

# REPORT

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## **Medicaid Rate-Setting for Managed Long-Term Services and Supports: Basic Practices for Integrated Medicare-Medicaid Programs**

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## I. INTRODUCTION AND PURPOSE

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State Medicaid agencies are increasingly shifting their purchasing strategies for long-term services and supports (LTSS) from a fee-for-service model (FFS) to managed care, with 21 states offering managed LTSS (MLTSS) programs in 2015,<sup>1</sup> up from 8 states in 2004 (Saucier et al. 2012). Many states—including 10 participating in the Centers for Medicare & Medicaid Services (CMS) financial alignment demonstration—are also using the model of capitated managed care to integrate Medicare-paid acute health care with Medicaid-paid LTSS services for beneficiaries who are eligible for both. Because most states have only recently implemented the MLTSS model (whether for non-integrated Medicaid-only or integrated Medicare-Medicaid programs), many states, actuaries, and managed care organizations have limited experience in setting and implementing capitated rates in MLTSS settings.

States that expand MLTSS to populations that were formerly served in Medicaid's FFS system face a number of challenges in setting rates for MLTSS programs. First, it can be difficult to predict utilization of the new MLTSS programs, especially when the services covered under the FFS system were limited by enrollment caps and care needs assessment systems are being liberalized in MLTSS programs. Second, the LTSS data may be less complete or representative of costs than data on acute services; community-based LTSS providers are often small in size and have limited data-reporting capabilities, and states use a variety of non-standard systems to pay them.

States that are integrating Medicare and Medicaid services under capitated managed care, including states that are part of the financial alignment demonstration, face similar challenges in that they must set the rates that Medicaid pays participating health plans for the services it covers, which are primarily LTSS. CMS gives states some discretion in how they structure capitated rates for Medicaid services in the financial alignment demonstrations, as long as the process meets the criteria described in its August 2013 guidance on the joint rate-setting process (CMS 2013b). Rates must also support the goals of an MLTSS program, which include holding providers accountable through performance-based incentives and/or penalties (CMS 2013a). Because rate-setting is a major program design issue for Medicaid MLTSS programs, it is important for all states that are developing and expanding MLTSS programs to understand the basic components of rate development, as well as their options for a rate-setting methodology.

In choosing a methodology to use in setting its rates, a state should have three main goals. First, the methodology should match payment to the risk of the enrolled population and meet CMS requirements, including that of actuarial soundness (discussed below). Second, it should advance the policy goals of the managed care program, which generally include serving beneficiaries in the least restrictive setting. Third, it should enable the state to operationalize the rates and pay health plans in a timely way, taking into account any limitations that may exist in state systems. If done well, the monthly payments to managed care organizations for each plan enrollee will have a positive influence on many factors critical to the success of managed care, including (1) health plans' willingness to contract with state Medicaid agencies, (2) the ongoing

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<sup>1</sup> Mathematica's analysis of MLTSS programs, conducted for the Centers for Medicare & Medicaid Services as part of the National Evaluation of 1115 Demonstrations, 2016.

solvency of participating plans, (3) plans' ability to pay providers adequately, (4) the potential to save costs compared with FFS, and (5) beneficiary access to high quality care.

In this brief, we discuss rate-setting strategies that can help a state achieve each of these goals. First, we summarize the basic approach to rate-setting in managed care, with a specific focus on Medicaid requirements. Next, we review the main options available to states in structuring their MLTSS rates. We present both the approaches of states that have financial alignment demonstrations and states with long-standing MLTSS programs. (Details of the approaches are also summarized in Appendix 1.) We conclude by highlighting the policy and operational considerations that should influence a state's choice of strategy. Information on the Medicare Advantage (MA) and Part D rate-setting processes, which may help those states pursuing integrated programs as they negotiate with MA plans, is presented in Appendix 2.

## **A. Fundamental principles of rate-setting**

The primary goal of rate-setting is to match payment to risk. The degree and variation of risk often dictates the complexity of the rate structure and rate-setting methodology. To the extent that utilization and the service mix for a given population are predictable, states can design rate-setting methodologies that are fairly simple. For example, an MLTSS program that only covers nursing facility residents would be fairly predictable, both in terms of population risk and per capita expenditures, so capitated payment systems covering just those services could be relatively straightforward. However, when the managed care program covers a broad array of services—acute, primary, behavioral health, and LTSS—for a diverse population that includes individuals at varying levels of need and health status, more complex payment methodologies are needed.

To match payments to risk, federal regulations require states to set capitation rates for risk-based Medicaid managed care programs using “actuarially sound” principles.<sup>2</sup> In practical terms, a Medicaid benefit plan's premium rate is actuarially sound if, for a given state and time period, “projected capitation rates and other revenue sources provide for all reasonable, appropriate, and attainable costs.”<sup>3</sup> Projected premiums include Medicaid agency payments to health plans, as well as expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. Appropriate and attainable costs<sup>4</sup> include health benefits, health benefit settlement expenses, administrative expenses, any government-mandated

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<sup>2</sup> According to 42 CFR 438.4(b), which goes into effect July 5, 2016, capitation rates must, among other things: have been developed in accordance with generally accepted actuarial principles and practices; be appropriate for the population to be covered, and the services to be furnished under the contract; be specific to payments for each rate cell under the contract; be certified by an actuary as meeting the applicable requirements; and be developed so that the MCO, PIHP, or PAHP would reasonably achieve a medical loss ratio standard of at least 85 percent for the rate year.

<sup>3</sup> 42 CFR 438.4(a).

<sup>4</sup> In this context, “attainable costs” means that the health plan can provide all necessary services within the capitation payment, including fulfilling medical, administrative, and reserve requirements. For some services, like health benefits, the term may also assume that health plans can achieve additional savings through the use of care management.

assessments, fees and taxes, and the cost of capital. CMS uses an actuarial rate-setting checklist to verify compliance with regulatory requirements.

