing home placement may be combined into one rate cell, regardless of whether they are utilizing a nursing facility or community-based waiver services. The rate would reflect the expected costs based on a historical relationship of the location of care provided. This allows plans to realize savings for delaying admission into nursing facilities through greater use of less costly community-based services.



Shelly Brandel, FSA, MAAA, is principal and consulting actuary at Milliman, Inc. in Brookfield, Wis. She can be reached at [shelly.brandel@milliman.com](mailto:shelly.brandel@milliman.com).



Michael Cook, FSA, MAAA, is a consulting actuary at Milliman, Inc. in Brookfield, Wis. He can be reached at [michael.cook@milliman.com](mailto:michael.cook@milliman.com).

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es. Alternatively, the state may use transitional rates and delay payment level changes for several months when members move from a community rate cell to a nursing facility rate cell or vice versa.

The Medicaid capitation rates may be further risk adjusted beyond rate cell definitions to account for variation in the mix of types of individuals participating in the demonstration (for example, institutionalized members and members receiving community-based waiver services).

The Medicaid baseline rate development must be approved by CMS with review from their contracted actuaries (Milliman and Actuarial Research Corporation). Similar to the Medicare Part A/B rate, the Medicaid baseline projection will be multiplied by the established savings percentage, withhold percentage, and other adjustments as applicable to determine the final Medicaid capitation rate under the demonstrations.

#### ***Medicare Part D***

The capitation rate for Medicare Part D covered benefits will be set at the national average monthly bid amount each year (\$79.64 for 2013). The Part D claims for demonstration plans will be subject to the same subsidies and end-of-year settlements as other Part D plans.

One item to note is that CMS is encouraging demonstration plans to buy down cost sharing below the standard low-income levels for its members without forfeiting the low-income cost-sharing subsidies. This option represents a competitive advantage over Part D plans not participating in the demonstration, as they must forgo the cost-sharing subsidy to the extent their benefit design is richer than the defined standard structure.

#### **SOURCES OF COST SAVINGS**

The sources of potential savings resulting from the capitated model vary depending on the type of service being provided:

##### ***Acute Care***

Acute care is primarily covered by Medicare, with Medicaid paying deductibles and cost-sharing amounts for dual eligibles. Therefore, under the current delivery system, there is limited financial incentive for Medicaid programs to better coordinate acute care because most of the resulting savings would accrue to Medicare. The demonstration program is anticipated to result in acute care savings resulting from efforts, among others, to:

- Coordinate treatment of multiple chronic conditions.
- Provide care in the most appropriate setting, emphasizing community-based care.
- Reduce or eliminate unnecessary tests or procedures.
- Better manage ambulatory sensitive admissions to reduce avoidable emergency room visits and inpatient admissions or readmissions.

##### ***Behavioral Health***

Financial responsibility for behavioral health services is currently shared between Medicare and Medicaid. Anticipated savings on behavioral health services are expected based on improved coordination between services covered by Medicare versus those covered only by Medicaid and emphasizing community-based care.



### ***Long-Term Care***

Long-term care services are primarily covered by Medicaid. For states where dual eligibles are not covered by Medicaid managed care programs, anticipated savings result from delaying members' entry into nursing home facilities through the increased use of home- and community-based waiver services, as well as discouraging unnecessary inpatient hospital admissions from the nursing facility. For example, financial responsibility currently shifts from Medicaid to Medicare and increases nursing facility payments to Medicare levels for the first 100 days after readmission to the nursing home. With health plans having fiscal responsibility for both Medicaid and Medicare services under the demonstration, they will have an incentive to modify contracting and coordination efforts with facilities to reduce inpatient hospital admissions from the facilities.

### ***Administrative Costs***

Administrative costs for managed care organizations in states with current Medicaid managed care programs may decrease on a per-member-per-month basis for a variety of reasons. One possible reason is increased enrollment over which to spread fixed administrative costs. Another is potentially reduced marketing costs, depending on the enrollment methodology for the demonstration and the competitive environment.

States may also request changes to administrative processes that reduce administrative costs or improve beneficiary experience (for example, integrating Medicare and Medicaid appeals processes), which can be incorporated into the demonstration with CMS approval.

### **SAVINGS DEVELOPMENT PROCESS**

The savings percentages applied to the Medicare Part A/B and Medicaid baseline projections will be established by CMS and each state. The general process is outlined below:

1. CMS will provide preliminary savings calculations developed by its actuarial contractors to each state. The savings calculations are based on a consistent set of assumptions derived from

an extensive literature review of the financial impact of care management activities on similar populations for each source of savings discussed above. These savings assumptions are applied to actual historical Medicare and Medicaid utilization and cost data for each group of individuals eligible for the demonstration in a particular state to calculate the preliminary savings.

The savings percentages have the potential to vary by state, depending on program characteristics, including:

- Populations included under the demonstration (for example, seniors not eligible for nursing home care, nursing home eligibles only, dual-eligible enrollees under the age of 65, etc.)
- Services covered under the demonstration and other program structure differences.
- Penetration of managed care prior to the implementation of the demonstration program.
- Historical acute care and long-term care utilization patterns of the targeted population.

2. CMS and each state will then establish the applicable savings percentages for each year of the demonstration, with the percentages expected to increase each year. In the capitated model MOUs completed for Ohio and Massachusetts, the savings percentages are 1 percent for the first demonstration year, 2 percent for the second year, and 4 percent for the last year.

3. The same savings percentages will be applied to both the Medicare Part A/B and Medicaid components of the capitation rates. Although the actual savings are likely to accrue disproportionately between Medicare and Medicaid services, the capitation rates in the demonstration are designed to allow both programs

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(Medicare and Medicaid) to share in the savings resulting from improved coordination. For purposes of the demonstration, CMS considers the existing Medicaid capitation actuarial soundness requirements to be flexible enough to consider differing efficiencies and savings that may be associated with Medicare versus Medicaid services. Therefore, CMS does not believe a waiver of Medicaid actuarial soundness principles is necessary.

#### QUALITY WITHHOLDS

The Medicare Part A/B and Medicaid capitation rates will be reduced by any quality withholds specified in the MOU. These withholds can be earned back by meeting certain quality standards. The withhold percentages and core quality measures will be consistent across all states, although some states may include state-specific quality measures in addition to the core quality measures.

### Monitoring And Evaluating The Financial Alignment Demonstrations

CMS has contracted with RTI International to monitor ongoing experience and evaluate the impact

of each state demonstration. This evaluation will include a review of health outcomes and beneficiary experience, service utilization, and financial impact measurement. Delivery systems and payment mechanisms determined to be effective may be considered for replication in other states.

*For additional details on the Financial Alignment Demonstrations, please visit <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html>.* ■

#### END NOTES

- <sup>1</sup> Centers for Medicare and Medicaid Services, *Medicare-Medicaid Enrollee State Profile, The National Summary*, 1.
- <sup>2</sup> *Medicare-Medicaid Enrollee State Profile*, *ibid*.

