Medicaid Managed Care Rate Setting Policy
Creating a framework for value-based purchasing

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Analysis and recommendations to address CMS policy hurdles in leveraging private capital in outcomes based payment systems including Pay for Success
The problem with the current system

Would you believe that investing in preventative care could cost a Medicaid MCO many times the amount of money they will save?

**Situation**
An investor funds a project and the MCO only has to pay them back if the project decreases the cost of providing high-quality care to a target population… and the project is a success.

**The problem is that they will be expected to do more while being paid less**

- Next year, the plan gets paid less through a rate setting process because the intervention has done three things:
  1. Reduced the number of high-risk patients by preventing care needs,
  2. Lowered the real cost of providing care within each risk category, and
  3. Provided services not included in the calculation of cost-of-care to do so.

- Then, with less money coming in, the plan has to repay the investor and that can reduce administrative budgets by an additional 1.25 times the cost savings, if they can pay at all.

- Now, without funding more interventions, the MCO’s cost of care goes back up and they will still be paid the new lower rate, taking a second loss for the same service.

Source(s): GHHI analysis of publicly available data.
This presentation will propose a method of opening the door for private investment in public-health outcomes.

Why you’re reading this
To learn how Pay for Success transactions can be mutually beneficial for public and private partners.

Why it matters
This is important because Pay for Success can:
• Leverage private capital at no additional cost to tax-payers,
• Improve health outcomes by investing in prevention for low-income communities;
• Reduce the cost of providing care at no financial risk to the tax-payers; and
• Provide long-term economic incentives for health-system innovation.

How we’re going to do it
To accomplish this we will identify, analyze, and provide recommendations to address key issues preventing Pay for Success in public health.

Source(s): GHHI analysis of publicly available data.
Pay for Success can become a viable financing model for public health innovation if we address two key challenges.

**What is Pay for Success**
Pay for Success is a financing mechanism that delivers results;
- Investors supply funds up-front at no initial cost;
- Providers use funding to deliver services that improve outcomes;
- The project data is evaluated to determine if it worked; and
- Investors are only repaid if the project is successful.

**Why aren’t MCOs using private capital to fund innovation now?**
There are two key issues to implementing Pay for Success for MCOs:

1. The process of rate setting based on historical medical expenditures prevents investor repayment by reversing incentives to innovate; and

2. Pay for Success investments in prevention are not considered medically relevant expenses, creating accounting issues.
We recommend undertaking two courses of action that will enable Pay for Success projects and incentivize innovation.

1. Establish a framework to equitably share cost-savings that:
   - Allows investment and repayment of private capital; and
   - Creates incentives for innovation that improve health outcomes and lower the cost of care.

2. Treat pay for health outcomes as paying for medical expenses
Set expectation that all Pay for Success project expenditures are to be treated as medically relevant expenses that should be considered reimbursable medical expenses in lieu of plan services.

Note(s):
Both of these policy actions move payments in the direction of payment for value of care by creating capitated subpopulations that could be the basis for future policy innovations.

Source(s):
GHHI analysis of publicly available data.
In consultation with Jack Meyer of Health Management Associates
Purpose of Pay for Success

Pay for Success programs aim to rapidly transition research into self-funded programs that produce a net-benefit for society.

Program purpose matrix

<table>
<thead>
<tr>
<th>High cost</th>
<th>Low cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Narrow scope</td>
<td>Broad scope</td>
</tr>
</tbody>
</table>

Research program (Start) ➔ Evidence-based service program (Post PFS)

Pilot program (feasibility study) ➔ Startup (PFS project)

Feasibility studies
Attempt to rapidly determine if a program can work and under what conditions.

Pay for Success Project
Will scale a project to determine if the business model can work and generate a net benefit.

After Success
Considerations need to be given to what it takes to have a successful Pay for Success transaction and what conditions make it sustainable after the project has succeeded.
Key Issue #1

Equitable value sharing
A policy tool to incentivize private innovation and investment in public health
Establishing a framework for equitably sharing cost savings will incentivize private innovation and drive long-term public cost savings.

**Recommended equitable value framework methodology**

1. Include outcomes-based payments in lieu of existing State Plan services for preventative services in Managed Care contracts:
   - Can be allowed through contract amendments immediately, or
   - Can be implemented through including language in next renegotiation.

**Key takeaway**

The long-term public benefits of incentivizing innovation outweigh the short and medium-run price concessions.

**Note(s):** 1. This payment policy is a move in the direction of payment for value of care analogous to creating capitated subpopulations.

**Source(s):**
- GHHI analysis of publicly available data.
- In consultation with Jack Meyer of Health Management Associates.
There are two components of rate setting mechanisms that determine the cost of care and both need to be addressed.

### Rate setting concept model

- **Risk stratification**
  - Number of persons
  - Number of persons
  - Number of persons

- **Price per tier**
  - Price per person
  - Price per person
  - Price per person

- **Total costs**

**Compensation rate**
The total compensation rate is composed of two parts:
- Number of persons at an amount of risk, and
- The set price per person per tier.