## B. Components of managed care rate-setting

To develop capitation rates for managed care programs, states and their actuaries determine spending amounts and make adjustments for the five components shown in the figure below (Dominiak 2013).<sup>5</sup>

**Figure I.1. Components of managed care rates**



1. **Base data and adjustments:** Base data can either be FFS data (generally appropriate for new and smaller programs) or managed care encounter data (for more mature and larger programs). Depending on the data source they select, states and their actuaries may adjust the base data so they better reflect the populations and services that will be covered under the integrated program. For example, adjustments may address lags in provider claim submission, missing encounter records, costs outside of the Medicaid Management Information System (MMIS), and patient liability. In addition, the base data should be adjusted for any differences in the covered population, such as differential risk arising from voluntary enrollment into managed care.
2. **Program and policy changes** include any one-time changes to the program design or policy that are made between the base period and the contract period and that occur outside of normal trend (the next component). Examples include state and federal mandates, such as changes in provider fee schedules; changes in benefits or eligibility; changes to Medicare for dual Medicare-Medicaid eligibles; or other state/federal legislative actions.
3. **Trend** reflects changes in the quantity, mix, and price of services on a per capita basis, compounded over time. Trend factors are applied to base period data in order to estimate or

<sup>5</sup> 42 CFR 438.5(b), which goes into effect July 5, 2016, requires that states follow six steps in setting actuarially sound capitation rates, which cover the same concepts but follow a different structure and order than the steps presented in this brief. The steps required by 438.5(b) are: (1) identify and develop the base utilization and price data; (2) develop and apply trend factors; (3) develop appropriate and reasonable projected costs for non-benefit costs in the rating period; (4) make appropriate and reasonable adjustments to the historical data, projected trends, or other rate components; (5) consider historical and projected Medical Loss Ratio; and (6) select an appropriate risk adjustment methodology, apply it in a budget neutral manner, and calculate adjustments to plan payments as necessary.

“project forward” contract period costs. Program and policy changes and managed care adjustments should be excluded from trend so their effects are not double-counted.

4. **Managed care adjustments (or delivery system differences)** include any differences between the service delivery for the projected MLTSS program and the system under which the base data were produced. For example, in a new MLTSS program, delivery system differences should reflect realistic cost savings for a managed LTSS program in comparison with unmanaged FFS. Other examples include changes in the mix of users for nursing facility and home and community- based services (HCBS), more effective use of personal care and home health services, reductions in unnecessary hospitalizations and readmissions, increases in physician services, or changes in outpatient hospital utilization and home and community-based services.
5. **Administration and care management** adjustments include the health plan’s administrative costs and expected underwriting gain (profit) as well as its contribution to surplus based on a state’s risk-based capital requirements. Administrative costs can be calculated as either a percentage of premiums or as a fixed per member per month (PMPM) amount. Because MLTSS participants have complex care needs, PMPM administrative costs for MLTSS programs are generally higher than they would be for programs that cover acute care only.

### C. Financing approaches that support policy goals

One of the primary goals for most MLTSS programs, including those that integrate Medicare and Medicaid financing, is to increase the proportion of beneficiaries who receive LTSS in their community and not in an institution. Most people prefer to remain in their community if at all possible, and there is evidence that encouraging community-based care over institutional care can save Medicaid money (Fox-Grage and Walls 2013). There are many strategies that states and their actuaries can use to encourage using HCBS instead of nursing facility (NF) services. These strategies range in complexity from (a) static rate cells<sup>6</sup> that an individual moves into or out of based on categorical level of care needs to (b) risk adjustment that calibrates payment based on incremental variations in health status and care needs. Four common strategies are described next, and their advantages and disadvantages are presented in Table I.1. States can tailor these strategies to meet their specific needs and goals through (1) variations in the rules that govern placement in one rate category or another and (2) changes over time in the overall HCBS/NF target.<sup>7</sup>

<sup>6</sup> 42 CFR 438.2 defines rate cell as a “set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment; such characteristics may include age, gender, eligibility category, and region or geographic area. Each enrollee should be categorized in one of the rate cells for each unique set of mutually exclusive benefits under the contract.”

<sup>7</sup> CMS guidance indicates the agency prefers states to use or move toward adoption of a blended rate approach. See Centers for Medicare & Medicaid Services, “2016 Medicaid Managed Care Rate Development Guide.” September 2015. Available at <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/2016-medicaid-rate-guide.pdf>.

**Table I.1. Advantages and disadvantages of rate-setting approaches**

Payment approach	Description	Advantages	Disadvantages
Separate NF and HCBS rates	State pays separate rates based on setting of care (community or nursing facility [NF]) for those members who meet the state's criteria for nursing facility level of care	<ul style="list-style-type: none"> <li>• Matches capitation payment to health plan risk more closely than blended approaches do</li> <li>• Removes financial incentive for a plan to “cherry-pick” by targeting enrollment of community-based members and avoiding enrollment of institutionalized members</li> </ul>	<ul style="list-style-type: none"> <li>• No financial incentive to increase home and community-based services (HCBS) and reduce NF placements</li> <li>• Plans may target members of a particular rate cell (e.g., NF residents or community) based on plans' provider network capacity rather than member care needs</li> <li>• Potential to be administratively or operationally complex depending on rate cell definition, frequency of rate cell changes, and assignment of members to new rate cells</li> <li>• Requires additional monitoring to ensure assignment to appropriate rate cell</li> </ul>
Blended NF/HCBS rate	State pays a single blended rate each year that combines all covered MLTSS costs, including NF and HCBS, for those members who meet the state's criteria for nursing facility level of care regardless of setting; mix of NF and HCBS in the blended rate may change from year to year	<ul style="list-style-type: none"> <li>• Provides a strong financial incentive to serve members in the community rather than in long term institutions</li> <li>• Encourages plans to proactively transition members out of NF settings and develop processes to prevent members from entering NFs in the first place</li> </ul>	<ul style="list-style-type: none"> <li>• Mix of HCBS and NF members can be difficult to predict at both the program and plan levels</li> <li>• Plans may have an incentive to target less costly HCBS members and avoid enrolling members in long term institutionalization</li> </ul>
Transitional NF/HCBS rate	State uses separate rate cells to reflect variation in frailty and/or setting, but delays the change in individuals' assignment to the new rate cell to encourage the use of HCBS over NF	<ul style="list-style-type: none"> <li>• Provides financial motivation to encourage the transition of institutionalized members to the community and discourage transitions to the NF</li> <li>• Reduces risk of over- or underpayment when NF/HCBS mix is unpredictable</li> <li>• Removes financial incentive to enroll community-based members (lower costs) and avoid institutionalized members (higher costs)</li> </ul>	<ul style="list-style-type: none"> <li>• Financial incentives to increase HCBS and reduce NF placements are not as strong as in fully blended approach</li> <li>• Plans may target members of a particular rate cell (e.g., nursing facility residents or community) based on network capacity or other factors unrelated to member care needs</li> <li>• Plans may be encouraged to initially place members in the NF to receive the higher institutional rate along with any incentive payments if a person is then transitioned to the community</li> <li>• Requires sophisticated data and tracking, therefore difficult to operationalize and administratively burdensome</li> </ul>

