Rate-Setting Strategies to Advance Medicaid Managed Long-Term Services and Supports Goals: State Insights

Tuesday, August 16, 2016
1:00 - 2:30 pm ET

Made possible by the West Health Policy Center
About the Center for Health Care Strategies

CHCS is a non-profit policy center dedicated to improving the health of low-income Americans

Our Priorities and Strategies

- Enhancing access to coverage and services
- Advancing delivery system and payment reform
- Integrating services for people with complex needs

Best practice dissemination
Collaborative learning
Technical assistance
Leadership and capacity building
I. Welcome

II. Introduction to the Medicaid Managed Long-Term Services and Supports (MLTSS) Rate-Setting Initiative

III. MLTSS Rate-Setting Incentives to Promote Community-Based Care

IV. State Spotlight: Insights from Tennessee

V. Considerations for Risk Adjustment in MLTSS Programs

VI. State Spotlight: Risk Assessment and Family Care Capitation Rates in Wisconsin

VII. Closing Remarks
Panelists

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Wisconsin Department of Health Services
Introduction to the Medicaid Managed Long-Term Services and Supports (MLTSS) Rate-Setting Initiative

Michelle Herman Soper
Director of Integrated Care
Center for Health Care Strategies
Eight states working on refining rate-setting strategies for MLTSS and/or Medicare-Medicaid integrated care programs

- Arizona, Kansas, Massachusetts, Minnesota, Tennessee, Texas, Virginia, and Wisconsin
- Focus on using functional assessment data for risk-adjustment purposes
- Collaboration between the Center for Health Care Strategies (CHCS), Mathematica Policy Research and Airam Actuarial Consulting
- Supported by the West Health Policy Center

For information about the MLTSS Rate Setting Initiative: [http://www.chcs.org/project/medicaid-managed-long-term-services-supports-rate-setting-initiative/](http://www.chcs.org/project/medicaid-managed-long-term-services-supports-rate-setting-initiative/)
Medicaid MLTSS Rate-Setting Context

- More than 20 states have or will soon establish MLTSS programs
- Different issues in setting MLTSS program rates compared to traditional Medicaid rate setting:
  - Diverse needs of enrolled populations
  - Incentives for plans to serve beneficiaries in home- and community-based settings rather than in institutions
  - Different cost drivers
State Considerations for Developing MLTSS Program Rates/Risk Adjustment Methodologies

- State program elements that impact incentive structures or risk-adjustment methodologies
- Data systems and tools needed to collect data
- Aspects of functional status and other actuarial issues to address to improve the predictive accuracy of costs and utilization
- Resources needed by states to implement these programs
Upcoming Toolkit: *Resources for Rate Setting in Medicaid MLTSS Programs*

- **Foundational Concepts**
- **State Policy and Operational Considerations**
  - Developing Capitation Rates for Medicaid MLTSS Programs: State Considerations
  - Tennessee’s Approach to Ensuring Accurate Functional Status Data in its Medicaid MLTSS Program
  - Engaging Managed Care Plans in Medicaid MLTSS Rate Setting Activities
  - Medicaid MLTSS Risk Mitigation Strategies
- **Risk Adjustment for Functional Status**
  - Look Before You Leap: Risk Adjustment for Managed Care Plans Covering LTSS
  - Population Diversity in MLTSS Programs: Implications for Risk Adjustment and Rate Setting
  - Building Medicaid MLTSS Risk-Adjustment Models: State Experiences Using Functional Data
- **Federal and Professional Guidance**
MLTSS Rate-Setting Incentives to Promote Community-Based Care

Jenna Libersky
Researcher
Mathematica Policy Research
MLTSS Rate-Setting Objectives

- Match payment to the cost of the enrolled population
  - Degree and variation of risk will influence the complexity of the rate structure and rate-setting methodology
- Promote the policy goals of the MLTSS program
  - Especially rebalancing
- Minimize selection bias
- Meet CMS requirements in 42 CFR 438.3 – 438.8 and the actuarial rate-setting checklist
- Assure that rates can be administered and operationalized
Rate Cell Basics