### The impact of Pay for Success
A successful pay for success project will ideally reduce both the number of persons at high-risk strata and the cost of caring for persons in those strata.

### Key issue
For Pay for Success to really work, the total compensation rate needs to be held constant for the project term, not just the price within a given strata.
The Pay for Success project will lower the cost of providing care to the target population.

Value-sharing framework explained

Rate adjustment mechanism concept

\[ \text{Current cost of care} \]

\[ \text{New cost of care} \]

Source(s): GHHI analysis of publicly available data.
Value-sharing framework explained

Negotiating a new rate that lets the MCO retain a portion of the cost savings will incentivize future projects or cover unforeseen costs.

Rate adjustment mechanism concept

$\begin{align*}
A & \rightarrow \text{Current cost of care} \\
C & \rightarrow \text{Negotiated rate} \\
B & \rightarrow \text{New cost of care}
\end{align*}$

Note(s): In our discussions with many health plans, they expressed hesitation to fully absorb the risk that there will be no unforeseen additional costs, such as increases in regular medication use et cetera, and that there are no relapses in cost of care.

Source(s): GHHI analysis of publicly available data.
Holding the compensation rate constant for the duration \( (D) \) of the project will enable the MCO to provide investor returns.

**Value-sharing framework explained**

**Rate adjustment mechanism concept**

\[
\begin{align*}
\text{A} & \quad \text{Current cost of care} \\
\text{B} & \quad \text{Negotiated rate} \\
\text{C} & \quad \text{New cost of care} \\
\text{D} & \quad \text{End of project}
\end{align*}
\]

Source(s): GHHI analysis of publicly available data.
Value-sharing framework explained

Negotiating a transitional period will allow for the MCO to adjust to new rates and provide them capital incentives to undertake new projects.

Rate adjustment mechanism concept

$\begin{align*}
\text{A} & \quad \text{Current cost of care} \\
\text{C} & \quad \text{Negotiated rate} \\
\text{B} & \quad \text{New cost of care} \\
\text{D} \quad \text{E} & \quad \text{Rates transitioned in}
\end{align*}$

Source(s): GHHI analysis of publicly available data.
A successful project will reduce the cost of care over time.

Value-sharing framework explained

Source(s): GHHI analysis of publicly available data.
The cost-saving captured by the MCO during the project will be used to provide investor returns.

Value-sharing framework explained

Rate adjustment mechanism concept

- Current cost of care
- Negotiated rate
- New cost of care
- Cost of care
- MCO retained value
- MCO captured value repaid to investors

Source(s): GHHI analysis of publicly available data.
The subsequent cost savings will serve to provide capital to sustain the program and incentivize undertaking new projects.

Value-sharing framework explained

Rate adjustment mechanism concept

Source(s): GHHI analysis of publicly available data.
Value-sharing framework explained

The public will begin to capture value as the new rates transition in after the project’s completion.

Rate adjustment mechanism concept

$\begin{align*}
\text{A} & \quad \text{Current cost of care} \\
\text{C} & \quad \text{Negotiated rate} \\
\text{B} & \quad \text{New cost of care} \\
\text{D} & \quad \text{Cost of care} \\
\text{E} & \quad \text{MCO retained value} \\
\end{align*}$

- MCO retained value
- MCO captured value repaid to investors
- Medicaid retained value is split between Federal CMS and the State

Source(s): GHHI analysis of publicly available data.
Over time, the public benefits most from cost savings, improved quality of care, and providing incentives for private sector innovation or investment.

Value-sharing framework explained

Source(s): GHHI analysis of publicly available data.
Recommendations for equitable value sharing

The right rate-setting framework enables private investment in public health, incentivizes innovation, and ensures long-term public benefits.

**Recommendations**

1. Hold the initial compensation rates (A) constant for the duration of the project (D) to allow investor repayment.

2. Determine the new cost of care (B) from the data provided. Negotiate a new rate (C) that allows the MCOs to retain a portion of cost savings (C-B) continuously.

3. Negotiate a rate adjustment period (E-D) after completion to incentivize future projects.

**Key takeaway**

The long-run public benefit of a successful initiative will substantially outweigh the short and medium-run price concessions.

**Rate adjustment mechanism concept**

<table>
<thead>
<tr>
<th>Time</th>
<th>A</th>
<th>C</th>
<th>B</th>
<th>D</th>
<th>E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of care</td>
<td>MCO retained value</td>
<td>Investor return</td>
<td>Medicaid retained value</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
An equitable value-sharing framework can incentivize a transformation in public-health financing creating a mutually beneficial situation.

1. **The public benefits most in health and cost**
   - Both health outcomes and the cost of providing care are improved, putting the population on a better trajectory in health and expenditures.

2. **Service providers gain sustainable funding**
   - By creating a direct link to their generated outcomes, effective service providers will develop new funding sources that are cost-effective.

3. **Payers provide better care at lower cost, turning lemons into lemonade**
   - New service delivery mechanisms can turn the most costly demographics into potential profit earners by providing the best value of care.

