CHCS Center for Health Care Strategies, Inc.

Technical Assistance Tool

Integrated Care Program Design: A Checklist for States

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Introduction

Today, more than seven million Americans are defined as "dual eligibles" – low-income people who are elderly or have disabilities and are covered by both Medicare and Medicaid. Most have extensive medical, social, and long-term care needs. Their health care costs are nearly double those of other adults covered by Medicare and eight times higher than Medicaid spending for children. The largely disorganized intersection of Medicare and Medicaid—each governed by its own delivery, financing, and administrative policies—results in misaligned benefit structures, opportunities for cost-shifting, and unresolved tensions between the federal and state governments. Integrating care across service settings and funding streams has great potential for improving the quality, coordination, and cost-effectiveness of care for this population. The creation of Special Needs Plans (SNPs) in the 2003 Medicare Modernization Act (MMA) also offers significant new opportunities to integrate Medicaid and Medicare coverage for beneficiaries who are dually eligible.

Through the *Integrated Care Program*, the Center for Health Care Strategies (CHCS) used resources from the Robert Wood Johnson Foundation (RWJF) to provide grants to five states – **Florida, Minnesota, New Mexico, New York,** and **Washington** – to develop and/or expand models of care that integrate the financing, delivery, and administration of primary, acute, behavioral health, and long-term care services and supports for beneficiaries with chronic conditions who are dually eligible or covered solely by Medicaid. The Integrated Care Program (ICP) is also helping states develop the infrastructure for integrating health care services and contracting with SNPs.

In support of this initiative, CHCS is using RWJF funds as well as supplemental grants from Evercare and Schaller Anderson, Incorporated to create a comprehensive technical assistance strategy. The states identified three priority areas for technical assistance: (1) *administrative simplification*; (2) *rate setting and risk adjustment*; and (3) *performance measurement*. Three workgroups are designing and disseminating standardized, yet flexible, approaches within priority areas that states and their federal and delivery system partners could use as starting points for tailoring to their specific needs/uses. This checklist to help guide states in developing integrated care approaches was developed by the ICP Rate Setting and Risk Adjustment Workgroup.

States designing integrated care approaches need to consider several interrelated questions regarding program design, data infrastructure/capabilities, and coordination with Medicare in determining Medicaid rate setting and risk adjustment. The *Integrated Care Program Design: Checklist for States* guides states on rate setting and related program design considerations to build the foundation for more detailed discussions with the state's actuaries. The checklist outlines considerations for basic program design, data, and coordination with Medicare. The focus is primarily on capitated rate setting and risk adjustment for Medicaid-covered services, but always in the context of moving toward the goal of combining Medicaid and Medicare services in a single integrated benefit package.

ICP Rate Setting and Risk Adjustment Workgroup

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PROGRAM DESIGN ISSUES		
Questions	***Why Important***	***Implications***
1) What populations should be covered? ▪ By aid category (aged, blind, disabled) ▪ Duals, non-duals, or both? ▪ Subpopulations such as developmentally disabled (DD), ventilator dependent, chronically mentally ill (CMI), traumatic brain injury (TBI), HIV/AIDS? ▪ Level of care such as nursing home certifiable (NHC) only, nursing facility (NF) residents, all duals? ◆ What is the definition of NHC and how is this determined? (e.g., assessment tool, ADLs, etc.)	Decisions about population coverage will help determine the comprehensiveness of your integrated care program and facilitate or impede care coordination and service integration. Some populations and their care providers may be more distinct and separable than others, so excluding them may be more feasible administratively (TBI, for example).	Some populations and their providers may be more organized and resistant to managed care than others, so there may be trade-offs between maximizing opportunities for integration/ coordination and political feasibility.
2) What services should be covered? ▪ Acute care services not covered by Medicare (vision, dental, transportation, etc.) ◆ These are low-cost services, but may be attractive for plan marketing purposes ▪ Services currently shared by Medicare and Medicaid (DME, home health, skilled NF) ▪ Medicaid long-term care services ◆ Nursing facility ▪ Limits on days covered? ◆ Home health ◆ HCBS ▪ In their own home ▪ In the community (adult foster care) ▪ Comprehensive case management ▪ Behavioral health ◆ Coverage in Medicare is limited, but inclusion in managed care may be controversial for beneficiaries and providers	Decisions about service coverage will shape the extent to which a managed care program can facilitate a better and more equitable distribution of services, especially long-term-care (LTC) services. If the goal is to move toward as full integration of Medicare and Medicaid services as possible, including all related services in a single managed care organization (MCO) benefit package is desirable.	Including only Medicaid acute care services not covered by Medicare in a Medicare MCO benefit package does not advance integration significantly, unless it is a step toward integrating long-term-care services. Nursing facility, home health, and HCBS should be included in the benefit package to the extent possible, since they are substitutes for each other and can result in more cost-effective care if administered together and if one entity is at risk for all of them. Specific types of providers, especially nursing facility, HCBS, and mental health providers, may resist being included in capitated managed care programs, as may some beneficiaries and their advocates. This may present significant constraints in developing a broad and inclusive managed care benefit package, especially in the short term, so addressing these concerns is an important part of ICP development.