• Rate cells structure rates to be paid for similar populations or services
  ► Cells are mutually exclusive categories distinguished by population characteristics
    ▪ For example, age, gender, geography, or eligibility (Medicare status, institutional versus community-based long term care)
  ► Distinguishing rate cells by diagnosis or degree of frailty (for example, nursing home level of care) is a basic form of risk adjustment

• Rates must be actuarially sound

• States *could* directly match payments to rate cells, *however*:
  ► There would be no financial incentive to increase home- and community-based services (HCBS) and reduce nursing facility (NF) placements
  ► Plans may seek to enroll members with particular rate cell classifications based on network capacity, not care needs
Transitional Rates

• Pay separate rate cells based on setting, but limit the availability of the NF rate cell to encourage the use of HCBS over NF

• Massachusetts and Minnesota use this approach

• Pros:
  ► Encourages transition of institutionalized members to the community, but incentives may not be as strong as those in a blended rate
  ► Reduces risk of under/overpayment when NF/HCBS mix is unpredictable

• Cons:
  ► Encourages plans to target particular beneficiaries over others (e.g., NF residents or HCBS)
  ► Requires sophisticated data and tracking, therefore difficult to operationalize and administratively burdensome
Pay a single blended rate for those members who meet that state’s NF level of care criteria regardless of setting
  ▶ Blend generally reflects current institutional vs. community mix, but can be adjusted each year to encourage more community care

Arizona, Kansas, Tennessee, and Virginia use this approach

Pros:
  ▶ Can provide a strong financial incentive to serve members in the community rather than in an institution
  ▶ CMS prefers states use or move toward adoption of a blended rate approach

Cons:
  ▶ Mix of members can be difficult to predict
  ▶ Plans avoid enrolling more costly NF or other institutional residents in favor of members using less costly HCBS
Operational Questions for Blended Rates

- What mix percentage should states use – the actual mix of enrollees in each plan or a target ratio that all plans should achieve?

- How often should states revise the blend – annually or more often?

- How much should states increase the blend from year to year?
  - Should the increase consider a plan’s starting point (current ratio of HCBS:NF use) or local HCBS capacity?

- Should there be a statewide blend, or should it be adjusted by region?

- How should a state incorporate transition bonuses?
  - Bonuses could include payments to plans for each long-term NF resident they successfully transition to the community
STATE SPOTLIGHT:
RATE-SETTING STRATEGIES TO ADVANCE MEDICAID MANAGED LONG-TERM SERVICES AND SUPPORTS: State Insights

Center for Health Care Strategies
MLTSS Rate-Setting Initiative
August 16, 2016
Goals for MLTSS Rate Setting

• Harness advantages of managed care
• Align incentives to accomplish key program objectives
  ▫ **Improve quality**—based on the member’s experience (person-centered approach)
  ▫ **Improve coordination** of physical and behavioral health and LTSS needs
  ▫ **Expand access to HCBS** (NF diversion/transition), ensure that HCBS are appropriate for sustained community living
  ▫ “Balance” LTSS expenditures
Approach to MLTSS Rate Setting

- Regional implementation in 2010 with multiple MCOs
- Full risk actuarially sound capitation rates (PMPMs)
  - Blended rate – NF% v. HCBS %
  - Includes medical and behavioral
  - Duals and Non-duals
  - Set by region
Approach to MLTSS Rate Setting

- Close monitoring of expense trends, responding to significant shifts
- Service setting mix targeted to support rebalancing
- Risk adjustment by service site mix
## Level of Care for MLTSS Program