**Table I.1.** *(continued)*

Payment approach	Description	Advantages	Disadvantages
Needs-based risk- adjusted rate	State pays using a sophisticated classification algorithm based on a member's functional, cognitive, and behavioral needs, and on medical condition	<ul style="list-style-type: none"> <li>• Provides more equitable payments between health plans, with strong financial incentive to manage the care regardless of setting</li> <li>• Minimizes incentives for health plans to select healthier, lower- cost members</li> <li>• Protects health plans that serve a disproportionate number of high-risk, high-need beneficiaries</li> <li>• Reduces incentives to avoid enrolling high-cost, high-need beneficiaries</li> <li>• More accurately predicts the risk of new populations being enrolled into the MLTSS program in the event of any program expansion</li> </ul>	<ul style="list-style-type: none"> <li>• Requires electronically available assessment data and detailed encounter information</li> <li>• Diagnosis information from hospitals, physicians, and Rx drug use may be more limited for Medicare-Medicaid enrollees unless Medicare claims files are available</li> <li>• No national model exists for MLTSS risk adjustment, so sophisticated data modeling is required to develop the initial model and refine it over time</li> <li>• Model development and ongoing maintenance review and risk score revisions can be time-consuming and resource-intensive</li> <li>• Some variables can be easily gamed by the health plan, particularly if the health plan is performing the assessments and reassessments</li> <li>• Does not address the issue that the mix of HCBS and institutionalized members used to develop the base rate can be difficult to predict</li> </ul>



## 1. Basic Medicaid rate cell structure

An appropriate rate structure should provide for variations in the risk of the population covered by managed care so as to make risk more predictable and reduce opportunities and incentives to enroll people whose care costs are likely to be below the capitation rates. States pursuing financial alignment demonstrations have incorporated a number of common variables as part of their rate structure, including age, gender, region, diagnosis, degree of frailty, setting of care (institutionalized and community), and enrollment in 1915(c) waivers. In addition, states determine when to assign individuals to rate cells (also referred to as rating categories) and how often their assignment changes. At a minimum, it should change when an individual moves to a new care setting, perhaps with a delay to encourage community placements. For administrative ease, a state might choose to make these assignments and reassignments only once a year, but that practice can attenuate the precision of the rate cells within the year.

In Massachusetts, participants in its One Care financial alignment demonstration are assigned to one of six Medicaid rating categories based on functional status, care setting, and diagnosis: (1) facility-based care; (2) very high or (3) high community LTSS need that meet a nursing facility level of care; (4) very high or (5) high community-based behavioral health needs that do not meet a nursing facility level of care; and (6) and other community-based needs. Capitation amounts paid for each category vary by region. (MassHealth 2016). Massachusetts's rate cell structure is presented in Table I.2

**Table I.2. Massachusetts One Care's Medicaid rate cell structure**

Rating category	Functional level	Diagnosis	Relative cost of rate cells (varies by region)
<b>Care setting: community</b>			
C1	Not nursing facility level of care	N/A	\$
C2A	Not nursing facility level of care	High behavioral health need	\$\$
C2B	Not nursing facility level of care	Very high behavioral health need	\$\$\$
C3A	Nursing facility level of care	High community need	\$\$\$\$
C3B	Nursing facility level of care	Very high community need based on certain diagnoses	\$\$\$\$\$
<b>Care setting: facility</b>			
F1	Nursing facility level of care	N/A	\$\$\$\$\$\$

Some states use rate structures similar to that of Massachusetts and pay the rate that corresponds directly to the rating category of each individual. An individual can change from one rating category to another on a monthly basis, which does not provide incentives for HCBS over facility placement. Massachusetts, however, delays the payment of its nursing facility rate for individuals who enter from the community. This approach is described in more detail in Section C.3.

## 2. Blended HCBS/NF rates

The most common strategy used to encourage community-based placement for all beneficiaries who meet the state's requirements for needing a nursing facility level of care is to

pay the same rate regardless of care setting. To accomplish this, a state and its actuaries add together the expected MLTSS costs for individuals in both institutional and home and community-based waiver services and multiply the resulting number by the percentage of individuals that a state aims to have residing in each of those settings.

For example, Virginia's Commonwealth Coordinated Care, one of the financial alignment demonstration programs, pays a blended rate for all nursing facility eligibles that is an average of the capitation amount paid for (1) those living in an institution and (2) those enrolled in the state's Elderly or Disabled with Consumer Direction (EDCD) Waiver. This approach is shown in Table I.3. By blending the capitation payment, Virginia provides an incentive for plans to serve members in the least costly setting (that is, in the community) (Virginia Department of Medical Assistance Services 2016).

**Table I.3. Virginia's blended rate approach**

Rate cell/eligibility category	Relative cost (varies by age group and region)
Nursing home eligible (NHE) average	\$\$\$
NHE-institutional	\$\$\$\$
NHE-waiver	\$
Community well	\$

To protect against the uncertainty of using historical data and actual enrollment across plans, Virginia proactively adjusts the rates based on the percentage of institutional and waiver use in the month before enrollment, and periodically updates the rates as new members join.<sup>8</sup> In its financial alignment demonstration, Ohio adjusts its rates semi-annually, which helps provide more revenue to health plans that have a greater proportion of high risk or high cost beneficiaries who reside in an institution, while maintaining the incentive of the blended rate to serve individuals in the community. Arizona performs a similar adjustment in the MLTSS program of its Arizona Long Term Care System, but does so retroactively through a year-end reconciliation process that aligns the actual nursing facility/HCBS mix with the expected mix. If the actual mix percentage is within one percentage point of the expected percentage, there is no change in payment. However, if the actual mix percentage is above or below one percentage point, the underpayment or overpayment is shared 50/50 between the state and the health plan (Arizona Health Care Cost Containment System 2015).