PROGRAM DESIGN ISSUES *(cont')*		
Questions	***Why Important***	***Implications***
3) Should MCO enrollment for Medicaid-covered services be mandatory or voluntary?	Rate setting is much more difficult when enrollment is voluntary because health care costs of those who choose to enroll are very hard to predict. A mandatory plan still requires estimating variation in enrollment mix by plan, if there is more than one participating plan. Generating MCO interest is much more difficult in a voluntary program, since it is hard to predict the number of participants, and MCOs require a critical mass of covered lives in order to achieve administrative efficiencies and cover start-up costs. Provider contracting is also easier if reluctant providers realize that if they do not contract they run the risk of losing patients. If they know there will be a fee-for- service option they can refuse to contract.	Provider and beneficiary opposition will be much greater if enrollment is mandatory. In addition, enrollment for Medicare services must be voluntary. These factors impose significant constraints in designing ICPs that include mandatory enrollment for Medicaid services. Nonetheless, voluntary managed care programs tend to have low and unpredictable enrollment, which makes rate setting difficult and limits MCO interest. Thus, states should push as far as they can in the direction of mandatory enrollment.
4) Should we try to contract with: • One or more Medicare Advantage (MA) Special Needs Plans (SNPs) to cover some or all Medicaid services in a single SNP benefit package (integrated model)? • A single company (or companies) that will cover Medicaid and Medicare services in plans that are separate for contracting, rate-setting, and administrative purposes (side-by-side model)? • Medicaid MCOs for Medicaid LTC services, with no direct link to Medicare (separate model)?	This is an important threshold question that will go a long way toward determining what ICP program design options you will have, so it is important to keep it in mind as you consider the first three questions outlined above. The option you pick will likely depend on the availability and willingness of SNPs and other MCOs to contract with the state, concerns of provider and advocacy groups, state administrative and contracting resources, and your specific ICP goals.	If you cannot immediately get to the "gold standard" of full integration, there may be more incremental steps you can take that can help to lay the groundwork for fuller integration over time. The "separate model," for example, could lead to fuller integration of services if the Medicaid LTC MCO subsequently partnered with a Medicare MCO, or became a SNP, thereby bringing together both acute and LTC Medicare and Medicaid services. This decision should be an iterative one; if you determine that choosing one of these threshold options might unduly inhibit or even foreclose development of ICP program elements you believe to be important (e.g., better coordination of acute and LTC services), the decision could be revisited as program design thinking evolves.

PROGRAM DESIGN ISSUES *(cont')*		
Questions	***Why Important***	***Implications***
5) What program design options are available that would give MCOs incentives to reduce nursing facility care and increase community care?	The main way MCOs can reduce overall nursing facility expenditures is to provide less-expensive care for those who would otherwise be in nursing facilities. Identifying such individuals and developing effective programs to serve them in the community is not easy however, so programs must be carefully designed to align MCO incentives and payments effectively. Some options include: • Paying a fixed PMPM rate that assumes a specified mix of NF and HCBS care (AZ) o MCOs that serve more enrollees in the community can achieve savings • Paying a specific incentive for each enrollee moved out of NF care and into the community (MN) • Paying at the NF or HCBS rate for a period of time after the enrollee moves from one setting to another (MA) o MCOs have short-term savings if enrollees move to HCBS settings, and short-term losses if enrollees move to NFs	There is a significant risk that MCOs may be over- or under-paid in any capitation system that seeks to maximize use of lower-cost community care for enrollees who are eligible for nursing facility care, since predicting the portion of these enrollees who could be successfully served in the community can be quite challenging, especially when MCO enrollment is voluntary. If the existing FFS system is not currently meeting the full need for community services and/or if there are waiting lists for services, the FFS base may not truly represent adequate base period costs for rate development purposes. Accounting for this entails estimating the impact of the "woodwork" effect on the number of enrollees who will utilize services (percent of those eligible) as well as the amount of services existing and new enrollees may use when access and/or provider network adequacy is improved. Options to consider that can mitigate MCO risk are risk corridors that focus on overall plan expenditures, stop-loss provisions that focus on individual high-cost cases, and administrative-services-only (ASO) arrangements that do not put plans at risk for health care service costs.
6) What implementation time frame is appropriate?	Implementing a program too quickly can have significant technical and political disadvantages. If planning and implementation is unduly protracted, however, there is a risk of losing momentum and MCO interest.	A variety of phase-in options should be explored, including starting in limited geographic areas, allowing some enrollees to opt out if dissatisfied, and sharing risk with MCOs for a limited period of time through one or more of the methods outlined above in question 5.