<table>
<thead>
<tr>
<th>Assessment Tool</th>
<th>Submitting Entities</th>
<th>Determination</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2 levels of care</td>
<td>• Area Agencies on Aging Disability (ADRCs)</td>
<td>• Made by Registered Nurses TennCare LTSS Division</td>
</tr>
<tr>
<td>o Nursing Facility (NF) – medical eligibility for NF comprehensive HCBS</td>
<td>• MCOs</td>
<td>• Approximately 19 PAEs per per day (20-25 min each)</td>
</tr>
<tr>
<td>o At-Risk of NF medical eligibility for modified package of</td>
<td>• NFs (NF only)</td>
<td>• Performance targets</td>
</tr>
<tr>
<td>• State-specific tool – Pre Admission Evaluation</td>
<td>• 16 hospitals (NF only)</td>
<td>o ~2,500 applications per month</td>
</tr>
<tr>
<td>• Secure web-based system customized for electronic PAE submission workflow processing</td>
<td>• Must complete state and be approved as a “Certified Assessor”</td>
<td>o ~30,000 applications year</td>
</tr>
<tr>
<td>• PAE manual available at: <a href="https://tn.gov/assets/enttitie">https://tn.gov/assets/enttitie</a> tenncare/attachments/PAE ual.pdf</td>
<td>• Assessment certified by Physician, NP, PA, or Licensed Nurse, or Licensed SW</td>
<td>o Average salary</td>
</tr>
<tr>
<td></td>
<td>• NF LOC certified by NP, PA or Clinical Nurse Specialist (for NF only)</td>
<td>o 75% federal match</td>
</tr>
</tbody>
</table>

- 8 business-day turnaround court order for NF PAEs)
- **100% review of all LOC applications**, including medical evidence
Level of Care

- Assigns a weighted value to response to each ADL, ADL-related function, or skilled or rehabilitative need, based on amount of assistance required for that type and level of deficiency
- Must be supported by the medical evidence submitted with the PAE
- For HCBS PAEs only, may include documentation completed by the submitter (Applicant and collateral interview tools required)
- At least one (1) significant deficiency required for At-Risk LOC
- Score of at least 9 (out of total possible score of 26) is sufficient for approval of NF LOC
- Score < 9 may qualify for NF LOC based on safety determination if needs cannot be safely met in the community with array of services available for individuals “At Risk” of NF placement

### Acuity Scale

<table>
<thead>
<tr>
<th>ADL (or related) Deficiencies</th>
<th>Weights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Measure</td>
<td>Condition</td>
</tr>
<tr>
<td>Transfer</td>
<td>Highest value of two measures</td>
</tr>
<tr>
<td>Mobility</td>
<td>Highest value of two measures</td>
</tr>
<tr>
<td>Eating</td>
<td>0</td>
</tr>
<tr>
<td>Toileting</td>
<td>Highest value of three possible questions</td>
</tr>
<tr>
<td>Incontinence care</td>
<td>For the toileting measure</td>
</tr>
<tr>
<td>Catheter/ostomy care</td>
<td>0</td>
</tr>
<tr>
<td>Orientation</td>
<td>0</td>
</tr>
<tr>
<td>Expressive communication</td>
<td>Highest value of two possible questions for the communication measure</td>
</tr>
<tr>
<td>Receptive communication</td>
<td>0</td>
</tr>
<tr>
<td>Self-administration of medication</td>
<td>First question only (excludes SS insulin)</td>
</tr>
<tr>
<td>Behavior</td>
<td>3</td>
</tr>
<tr>
<td>Maximum Possible ADL (or related) Acuity Score</td>
<td>21</td>
</tr>
</tbody>
</table>

### Skilled Services

<table>
<thead>
<tr>
<th>Skilled Services</th>
<th>Acuity Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ventilator</td>
<td>5</td>
</tr>
<tr>
<td>Frequent tracheal suctioning</td>
<td>4</td>
</tr>
<tr>
<td>New tracheostomy or old tracheostomy requiring suctioning through the</td>
<td>3</td>
</tr>
<tr>
<td>Total parenteral nutrition (TPN)</td>
<td>3</td>
</tr>
<tr>
<td>Complex wound care (i.e., infected or dehisced wounds)</td>
<td>3</td>
</tr>
<tr>
<td>Wound care for stage 3 or 4 decubitus</td>
<td>2</td>
</tr>
<tr>
<td>Peritoneal dialysis</td>
<td>2</td>
</tr>
<tr>
<td>Tube feeding, enteral</td>
<td>2</td>
</tr>
<tr>
<td>Intravenous fluid administration</td>
<td>1</td>
</tr>
<tr>
<td>Injections, sliding scale insulin</td>
<td>1</td>
</tr>
<tr>
<td>Injections, other IV, IM</td>
<td>1</td>
</tr>
<tr>
<td>Isolation precautions</td>
<td>1</td>
</tr>
<tr>
<td>PCA pump</td>
<td>1</td>
</tr>
<tr>
<td>Occupational Therapy by OT or OT assistant</td>
<td>1</td>
</tr>
<tr>
<td>Physical Therapy by PT or PT assistant</td>
<td>1</td>
</tr>
<tr>
<td>Teaching catheter/ostomy care</td>
<td>0</td>
</tr>
<tr>
<td>Teaching self-injection</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
</tr>
<tr>
<td>Maximum Possible Skilled Services Acuity Score</td>
<td>5</td>
</tr>
</tbody>
</table>