### 3. Transitional rates

When a state uses multiple rate cells that reflect variation in beneficiaries' frailty or care setting, the state may choose to adjust the timing of the placement of an individual in a different rate cell in order to provide an incentive for HCBS over institutionalization. Typically, lower HCBS rates are retained for a period of time following movement from HCBS to an NF setting,

<sup>8</sup> Memo from PriceWaterhouseCoopers to the Virginia Department of Medical Assistance Services. "Virginia Dual Demonstration MEMA Adjustment." September 30, 2013. Available at [http://www.dmas.virginia.gov/Content\\_attachments/altc/cntct-mmfa\\_cr3.pdf](http://www.dmas.virginia.gov/Content_attachments/altc/cntct-mmfa_cr3.pdf). Accessed April 7, 2016.

and higher NF rates are retained for a period of time following movement to an HCBS setting. For example, in the first year of Illinois' Medicare-Medicaid Alignment Initiative the state used five rate cells to reflect setting of care, which also varied by age band and region. From highest to lowest PMPM amount, the cells were: (1) Nursing Facility, (2) Waiver Plus, (3) Waiver, (4) Community Plus, and (5) Community, as shown in Table I.4. For individuals who transition from a nursing facility to the community to receive HCBS waiver services, Illinois paid the transitional Waiver Plus rate for the first three months following discharge. Similarly, if an individual using HCBS waiver services became eligible for nursing facility placement, Illinois paid the Waiver Plus rate for the first three months following NF eligibility, so long as the individual continued using HCBS waiver services and was not placed in an NF. The Community Plus rate was similar to the Waiver Plus rate in that it paid a transitional rate for individuals who were not enrolled in an HCBS waiver, but who remained in the community for 90 days following NF eligibility or discharge; this was done instead of moving them directly to the lower Community rate (Illinois Department of Healthcare and Family Service and CMS 2013). This structure offered a financial incentive to serve the individual in the community for some period of time, but allowed payments to align with higher costs of care if long-term placement changes. Due to difficulties operationalizing the approach, Illinois has since adopted a blended rate for nursing facility and HCBS waiver members that assumes a certain percentage of members will be served in the home or community.

**Table I.4. Illinois' transitional rate approach (Demonstration Year 1 only)**

Rate cell/eligibility category	When rate is paid on eligibility and setting of care	Relative cost of rate cells (varies by region)
Nursing Facility (NF)	NF-eligible and placed; rate paid for <90 days following first NF entry	\$\$\$\$\$
Waiver Plus	Waiver-eligible, but <90 days before or after NF entry or discharge	\$\$\$\$
Waiver	Waiver-eligible, but 90+ days before NF entry or discharge	\$\$\$
Community Plus	Not waiver eligible; rate paid for <90 days after NF entry or discharge	\$\$
Community	No waiver or NF eligibility	\$

Like Illinois, for individuals in Massachusetts who enter a facility from the community and are determined to require an NF level of care, the state will not pay the facility-based rate until an individual has been in an institution for at least 90 days, providing an incentive to quickly transition individuals who enter a facility back to the community (MassHealth 2016). Similarly, Ohio pays a transitional rate for enrollees that transition from receiving services in the community to requiring an NF level of care. For individuals in one of the three age-based "Community Well" rate cells who transition to an NF level of care, Ohio will pay the Community Well rate for the first 100 consecutive days that they spend in an NF. Beginning the month following the 101st day, the state will pay the rate for the NF level of care. Ohio will continue to pay the NF level of care rate for three full months following a transition back to the community (Ohio Department of Medicaid and CMS 2014).

#### **4. Needs-based risk adjustment**

Though rate cells alone can account for some of the variation in the cost of the enrolled population, more sophisticated risk adjustment models can stratify risk and reflect LTSS resource use regardless of setting by focusing directly on measures of enrollee health status and care needs. Additional detail is useful for rate-setting because, even among the group of beneficiaries at a nursing facility level of care, individuals have diverse LTSS needs depending on their functional status, cognitive and behavioral needs, medical condition, and access to informal supports (Kronick and Llanos 2008). Risk adjustment models can more accurately capture the relative costs of some of these variables so that payment rates better match the risk profile of the enrolled population.

Although risk adjustment models based on enrollee health status are prevalent in Medicaid managed care programs that cover acute care services, they are far less common in MLTSS programs. The main reason is that measuring health status by using the diagnoses on health care claims is a reasonably reliable predictor of acute care service use, whereas LTSS use depends more on functional limitations on activities of daily living (ADLs) and instrumental activities of daily living (IADLs), and other measures that are typically not recorded on claims for payment. Currently, no existing national risk adjustment model includes LTSS. However, several states have developed their own risk adjustment models for MLTSS, including New York, which uses data from functional assessments to adjust rates for its Managed Long Term Care and Fully Integrated Duals Advantage plan based on members' condition and needs. The state collects functional assessment data in its Uniform Assessment System (UAS), which combines information previously collected through multiple tools. The UAS is based on the Community Health Assessment by InterRAI, and includes many different variables that strongly correlate with cost, including number and type of ADLs/IADLs, disruptive behaviors, impaired behaviors, memory/speech limitations, incontinence and diagnosis (Roohan 2015). Over 20 of these variables are used to develop a risk score that predicts variation in PMPM costs for long-term care among contracted plans. Each health plan receives a risk score, which is updated annually to adjust the baseline capitation rate.

For states like New York that link functional assessment information to payment rates through risk adjustment or rate cell determination, having a uniform assessment tool can also help to streamline eligibility processes and provide better consistency in determining level of need. Assessment tools determine eligibility by evaluating a person's physical and cognitive functioning, often by reviewing limitations in ADLs and certain IADLs, along with other behavioral and clinical factors. Who performs the assessments, how consistent the information collected in the assessment is, how often the assessments take place, what triggers reassessments, and how the information is linked to payment systems—either for development of care plans, risk adjustment, or quality monitoring—can impact program performance and financial results.