4. **Investors can earn a return by doing good**
   - Monetary compensation is, by definition, their motive; but doing so in a way that also generates social good has proven a strong motive.
Key issue #2

Prevention as a medically relevant expense
Key issues with medical expenses

Current policies and practices for calculating compensation are a barrier to Pay for Success projects leveraging private capital to fund innovation.

**Current accounting policies…**
- Managed-care organizations classify expenses as medically relevant (termed medical losses) or not medically relevant (termed admin).¹
- Plans’ compensation is based on historical medical losses projected forward – you are not reimbursed for things not on the plan.
- They are required to maintain a ratio of greater than 80 percent medical to 20 percent non-medical spending.

… Create barriers to Pay for Success projects. Pay for Success project spending is not included in the cost of care despite the aim of improving the value of care provided. This creates two barriers:

A. Pay for Success spending projects negatively impacts an organization’s medical loss ratio, which has unintended consequences; and

B. Future payment is calculated based from medical losses that exclude services outside the state plan, including investments or investor returns.

Note(s) 1 Only state-plan approved services are included in calculating the cost of providing care.

Source(s): GHHI analysis of publicly available data. In consultation with Jack Meyer of Health Management Associates
We recommend a direct solution that fully opens the door to innovation and private investment in public-health.

**Direct solution**
Communicate that outcomes-based payments like Pay for Success projects are reimbursable medical expenses in lieu of State Plan services that cannot exceed the initial cost of care.

**Pros**
- It’s simple, and you can do it now.

**Cons**
- Needs CMS commitment

**Ad-hoc solution of waivers and plans**
Every time an organization wants to try something new, go through the waiver or state-plan amendment process.

**Pros**
- CMS pre-committed to match funds

**Cons**
- Active management of every single project, time, and expense

Source(s): GHHI analysis of publicly available data. In consultation with Jack Meyer of Health Management Associates
The problem with calculating compensation policies result in unintended consequences for innovative programs, starting with the medical loss ratio.

Organizational spending classification

Before (80-20)

<table>
<thead>
<tr>
<th>Non-medical loss</th>
<th>Medical loss (Cost of care)</th>
<th>Total cost-savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>80</td>
<td>10</td>
</tr>
<tr>
<td>20</td>
<td>70</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

Result

If repaying investors or cost savings do not count as medical losses (expense), they will be penalized for dropping below their regulated 80-20 MLR simply because they invested in preventative care.

Scenario

A MCO with a $100 million budget and existing 80-20 medical loss ratio undertakes a Pay for Success project that:

- Reduces cost of care by $10 million per annum, and
- Repays investors $5 million per annum.

Source(s):
GHHI analysis of publicly available data.
The problem with calculating compensation

The compensation calculation policies result in unintended consequences for innovative programs.

### Organizational spending classification

<table>
<thead>
<tr>
<th>Category</th>
<th>Before (80-20)</th>
<th>Total cost-savings</th>
<th>After (80-20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investor repayment</td>
<td>20</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Admin budget</td>
<td>80</td>
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<td>7.5</td>
</tr>
<tr>
<td>Medical loss</td>
<td>70</td>
<td></td>
<td>87.5</td>
</tr>
</tbody>
</table>

- Required budget cut to maintain 80-20
- 12.5% reduction in total budget; and
- 37.5%* reduction in non-medical budget (excluding investor repayment as a restricted cash-flow).

### Results of $10 million project

- 12.5% (100 to 87.5) reduction in overall budget; and
- 37.5%* (20 to 12.5) reduction in non-medical budget (excluding investor repayment as a restricted cash-flow).

### Key insight

Each dollar of Pay for Success savings will result in:

- $1.25 reduction in overall budget; and
- Between $0.25 and $1.25 reduction in admin budget ($0.75 shown).*

Note(s): * If all savings are repaid to an investor in a given year, the unrestricted admin budget would be just $7.5 million or 62.5 percent less.

Source(s): GHHI analysis of publicly available data.
The problem with calculating compensation

Even if a Pay for Success project is excluded from calculation it may negatively impact MCO’s medical loss ratio (MLR).

Organizational spending classification

<table>
<thead>
<tr>
<th>Before (80-20)</th>
<th>Total cost-savings</th>
<th>After (80-20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>80</td>
<td>10</td>
<td>17.5</td>
</tr>
<tr>
<td>20</td>
<td>10</td>
<td>2.5</td>
</tr>
</tbody>
</table>

Scenario
A MCO with a $100 million budget and existing 80-20 medical loss ratio undertakes a Pay for Success project that:
- Repays investors $5 million per annum, and
- Reduces the cost of care by $10 million per annum,

Required budget cut to maintain 80-20

Non-medical loss

Net cost savings

Investor repayment

Medical loss (Cost of care)

Result of exclusion
Roughly 25 percent of the project size would be a required non-medical expense budget cut:
- **12.5 percent** reduction in non-medical budget.

Note(s):
Even if excluded from calculation, the project would drop the MLR to a 70-20 ratio and violate regulations.

Source(s):
GHHI analysis of publicly available data.