DATA ISSUES		
Questions	***Why Important***	***Implications***
7) Do you have a data infrastructure in place that can provide actuaries the data that will be needed to set capitated rates for long-term care, especially HCBS?	Medicaid is the market for HCBS, so there is little private sector experience for actuaries to draw on (unlike acute care). If Medicaid has not been paying HCBS and related LTC providers in ways that facilitate the collection of claim-level detail, there may be little reliable data for actuaries to draw on.	Since there is limited non-Medicaid provider capacity in HCBS, expansion of services in the short term may be difficult, and MCOs may be at a disadvantage in negotiating with HCBS providers regarding rates and service and payment requirements. Further, HCBS providers may not have accounting and billing systems that produce reliable data for actuaries to use, requiring the use of various approximation methods to set capitated rates for the services they provide.
8) To what extent can health- or diagnosis-based risk adjusters be used for LTC capitated rate-setting, as they have been for Medicaid acute care rate-setting (CDPS, ACGs)?	Reliable risk adjustment depends on the ability of actuaries to predict the likely future costs of MCO enrollees with specific characteristics, and diagnoses have proven to be reasonably reliable predictors of acute care costs. Other factors may be more reliable predictors of LTC costs, however, such as limitations on activities of daily living (ADLs), or an enrollees' ability to live in the community rather than in a nursing facility. A further consideration is that diagnostic information for dual eligibles may not be readily available on Medicaid claims, since the most complete and reliable diagnostic information is generally on inpatient hospital claims, which are paid by Medicare. In the absence of access to Medicare hospital claims data, Medicaid may be able to obtain inpatient hospital diagnoses for duals from the "crossover" claims that Medicaid pays for the first day of Medicare hospital stays.	The degree of uncertainty involved in setting capitated rates for LTC services is likely to be significantly greater than for acute care services, at least until there has been time to gather more data and experience. In addition, as noted under question 5, there is major uncertainty regarding the ability to substitute lower-cost services for NF care. This suggests again that states should consider sharing risk with MCOs in the early years of managed LTC. Dual eligible demonstration programs in Minnesota, Wisconsin, and Massachusetts have used a "frailty adjustor" based on ADL limitations as a component of the capitated Medicare rates paid to plans, and Medicare is considering use of a similar adjuster in the Medicare Advantage program. This is another option states could explore in the ICP context.

DATA ISSUES *(cont')*		
Questions	***Why Important***	***Implications***
9) Have you had any experience using screening tools to assist with rate setting and risk adjustment (in addition to care planning)?	There are a variety of screening tools that states and MCOs have used to help determine both plans of care and appropriate capitated rates for MCO enrollees. Such a tool could be especially useful in identifying characteristics of beneficiaries that could drive LTC costs but that may not show up in medical claims, such as limitations on ADLs. Not only is the tool important, but who administers the tool as well, since this may influence the measurements. LTC recipients should be re-assessed every 6 to 12 months.	Developing a common screening tool for ICP participants could help both states and MCOs make more efficient use of a resource that could greatly assist both care planning and rate setting. The ICP work group would like feedback from ICP states on whether such a common screening tool would be useful to them at this stage of their program development. In thinking about how the assessment tool ties into rate setting, states should consider who will perform the assessment (MCO or the state), how often the assessment will be performed (quarterly, semi-annually, annually, triggering event), and if any rate categories are tied to the assessment. All of this is important for the actuary to take into consideration when developing the capitation rates or determining the risk adjustment.
ISSUES RELATED TO COORDINATION WITH MEDICARE		
Questions	***Why Important***	***Implications***
10) What options are available to work with Medicare to coordinate Medicaid and Medicare capitated rate setting?	The experience of the dual eligible demonstration programs in Minnesota, Wisconsin, and Massachusetts has demonstrated both the difficulty and the value of developing greater integration of Medicare and Medicaid capitated rate setting.	ICP states that are considering developing either the integrated or side-by-side models referenced in the Program Design section of this checklist should explore options for joint Medicare and Medicaid rate setting, building on the experience of the dual eligible demonstration programs. CMS should be brought into these discussions to help determine how the dual eligible demonstration experience can be adapted to other settings. Issues for consideration include ways to reduce cost shifting between the two programs, implications for Medicaid of the allocation of Medicare bid "savings" to beneficiary premium and/or cost sharing reductions and supplemental benefits, use of Medicare service utilization and diagnostic data to help set Medicaid rates, and options for greater fungibility of Medicaid and Medicare funding streams.