#### **D. Risk mitigation**

Given the uncertainty of predicting MLTSS risk, particularly in new MLTSS programs or populations, states may wish to use risk mitigation techniques to protect the state from overpayment and the health plan from underpayment in the initial years of a program. Risk sharing, risk pools and reinsurance all reduce any incentives to underserve members or avoid

enrolling members with more costly and riskier profiles by transferring some of the risk back to the state or other contracted health plans.

## 1. Risk sharing

In a risk sharing arrangement, the state retains full or partial responsibility for costs above the aggregate capitation payments that exceed a predetermined threshold, or risk corridor. Similarly, if actual costs are below the total capitation payments, excess amounts within the risk corridor are either fully or partially returned to the state by the health plan. There are a number of ways to structure a risk corridor. Typically, risk corridors are symmetrical and establish an equal threshold above or below total capitation payments, although they can be asymmetrical and allow the thresholds to differ. The thresholds, or amount of risk shared, are often tiered. In addition, in integrated programs like the financial alignment demonstrations, the shared risk can be distributed across multiple payers (that is, Medicaid and Medicare) in proportion to their contributions.<sup>9</sup>

In its One Care demonstration, Massachusetts used a two-sided symmetrical risk corridor to protect the state, CMS, and health plans from risk in the first three years of the program (Table 5). In the first year, Massachusetts, CMS, and health plans shared the risk for gains and losses between 1 and 20 percent of the total premium paid. By the third year, the risk corridor narrowed substantially as health plans gained experience with the program, so that health plans shared 50 percent in the gains and losses that were between 4 percent and 8 percent and were fully responsible for gains and losses below 4 or in excess of 8 percent (MassHealth 2016).

**Table I.5. Massachusetts One Care risk corridor, Demonstration Year 1**

Percentage of actual costs relative to total premium paid	<80%	80–97%	97–99%	99–100%	100–101%	101–103%	103–120%	>120%
State and CMS share	0	50	90	0	0	90	50	0
Health plan share	100	50	10	100	100	10	50	100

## 2. Medical Loss Ratios

Medical Loss Ratios (MLR) are another form of risk sharing and could be considered a one-sided risk corridor, because they protect the state from paying for a health plan's excessive administrative expenses or profits, but do not protect the health plan in the event of adverse claims experience. Stated simply, the MLR represents the share of a health plan's total premium revenue that is spent on medical care. Health plans that spend a higher proportion of the premium on medical services are viewed as providing better value for the payer and consumer

<sup>9</sup> In the Massachusetts demonstration, risk of contractor gains or losses of 1.1–8.9 percent are shared with Medicare and Medicaid in proportion to their contribution. Any payments or recoveries above 8.9 percent are covered in full by Medicaid. For more details, see the Section 4.6.B.1 of the Massachusetts Three-Way Contract, available at <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassachusettsContract.pdf>.

than plans that spend a higher proportion of the premium on administrative expenses and profit margins (Dominiak and Libersky 2012).

Nearly all states participating in the financial alignment demonstration (except California and Massachusetts, which have two-sided risk corridors, and Texas, which uses an alternative MLR referred to as an “experience rebate”) require the plans in their demonstrations to meet a minimum MLR of 85 percent. Plans that spend more than the minimum 15 percent of total premiums on non-medical expenses must return the excess payment to Medicare and Medicaid in proportion to their contributions. In Virginia, plans that have an MLR of 85 to 90 percent may also be required to conduct corrective action planning or the state and CMS may recover one-quarter of the difference between 85 and 90 percent. Beginning in July 2017, MLTSS programs must also require their plans report and calculate an MLR, and if the state requires it, meet a minimum MLR of at least 85 percent.<sup>10</sup>

### **3. Risk pools**

In a risk pool arrangement, health plans gain protection against uncertainty of catastrophic risk by contributing a fixed amount to a pool that covers unanticipated costs for individuals with low frequency, high risk, and high cost conditions. Although they are not used often in Medicaid programs, Massachusetts had proposed to use risk pools its One Care demonstration for high-need users of community-based and facility based-care whose care costs exceed a certain level of spending on selected Medicaid LTSS, behavioral health, and dental services. A portion of the payment (<2 percent) that Medicaid made to plans on behalf of these two groups would have been allocated to a risk pool. At the end of each calendar year, the state would have distributed the risk pool to plans in proportion to the amount of spending on applicable LTSS, behavioral health, and dental services incurred above an established threshold amount for these high-need users (MassHealth 2016). Massachusetts eliminated high-cost risk pools for demonstration years 1-3. Risk pools have also been used in Medicaid managed care programs covering LTSS, like New Mexico’s Coordination of Long-Term Services (CoLTS) program.

### **4. Reinsurance**

Reinsurance protects a health plan from high cost, low frequency claims that can adversely impact the plan’s financial experience in a given year. Reinsurance is often used in conjunction with risk sharing to mitigate a health plan’s risk. In contrast with risk sharing, which provides financial protection from claims for a subgroup of enrollees, reinsurance protects against high costs incurred by individuals. For example, if an individual’s costs exceed \$100,000 in a given year, the costs in excess of \$100,000 can be shared or fully funded by the reinsurer. Plans may seek separate reinsurance arrangements with outside reinsurers, or the state can act as the reinsurer, covering the amounts in excess of the reinsurance threshold and adjusting the capitation payments accordingly.

The Arizona Long Term Care System offers three different types of reinsurance to contracted health plans: regular, catastrophic, and transplant. Regular reinsurance covers 75 percent of the costs of reinsurance-eligible services after the deductible is met. The deductible

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<sup>10</sup> Per 42 CFR 438.8, the MLR requirement applies to managed care organizations (MCOs), and prepaid inpatient and ambulatory health plans (PIHPs and PAHPS).

ranges from \$10,000 to \$30,000, depending on the size of the health plan and whether the member is eligible for Medicare Part A. Costs above \$650,000 are covered at 100 percent. Separate catastrophic reinsurance covers members receiving certain biotech drugs, hemophiliacs, members diagnosed with Von Willebrand's disease, Gaucher's disease, and users with certain high cost behavioral health service profiles. There is no deductible for catastrophic reinsurance (AHCCCS 2015). Transplant reinsurance is available to partially reimburse contractors for the cost of care for an enrolled member who meets the transplant reinsurance criteria and requirements (AHCCCS 2010). Transplant reinsurance is not available for members who have an alternate payer (for example, Medicare or third-party liability). Bone grafts or kidney and cornea transplants do not qualify for transplant reinsurance coverage, but may qualify under the regular reinsurance program.

