FINANCIAL INCENTIVES: CONTRACT EXAMPLES

Financial incentives can be structured to guide contractor behavior in one direction or another. Below are three examples of how states have used financial incentives to encourage community-based services and supports over institution-based services. The first example shows how Arizona uses a capitated payment based on a blended rate of the estimated cost to serve a member's LTSS needs in a nursing home or in the community. The second example, the Massachusetts language, shows how the program has incentives built in to encourage contractors to transition members from institutional to community-based settings. Third, the sample from Minnesota shows how the program offers a bonus payment for transitions out of nursing homes.

Arizona Long Term Care System (ALTCS)

From Arizona Health Care Cost Containment System Administration, Contract Amendment, Section D.56

HCBS Assumed Mix and Recoupment:
The Contractor's capitation rate is based in part on the assumed ratio ("mix") of HCBS member months to the total number of member months (i.e. HCBS + institutional). After the end of the contract year, AHCCCS will compare the *actual* HCBS member months to the *assumed* HCBS percentage that was used to calculate the full long term care capitation rate for that year. Member months for those members who received acute care services only are not included in this reconciliation. If the Contractor's actual HCBS percentage is different than the assumed percentage, AHCCCS may recoup (or reimburse) the difference between the institutional capitation rate and the HCBS capitation rate for the number of member months which exceeded (or was less than) the assumed percentage. This reconciliation will be made in accordance with the following schedule and ACOM 303 Policy:

Percent *over/under* assumed percentage:	Amount to be recouped/reimbursed:
0 – 1%	0% of capitation over/underpayment
>1%	50% of capitation over/underpayment

Massachusetts Senior Care Options

From MassHealth Senior Care Options, Attachment A, Contract for Senior Care Organizations, Section 4.5

MassHealth Transitions between Rate Cells [RC]

MassHealth Capitation Rates will be updated following a change in an Enrollee's status, based on the Minimum Data Set Forms (the MDS.20 and the MDS/HC) and the Status Change Form (SC-1) for Nursing Facility Residents, or any subsequent forms required by EOHHS. The MassHealth transition rules are as follows:

A. Institutional to Community RC
For a transition from an institutional RC (Tier 1, 2, or 3) into a community RC, the rate change will become effective on the first calendar day of the month following 90 calendar days after discharge.

B. Between Community RCs
For a transition between community RCs, if the MDS/HC form is received and approved on or before the last day of the month, the rate change will become effective on the first calendar day of the following month.

C. Between Institutional RCs
For a transition between institutional RCs, the rate change will become effective on the first calendar day of the month after the MDS 2.0 is received and approved by EOHHS.

D. Community to Institutional RC
For a transition from one of the community RCs into an institutional RC (Tier 1, 2, or 3), the rate will first change to NHC, if the Enrollee is not already assigned to that RC, on the first day of the month after the Enrollee becomes institutionalized. If the Enrollee has not been discharged after 90 calendar days, the rate will change to the appropriate institutional RC (Tier 1, 2, or 3) on the first day of the month following 90 calendar days at the NHC rate.

Minnesota Senior Health Options

From MHSO, section 4.5, Payments.

4.5 Senior Payment Rates. For MSHO and MSC+, monthly rates paid to the MCO shall be paid by the STATE according to the payment rates specified in Appendix II. The MCO shall receive for each Enrollee the rate of the county of residence.

4.5.1 Basic Care Rates for Seniors. For the Contract Year, monthly payments paid by the STATE to the MCO for Basic Care services for MSC+ and MSHO Enrollees shall be shown in the column titled, "*CY 2011 Plan Rate with Ratable Reduction*" in Appendix II. These payments shall:

(A) Be 100% demographically based for all Enrollees;
(B) Reflect removal of the MERC carve out from the base rates (amount shown in column titled, "MERC Carve Out"), excluding MSHO Dual Eligibles;
(C) Include Disproportionate Hospital Utilization (DHU) funding;
(D) Be reduced by 2.5% for a ratable reduction pursuant to Minnesota Statutes, §256B.69, subd. 5g and 5h.

4.5.2 Nursing Facility Add-on Rates for Seniors. Monthly payments paid by the STATE to the MCO for Nursing Facility services as described in section 4.26 of the contract shall be those identified in Appendix II.

4.5.3 Elderly Waiver Add-on Rates for Seniors. Monthly payments for Elderly Waiver services shall be made by the STATE to the MCO as shown in Appendix II, as applicable. The STATE agrees not to rebase the base rates for risk adjustment during the term of this Contract.

4.5.4 Long Term Care Elderly Waiver Risk Adjusted Payment System.
(A) Risk Adjustment Methodology. To account for variation in risk for the costs of EW services among Enrollees, the STATE will calculate an MCO-specific risk score for the EW add-on rate on an annual basis.

(1) Development of Factors. The State developed risk factors using individual data on costs and characteristics of EW recipients from the data available in the STATE's MMIS system including encounter data, LTCC screening document data submitted by MCOs and demographic information...
(2) The 2011 risk factors for Customized Living/ Corporate Foster Care (CL / CFC) were based on the number of Customized Living and Corporate Foster Care recipient months, as a percentage of total EW recipient months, within each MCO…
(3) Calculation of Annual MCO Elderly Waiver Risk Scores
    (a) The MCO's risk score for the Contract Year is based on an Enrollee roster derived from paid MCO capitation claims for the month of November of the current Contract Year. Area, Age Group, and ADL Group factors for each EW recipient are derived from the MMIS Data Warehouse claims and LTCC Screening document tables as of the first data update in November of the year prior to the start of the Contract Year. Elderly Waiver Enrollees without a valid and current LTCC Screening document are excluded from the calculation. CL / CFC percentages, rankings, and risk factors are derived from the previous calendar year's encounter data…
    (b) EW recipient-level risk scores will be averaged to derive the overall MCO risk score. The STATE will provide the MCO with EW recipient-level risk factors used in calculating the plan's overall risk score through its MN-ITS mailbox by November 30th.
    (c) Scores will be held constant for the entire Contract Year.