**TN**
# Review/Validation Processes

<table>
<thead>
<tr>
<th>Medical Eligibility</th>
<th>External HCBS Reliability Audit</th>
<th>Internal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Contract with independent party – Ascend Innovations</td>
<td>• Contract with third party – Ascend Management</td>
<td>• Independent RN reviewers</td>
</tr>
<tr>
<td>• Perform in-person LOC assessments</td>
<td>• Randomized referral</td>
<td>• 5% audit sample</td>
</tr>
<tr>
<td>• Gather additional medical evidence, as applicable</td>
<td>• 50% of approved PAEs for first 6 months</td>
<td>o PAEs with a submitted 9 with an adjudicated between 7 and 11</td>
</tr>
<tr>
<td>• Independent LOC determinations</td>
<td>• 25% of approved PAEs for next 18</td>
<td>o All PAEs approved through safety determination, or to be incomplete</td>
</tr>
<tr>
<td>• Participate in hearings</td>
<td>• Subsequent volume</td>
<td>through a safety determination</td>
</tr>
<tr>
<td></td>
<td>• In-person assessment, including applicant and collateral interviews, observations, and record</td>
<td>o 50% of all safety denials</td>
</tr>
<tr>
<td></td>
<td>review</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Assessment review</td>
<td>• Focus Audits</td>
</tr>
<tr>
<td></td>
<td>• Quality review, including material item</td>
<td>o New RN reviewers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o New program or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>o Areas of high deficiency, determined by</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Independent Care Unit also conducts chart including LOC</td>
</tr>
</tbody>
</table>
Quality Assurance

• Error = discrepancy between submitted and approved score as supported by medical evidence
• High impact error = PAEs submitted with score of ≥ 9 (sufficient for NF LOC), but approved with score < 9
• High impact error rate ~ 20% per month (> 500 applications)
• Monitored by submitting entity type (AAADs, MCOs, NFs) and by submitting entity (each AAAD, MCO, and NF)

Quality Improvement

• Review PAEs to identify trends/specific areas of concern
• Conduct webinars and/or issue training newsletters to address areas of concern
• Contact submitting entities with highest rates of high impact errors to share error rate
• Provide targeted training and technical assistance
• $2,000 per occurrence sanction for MCOs (may be doubled if caseload requirements not met)
• Monitor subsequent submissions

LTSS monitors and addresses high impact error rates in LOC determination process.
Using Functional Data for Rate Setting

Experience to Date

- Capitation payment, inclusive of physical and behavioral health and LTSS, differs based on level of care (NF vs “At Risk”)
- Capitation payment blended across NF and HCBS groups (for NF eligible population) and risk adjusted by service setting (relative mix of NF vs HCBS)
- Functional data used to help establish new capitation payment for individuals with lesser functional needs (i.e., “At Risk” of NF placement) in 2012

Future Opportunities

- Improved options for risk adjustment in the LTSS component of the capitation payment, using functional assessment data (from LOC assessment or MDS)
- Would require:
  - Process/ system modifications to begin collecting annual reassessment data
  - Processes to review/validate
- In new MLTSS program for I/DD, Supports Intensity Scale assessment data could also be utilized
- Additional incentives for system balancing and quality improvement related to person centered practices and member experience
THANK YOU

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Considerations for Risk Adjustment in MLTSS Rate Setting

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MLTSS Rate Setting - Overview

- Many states are expanding or creating Medicaid Managed Long Term Services and Supports (MLTSS) and/or Medicare-Medicaid integrated care programs
- Success of programs depends in part on:
  - Carefully structured rates that address diverse needs of enrolled populations
  - Incentives to promote higher quality services and cost-effective care
- Age, geographic region and race/ethnicity influence the type, amount, and duration of long term services and supports (LTSS) use
- LTSS costs are more strongly correlated with setting of care, activities of daily living (ADLs), instrumental activities of daily living (IADLs), certain diagnosis codes and other non-traditional variables
MLTSS Cost Drivers