### **E. Pay for performance and quality incentives**

"Pay for performance" provides additional incentives for health plans to meet policy goals, achieve quality targets, or drive changes in provider behavior throughout the delivery system. States may make performance incentive payments outside of the capitation payment to plans and providers that meet certain predefined targets or measures. Alternatively, states can withhold a portion of the capitation payments and allow plans to earn it back by achieving certain metrics. CMS allows for up to 5 percent of the capitation rate to be paid as quality incentives.<sup>11</sup> Non-financial rewards can also be used, such as priority in the state's auto-assignment algorithm for high performing plans.

States participating in the financial alignment demonstrations encourage Medicare-Medicaid Plans (MMPs) to meet performance expectations through a quality withhold. States and CMS withhold a portion of the Medicaid and Medicare (Parts A and B) capitation payment, which increases in demonstration years 1, 2, and 3 (1 percent in Year 1, 2 percent in Year 2, and 3 percent in Year 3). MMPs can earn this amount back if they meet expectations on (1) a core set of quality measures related to a beneficiary's quality of life and experience of care, changes in LTSS use, changes in behavioral health services use, and overall coordination of care; and (2) state-specific measures, which include physical accessibility of buildings and equipment, language accommodations, and health care planning (Lind 2013).

### **F. Policy and operational considerations that could impact payment systems**

State MLTSS and integrated programs vary in their choice of covered populations, services, and geographical areas. States also vary in the capacity of the claims processing and information technology they use to operate a program, which will ultimately determine whether a state can put its rate-setting strategy into action. An effective rate-setting approach should take these policy and operational considerations into account to minimize the potential for payments that do not correspond to costs. The questions below can help guide states in understanding how their program's specific characteristics may impact their choice of a rate-setting approach.

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<sup>11</sup> Section 42CFR 438.6(b)(2) and CMS Rate-Setting Checklist, November 10, 2014.

- **Does the program enroll eligible groups on a voluntary or mandatory basis?** States that allow voluntary enrollment may be particularly affected by selection bias, which can happen when a health plan has the opportunity to enroll healthy individuals who generate low costs and avoid less healthy individuals who generate higher costs. To mitigate selection bias, states should develop policies and financial strategies to discourage disenrollment of high risk individuals by, for example, allowing disenrollment only for specified reasons and penalizing plans that have unusually high disenrollment rates. In addition, incentives to disenroll high-risk individuals or cherry-pick low-risk individuals can be reduced by using risk adjustment or paying appropriate rates for these individuals.
- **By how much does the program intend to increase access to HCBS?** MLTSS and integrated programs offer states the opportunity to expand HCBS services to beneficiaries who may have been on waiting lists for services, or to allow access to LTSS services for a broader population. Any anticipated increase in enrollment should be reflected in a state's financial projections. If a state is paying blended rate, it may need to reflect the change in enrollment in its assumed NF/HCBS mix percentage.
- **Does the program exclude, or “carve out,” certain covered LTSS from the capitation rate?** To the extent that services that are carved out (for example, certain types of institutional services) can substitute for services that are carved in (for example, more cost-effective HCBS), states should develop strategies to ensure only those individuals who require them are placed in carved-out service settings.
- **Can the state's MMIS provide data to support the rate structure?** Some rate-setting approaches, including transitional NF/HCBS rates, require sophisticated tracking and assessment data to support payment. If the rate-setting structure is too complex, a state's MMIS may not be able to properly administer the capitated payments. States that use transitional rates may need to develop new rate codes in order to pay rates for individuals who transition between care settings over varying lengths of time. States that use rate categories that are dependent on diagnostic data (for example, to flag members with Alzheimer's disease and dementia) may have difficulty obtaining those data for Medicare-Medicaid enrollees, because most diagnostic information is on Medicare hospital and physician claims. States can obtain Medicare claims data for dual Medicare-Medicaid enrollees from CMS, although this can be a time-consuming process. If the health plan providing Medicaid MLTSS also covers Medicare services for dual enrollees, the state should be able to receive Medicare encounter data (with diagnoses) for those enrollees directly from the plan.
- **Is the state collecting and effectively using LTSS encounter data from health plans?** In the absence of complete and reliable encounter data on the LTSS provided by managed care plans and the costs of those services, adjusting future capitated rates and monitoring health plan performance and quality of care will be impaired. States pursuing financial alignment demonstrations or Dual Eligible Special Need plans (D-SNP) contracting should include in their contracts a requirement that health plans send both Medicaid and Medicare encounter data directly to the state.



- **Does the state have the capacity to collect and regularly update data on functional limitations that are not collected on health care claims for payment?** If such information is not available from enrollee surveys or periodic independent care needs assessments, it will be difficult for a state to use sophisticated risk adjustment methods for MLTSS. For states that have this capacity and link assessment information to payment rates through risk adjustment or rate cell determination, having a uniform assessment tool can also help to streamline eligibility processes and provide better consistency in determining level of need. Who performs the assessment will also impact payment. For example, health plans that perform the assessment that is used to set their capitation rates have an opportunity to game assessments so that the services they do (or do not) authorize increase their profit. In this scenario, states should review and monitor the assessment data—a task requiring a sufficient number of knowledgeable staff.
- **Does the state determine MLTSS eligibility in a timely manner?** Unnecessary delays in determining LTSS eligibility can cause a person’s condition to deteriorate and may result in extended stays in a nursing facility, making it difficult for that individual to transition back to the community. Institutional stays in turn can impact payment rates and the mix of nursing facility and community-based enrollees in MLTSS and integrated programs. To reduce unnecessary delays, states should consider adopting a “no wrong door” philosophy, so that regardless of the consumer’s point of entry, an eligible person either receives LTSS services or can learn about all LTSS services available to them. States may also consider using a standardized preadmission screening tool for nursing facility admissions, regardless of payer, to reduce nursing facility placements ahead of MLTSS eligibility determination, as New York does (Engquist, Johnson, and Johnson 2010). Moreover, states could require in their contracts with health plans that preadmission screening for medical eligibility be scheduled within a certain (limited) period of time.

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## II. CONCLUSION

Financial payment strategies and incentives for MLTSS are as varied as the programs themselves. Certain fundamental principles, however, are critical to an effective payment strategy. Paying appropriate capitation rates, promoting the use of home and community-based services over utilization of nursing facilities when appropriate, and coordinating quality oversight and monitoring are key to maximizing value and minimizing any adverse consequences of an MLTSS or integrated program.

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## **APPENDIX A**

### **MEDICAID RATE-SETTING APPROACHES IN STATES WITH FINANCIAL ALIGNMENT INITIATIVES AND SELECTED STATES WITH LONG-STANDING MLTSS PROGRAMS**

**Table A.1. Medicaid rate-setting approaches in states with financial alignment initiatives and selected states with long-standing MLTSS programs**

State and program	Eligible population and enrollment requirements <sup>a</sup>	Services excluded from capitation <sup>a</sup>	Rate structure	Risk adjustment	Risk mitigation
Arizona Long Term Care System <sup>b</sup>	Mandatory enrollment of elderly and physically disabled (EPD) at an NF LOC statewide	None	Blended NF/HCBS rate with annual reconciliation process for mix percentage that exceeds +/-1% of assumed NF/HCBS mix in the capitation payments	Four rate cells, which vary by region: (1) EPD dual eligibles, (2) EPD non-dual eligibles, (3) prior period coverage rate, and (4) acute care only rate	State-sponsored reinsurance provides reimbursement for 75% of costs in excess of a deductible; also offers separate reinsurance for specific catastrophic conditions and transplants
Illinois Medicare-Medicaid Alignment Initiative <sup>c</sup>	Adult dual eligible beneficiaries in 21 counties grouped into 2 regions; excludes beneficiaries with developmental disabilities	ICF/MR services	Year 1: Transitional NF/HCBS rate; transitional rates paid for 90 days following NF admission or discharge. Future years: blended NF/HCBS rate. <sup>i</sup>	Five rate cells: (1) Nursing Facility, (2) Waiver, (3) Waiver Plus, (4) Community, and (5) Community Plus; Waiver Plus and Community Plus serve as “transitional” rates; rates also vary by age band and region	Minimum MLR of 85%; excess payments will return to Medicare and Medicaid in proportion to their contributions
Massachusetts Demonstration to Integrate Care for Dual Eligible Individuals (One Care) <sup>d</sup>	Non-elderly adult dual eligible beneficiaries in 1 partial and 8 full counties.	DD targeted case management services and mental health rehabilitation option services  (Note that demonstration adds supplemental diversionary behavioral health and community support services, and expanded Medicaid state plan benefits.)	Transitional NF/HCBS rate; six rating categories based on clinical status, care setting, and behavioral health need; community-based rates paid for 90 days following NF admission	Based on rating categories; initial assignment to rating categories based on scores from the MDS-HC assessment or length of stay in a facility	Symmetrical risk corridors used in Years 1–3. In Year 1, plans bear 100% of gains or losses ≤1% or >20%. Plans bear 10% and the state and CMS bear 90% of gains or losses from 1.1-3%. Plans bear 50% and the state and CMS bear 50% of gains or losses from 3.1%–20%. By Year 3, plans share 50% of gains or losses between 4% and 8%. Plans bear 100% of

**Table A.1.** (continued)

State and program	Eligible population and enrollment requirements <sup>a</sup>	Services excluded from capitation <sup>a</sup>	Rate structure	Risk adjustment	Risk mitigation gains and losses <4% or >8%
New York Fully Integrated Duals Advantage (FIDA) <sup>e</sup>	Adult dual eligible beneficiaries in 8 counties who require (1) NF or NF diversion, and (2) transitional HCBS waiver services or more than 120 days of community-based LTSS. Includes people who meet or are at risk of NF-LOC, or are “community well.”	Out-of-network family planning, directly observed therapy for TB, and methadone maintenance	Blended rate; prospective risk adjustment based on functional assessment; NF transition add-on is being used as the state moves from voluntary to mandatory enrollment of members residing in an NF	Single, blended rate cell, which varies by region. Each rate is risk adjusted based on functional status assessment scores	Minimum MLR of 85%
Ohio MyCare Integrated Care Delivery System (ICDS) <sup>f</sup>	Adult dual eligible beneficiaries in 29 counties grouped into 7 regions; mandatory enrollment for Medicaid services; excludes beneficiaries with an ICF/MR LOC	Habilitation and targeted care management for people with I/DD	Blended NF/HCBS rate (NF-LOC rate); Transitional Community Well rate paid for first 100 days of NF facility stay, if not otherwise in an HCBS waiver; NF-LOC rate paid for 3 months following transition to Community Well	Four rate cells, which also vary by region: (1) NF-LOC, (2) Community Well ages 18–44, (3) Community Well ages 45–64, and (4) Community Well ages 65+; NF-LOC rates adjusted semi-annually to reflect proportional enrollment in institutions and the Community Waiver (by three age bands) in each plan	Minimum MLR of 85%; excess payments will return to Medicare and Medicaid in proportion to their contributions

**Table A.1.** (continued)

State and program	Eligible population and enrollment requirements <sup>a</sup>	Services excluded from capitation <sup>a</sup>	Rate structure	Risk adjustment	Risk mitigation
Tennessee CHOICES <sup>g</sup>	Mandatory enrollment of elderly and physically disabled at NF-LOC or risk of NF-LOC	Pharmacy provided through separate PBM	Blended HCBS/NF rate for CHOICES 1 & 2, separate rate for CHOICES 3 (at-risk population)	Two rate cells, which also vary by region: (1) NF-LOC and (2) at risk of NF-LOC; rating categories are adjusted annually to reflect proportional Institutional/HCBS enrollment across plans	None
Virginia Commonwealth Coordinated Care <sup>h</sup>	Adult dual eligible beneficiaries in 104 localities grouped into 5 regions; excludes residents of ICF/MRs or long stay hospitals, DD waiver participants, and hospice patients	Medicaid targeted case management services and case management services for beneficiaries in assisted living	Blended HCBS/NF rates for nursing-home eligibles; separate transitional rates for Community Well; NF rate is paid for 2 months following the transition to Community Well	Four rate cells, which also vary by region: (1) NF eligible ages 21–64; (2) NF eligible ages 65+; (3) Community Well ages 21–64; (4) Community Well ages 65+; rating categories are adjusted every 180 days to reflect proportional Institutional/HCBS enrollment across plans	Minimum MLR of 85%; excess payments return to Medicare and Medicaid in proportion to their contributions