- Setting of care
  - Members residing in the nursing facility are generally two to three times the cost of members residing in the community

- Diagnosis
  - Specific neurological or musculoskeletal diagnoses such as Alzheimer’s/dementia, Parkinson’s/multiple sclerosis and paralysis drive LTSS needs
  - Behavioral health conditions coupled with medical conditions exacerbate the cost of care

- ADLs/IADLs
  - Number and type of limitations are strongly correlated with LTSS costs
Other non-traditional variables

- Behavioral indicators
- Communication and cognition
- Health services/treatments
- Specific health conditions
- Availability of natural supports and family caregivers
Why MLTSS Risk Adjustment?

- More accurately predicts risk of the enrolled population
- Provides more equitable payments between health plans with strong financial incentives to provide care in the most cost effective setting
- Minimizes selection bias and limits gaming
- Recognizes diversity of enrolled population
- Supports managed care plans and/or providers that prefer to specialize in specific population groups
Why Standard Risk Adjustment Models Don’t Work for MLTSS Rate Setting

- Traditional risk adjustment methods used in Medicaid rate setting rely on demographic and diagnosis information to predict costs
  - Less predictive of risk for MLTSS programs
- Risk adjustment methods using functional assessment data more accurately predict risk of enrolled population using LTSS
  - MLTSS risk models using functional assessment data are highly predictive (high R-squared)
  - Data intensive
MLTSS Risk Adjustment Data Sources

- Functional assessment data (demographics, setting of care, diagnosis, ADLs/IADLs, other non-traditional variables)
  - Level of care tool - used by states to determine eligibility for LTSS
  - Comprehensive assessment tool - used by states and/or managed care plans to identify service needs for establishing plans of care
  - Minimum Data Set (MDS)/Resource Use Groups (RUGS) – clinical assessment used to adjust nursing facility costs
  - Survey information
- Eligibility data (level of care, category of aid, setting of care, demographics)
- Encounter/claims data (setting of care, diagnosis, health service use)
- Other state agencies (e.g., restrictive measures, social determinants)
MLTSS Risk Adjustment Challenges

• No national model exists
  ➤ Sophisticated data modeling is required to develop model and refine over time

• Data availability
  ➤ Diversity of functional assessment tools
  ➤ Data systems/tools to link functional data to encounters/claims

• Data reliability
  ➤ Inconsistencies in data collection across assessors and settings
  ➤ Potential influence of financial incentives on data accuracy
  ➤ Ability to review/audit data

• State resources to support risk adjustment on ongoing basis
MLTSS Risk Adjustment Opportunities

- Strong interest from states and managed care plans to explore MLTSS risk adjustment models using functional data for rate setting
  - New York and Wisconsin are using MLTSS risk adjustment models in rate setting
  - Eight state workgroup to explore the use of MLTSS risk adjustment in rate setting
- High predictive value in New York and Wisconsin models
- Expansion of MLTSS, including enrollment of more diverse populations
- State shift towards use of uniform assessment tool
- Recent CMS guidance and new Medicaid managed care rules
- National focus on value-based purchasing strategies
Developing a MLTSS Risk Model: Key Considerations

• Data drives risk model development and variable selection
  ► Requires linkable functional assessment, eligibility and claims/encounter data
  ► Can be supplemented by other data sources

• Variables selected should be aligned with program goals and minimize gaming

• Different populations may require the inclusion of different variables and possibly different models

• A small number of variables, including ADLs, IADLs and certain diagnosis codes generally account for a majority of the predictive value

• Model development and ongoing maintenance is resource intensive
  ► Models need to be continuously monitored and refined as the program and data changes
State Spotlight:
Risk Assessment and
Family Care Capitation
Rates in Wisconsin

Michael Pancook
Health Care Rate Analyst
Division of Long Term Care
Bureau of Long Term Care Financing
8/16/16
Wisconsin’s Long-Term Care Programs