Sources: <sup>a</sup> Kaiser Commission on Medicaid and the Uninsured (KCMU). “Financial and Administrative Alignment Demonstrations for Dual Eligible Beneficiaries Compared: States with Memoranda of Understanding Approved by CMS.” Washington, DC: Kaiser Family Foundation, November 2013. Table 1. Available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/11/8426-05-financial-and-administrative-alignment-demonstrations-for-dual-eligible-beneficiaries-compared1.pdf>. Accessed May 16, 2016.

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<sup>c</sup> Illinois Department of Healthcare and Family Service and CMS 2013.

<sup>d</sup> MassHealth 2016.

<sup>e</sup> Contract Between United States Department of Health and Human Services Centers for Medicare & Medicaid Services In Partnership with State of New York, Department of Health. Issued July 3, 2014. Available at <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/NewYorkContract.pdf>. Accessed April 8, 2016

<sup>f</sup> Ohio Department of Medicaid and CMS 2014.

<sup>g</sup> TennCare. Statewide Contract with Amendment 3—January 1, 2016. Available at <https://www.tn.gov/assets/entities/tenncare/attachments/MCOStatewideContract.pdf>. Accessed April 8, 2016.

<sup>h</sup> Virginia Department of Medical Assistance Services, 2016.



**Table A.1.** *(continued)*

<sup>i</sup> Email correspondence with Laura Phelan, Illinois Department of Healthcare and Family Services. May 24, 2016.

Notes: Generally, the financial alignment demonstrations allow eligible beneficiaries to choose to enroll with a health plan on a voluntary basis before they are passively enrolled. Financial alignment demonstrations cover all Medicare and Medicaid services, except Medicare Hospice. Exceptions are noted in the table.

ALF = assisted living facility; HCBS = home and community-based services; ICR/MR = intermediate care facilities for individuals with mental retardation; I/DD = intellectual and developmental disabilities; LTSS = long term services and supports; Medical Loss Ratio = MLR; MDS-HC = minimum data set-home care; NF = nursing facility, LOC = level of care; PBM = pharmacy benefit manager; TB = tuberculosis.

## **APPENDIX B**

### **MEDICARE ADVANTAGE RATE-SETTING**

## **APPENDIX B**

### **MEDICARE ADVANTAGE RATE-SETTING**

For Medicare-Medicaid enrollees, Medicare is the primary payer for most acute care services, including hospital, physician, and short-term skilled nursing facility services. Medicare also covers services that may overlap in complex ways with Medicaid LTSS, including skilled nursing facility, home health, durable medical equipment, hospice, and transportation services.<sup>1</sup> Understanding what Medicare covers, how these services are incorporated in Medicare managed care benefit packages, and how Medicare Advantage (MA) adjusts risk based primarily on acute care diagnoses can help states work with Medicare managed care plans to better coordinate Medicare and Medicaid services.

Because states will have little interaction with rates paid for FFS or Original Medicare, this appendix focuses on rate-setting in Medicare Advantage. States that are interested in learning more about rate-setting in the financial alignment demonstrations can refer to guidance released by CMS (CMS 2013b).

#### **Rate-setting in Medicare Advantage (Part C)**

Medicare sets the MA payment to account for the difference between (1) an MA plan's bid amount to cover Parts A and B for a standard enrollee, and (2) the county benchmark, which is based on per capita Medicare FFS expenditures. Plans that bid above the benchmark are paid a base rate equal to the benchmark plus a basic premium from enrollees that, taken together, equals the bid amount. Plans that bid below the benchmark receive a base rate equal to a standard bid as well as rebates from CMS that must be returned to enrollees in the form of lower premiums, reduced cost sharing, or—especially for plans that specialize in serving Medicare-Medicaid enrollees—additional benefits (MedPAC 2015a).

#### **Rate-setting in Medicare Part D**

Like MA, Medicare's payments to stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs) are determined through a competitive bidding process. Plans submit annual bids based on expected costs for the average Medicare beneficiary, accounting for administrative costs and federal reinsurance subsidies. CMS then adjusts payments to plans to reflect the actual health status of the enrollee and the enrollee's premium, which CMS subsidizes at approximately 75 percent of the average bid (the actual premium can be higher or lower depending on the cost of the plan) (MedPAC 2015b).

#### **Risk adjustment**

Medicare uses beneficiaries' characteristics, such as age and prior health conditions, and a risk adjustment model—the CMS–Hierarchical Condition Category (CMS–HCC) system—to develop a measure of their expected relative risk for covered Medicare spending. The payment for an enrollee is the base rate for the enrollee's county of residence, multiplied by the enrollee's

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<sup>1</sup> See Medicare Basics brief for more description of the methodology used to set rates for each Medicare service: <http://www.integratedcareresourcecenter.com/PDFs/ICRC%20Medicare%20Basics.pdf>.

risk measure, also referred to as the CMS–HCC weight. Variants of this risk adjustment model are also used for Part D and beneficiaries with end stage renal disease.

**Star ratings**

MA plans that have high quality rankings (referred to as star ratings) have bonus amounts added to their benchmark levels. Star ratings are based on 47 performance measures that are derived from plan and beneficiary information collected in three surveys—HEDIS®, CAHPS®, and HOS—and administrative data. Payments are available to plans that have received four or more stars and can add five percentage points to the plan-wide benchmark payment rate. Beginning in 2017, CMS will adjust star ratings to reflect the socioeconomic status of individuals enrolled in each plan, represented by low income subsidies, dual eligibility Medicare and Medicaid, and/or disability status (CMS 2016).

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