Medicaid members requiring nursing home level of care

– Individuals with physical disabilities
– Individuals with developmental disabilities
– Frail elders
Wisconsin’s Long-Term Care Programs

Major programs

- Family Care: 42,600 members
- Family Care Partnership: 3,000 members
- Program of All-Inclusive Care for the Elderly (PACE): 630 members
- Include, Respect, I Self-Direct (IRIS): 12,000 members
- Remaining county-administered 1915 (c) Waivers: 3,200 members
Family Care Covered Services

• All Medicaid long-term care services
  – State plan
  – Home and Community-Based Services Waivers
  – Care management

• Nursing home services included
Risk Assessment Tool

• Long-Term Care Functional Screen (LTCFS)
  – Began October 2001 in Family Care and Partnership
  – Expanded to other long-term care programs in 2002

• Eligibility tool for Home and Community-Based Services Waiver programs
Long-Term Care Functional Screen

• Administered during enrollment and annually or if a significant change in care needs

• Screeners
  – Enrollment staff at Aging and Disability Resource Centers
  – IRIS program staff
  – Managed care organization (MCO) staff

• On-line tool; all data stored in Long-Term Care Data Warehouse
Long-Term Care Functional Screen: Information Gathered

- Activities of Daily Living (ADLs)
- Instrumental Activities of Daily Living (IADLs)
- Medical diagnoses
- Health-related services: frequency of need for assistance
- Communication and cognitive abilities
- Behavioral and mental health needs
Capitation Rate Model

• Linear regression model
  – LTCFS information
  – Encounter data (service and care management expenditures)

• Model created for each target group

• Assigning expenditures to member attributes
## Capitation Rate Model

<table>
<thead>
<tr>
<th>Variable</th>
<th>Estimate</th>
<th>Proportion with Variable</th>
<th>Incremental Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>IADL_4-5-6</td>
<td>678.69</td>
<td>0.73365308</td>
<td>497.93</td>
</tr>
<tr>
<td>Bathing_1</td>
<td>160.23</td>
<td>0.26067366</td>
<td>41.77</td>
</tr>
<tr>
<td>Bath_Equip_Eat</td>
<td>33.69</td>
<td>0.34566284</td>
<td>11.65</td>
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<tr>
<td>Overnight_Mental Illness</td>
<td>47.50</td>
<td>0.03022446</td>
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<tr>
<td>Offensive_1-2-3</td>
<td>224.09</td>
<td>0.06860526</td>
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<td>Alzheimers</td>
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<td>0.34012662</td>
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<td>Reposition</td>
<td>424.10</td>
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<td>31.74</td>
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<tr>
<td>Ulcer Stage 3-4</td>
<td>368.98</td>
<td>0.00393017</td>
<td>1.45</td>
</tr>
</tbody>
</table>
Capitation Rates

• Separate rate for each MCO in each region it serves: 29 rates

• Risk Adjustment
  – Target group rate based on actual members enrolled during rate development
  – Blend target group rates based on projected enrollment

• Represent the average expected per member per month expenditures on long-term care and care management services for that MCO in that region
Predictive Variables: Individuals with Developmental Disabilities

- Assistance with six IADLs
- Behavioral and mental health needs
Predictive Variables: Individuals with Physical Disabilities

• Level of care category based on needed health-related services
• Ventilator-related intervention at least weekly
• Number of IADLs requiring assistance
Predictive Variables: Frail Elders

- Level of care category based on needed health related services
- Number of IADLs requiring assistance
- Level of assistance with specific ADLs
  - Toileting
  - Bathing
Challenges

• Ensuring consistency between screeners
  – Dedicated screening staff
  – Certification and re-certification

• Addressing high cost outliers
  – Interaction variables
  – Data outside of assessment tool
  – Modifications to rate development

• Incorporating changes to assessment tool
Additional Information

• Long-term care functional screen:
  https://www.dhs.wisconsin.gov/functionalscreen/index.htm

• Rate reports:
  https://www.dhs.wisconsin.gov/familycare/mcos/capitationrates.htm
Visit CHCS.org to...

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- **Learn** about cutting-edge efforts to improve care for Medicaid’s highest-need, highest-cost beneficiaries

**Watch for the MLTSS Rate Setting Toolkit coming soon:**