

Developing Capitation Rates for Medicaid Managed Long-Term Services and Supports Programs: State Considerations

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IN BRIEF

Many states are creating or expanding Medicaid managed long-term services and supports (MLTSS) programs or Medicare-Medicaid integrated care programs in an effort to control costs and improve the quality of care for people who use LTSS. To accomplish these goals, MLTSS and other integrated care programs need to use capitation rate-setting methods that address the diverse needs of the populations they serve and establish incentives to promote higher quality services and more cost-effective care. This brief examines considerations for MLTSS rate setting and spotlights the experiences of eight states -- Arizona, Kansas, Massachusetts, Minnesota, Tennessee, Texas, Virginia, and Wisconsin -- in establishing MLTSS payment rates.

Spending on long-term services and supports (LTSS) accounts for a significant share of total federal and state Medicaid expenditures, particularly for Medicare-Medicaid enrollees.¹ Many states are creating or expanding Medicaid managed long-term services and supports (MLTSS) programs or Medicare-Medicaid integrated care programs in an effort to control costs and improve the quality of care for people who use LTSS. To accomplish these goals, MLTSS and other integrated care programs need to use capitation rate-setting methods that address the diverse needs of the populations they serve and establish incentives to promote higher quality services and more cost-effective care.

Through the *Medicaid Managed Long-Term Services and Supports (MLTSS) Rate-Setting Initiative*, supported by the West Health Policy Center, the Center for Health Care Strategies (CHCS) and its partners at Mathematica Policy Research and Airam Actuarial Consulting are working with eight states – Arizona, Kansas, Massachusetts, Minnesota, Tennessee, Texas, Virginia, and Wisconsin – and national experts to develop or refine rate-setting strategies for MLTSS and/or Medicare-Medicaid integrated care programs. This brief examines considerations for MLTSS rate setting and spotlights state experiences in establishing MLTSS payment rates. It can inform the development of MLTSS capitation rates in other states.

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Major Themes in MLTSS Rate Setting

The *MLTSS Rate-Setting Initiative* identified several themes that states may want to consider in improving rate-setting and risk-adjustment methods, including those that promote the delivery of services in home- and community-based settings:

- **Attention to MLTSS rate-setting fundamentals is essential.** Regardless of the state's current approach, methodology, and capacity to risk adjust rates, it is important to ensure the accuracy and actuarial soundness of monthly capitation rates for MLTSS enrollees. This requires ongoing attention to two fundamental activities: (1) collecting accurate, complete, and timely claims and encounter data; and (2) establishing the appropriate number and type of rate cells/categories for the population groups enrolled, and periodically updating the rate cells/categories to reflect changes in the enrolled population. In addition, other activities that likely improve the accuracy and actuarial soundness of MLTSS rates include: (1) adjusting for enrollees with predictably higher service use and costs; (2) balancing ambitious versus realistic targets for the mix of institutional and home- and community-based services (HCBS) (for blended rate methods), or using other methods to incent greater use of HCBS; and (3) determining the right level of spending on care management and care coordination given their importance to people using LTSS.
- **Use of functional status data for risk adjustment is challenging.** For enrollees in managed care programs that cover primarily acute care services rather than LTSS, health status – as reflected in claims and encounter data diagnoses – can be a reasonably reliable predictor of risk and costs. For LTSS however, functional status, such as the ability to perform various activities of daily living (ADLs), may be a more reliable predictor. Risk adjusting rates for enrollees' functional status requires data that are reliable, consistent, and unbiased by managed care plans conflicts of interest. It is not enough to collect data; it is also important to validate and audit it. To make effective use of functional assessment data, states must develop capacity to link the assessment data to encounter and/or claims data. These challenges may be compounded by the use of different functional assessment tools and data systems in different state programs, for different population groups, or by different managed care plans.
- **More analysis is needed to identify the key aspects of functional status or individual characteristics that most affect costs.** States need to understand more about the predictive power of specific variables—what are the key cost drivers for this population? Are certain ADLs or instrumental activities of daily living (IADLs) more important than others in predicting costs? Given the extreme heterogeneity in the populations enrolled in MLTSS programs, are certain characteristics more predictive of costs for some population groups compared to others? How important is it to take into account housing and other social determinants of health, or the availability and use of unpaid caregivers?
- **The need for risk adjustment is affected by factors that may vary in importance from state to state.** Given the challenges and resources required, state policymakers need to carefully consider the rationale and need for risk adjustment. For which markets is it

most important—e.g., only in urban areas, or for all regions within the state? Does the number or type of contracting managed care plans and the competitiveness among them for enrollees justify risk adjustment? Is risk adjustment required to ensure fair rates across plans? Are stakeholders (e.g., managed care plans, providers, consumer advocates) supportive?

- **Payment policies beyond the capitation rate hold promise in adjusting for risk.** While setting accurate monthly capitation rates is critical, other payment policies can be used to achieve program goals. For example, to limit managed care plans' risk for the highest-cost individuals, states can use risk sharing, reinsurance, and stop-loss arrangements. To ensure and improve quality, states can use withholds or bonuses to the capitation rate to reward plans that achieve certain quality targets.

Rate-Setting Challenges in MLTSS Programs

The eight states participating in the *Medicaid MLTSS Rate-Setting Initiative* operate diverse programs. Wisconsin offers a stand-alone LTSS benefit, while the others provide a comprehensive package of medical services and LTSS. Seven states – Arizona, Massachusetts, Minnesota, Tennessee, Texas, Virginia, and Wisconsin – operate MLTSS programs through an integrated Medicare-Medicaid benefit platform or require coordination through contractual requirements. Minnesota has comprehensive MLTSS programs that focus on the frail elderly, while the other seven states operate programs that serve both the frail elderly and people with physical and/or mental health disabilities. Five states – Arizona, Kansas, Massachusetts, Virginia, and Wisconsin – also include people with intellectual or developmental disabilities in their MLTSS programs. Three states – Arizona, Kansas and Texas – include children with disabilities.

The eight states also use different approaches to set MLTSS capitation rates; risk adjust the rates paid to each managed care plan; and collect and use functional assessment data for eligibility determination and rate setting (see Appendix 1 for more information). Following are common challenges with using functional status to set MLTSS capitation rates:

1. **Diversity of functional assessment tools.** Few states have one uniform assessment tool for all LTSS populations and programs, so there are often multiple assessment forms in use that have different data elements, formats, and reporting systems. Many states do not have a complete picture of all of the data they collect for LTSS populations and/or a crosswalk to connect them.
2. **Inconsistencies in data collection across assessors.** Risk-adjustment models depend on data that are complete, objective, reliable, accurate, and timely. Several state officials and experts expressed concerns about the accuracy and reliability of data collected from assessment and care planning tools that are administered by eligibility workers and managed care plan case managers with different levels of skills and training. Most states do not conduct extensive auditing of functional assessments due to the time and costs involved.
3. **Potential influence of financial incentives on data accuracy.** Risk measurement may be subject to manipulation by managed care plans or assessors if they have a

financial incentive to increase beneficiaries' functional status scores (e.g., record greater need for assistance with ADLs to receive a higher capitation rate). To reduce the opportunity to profit from this type of gaming, states should ensure that functional status assessments are conducted by conflict-free parties such as state-employed staff or independent contractors, or states should perform regular audits and validation of managed care plan-conducted assessments.

- 4. Linking functional data to encounters/claims.** Many technical challenges are involved in capturing and linking functional assessment data with encounter or claims data, and addressing these challenges can be very resource-intensive. Given the large amount of functional status data that may be included in comprehensive assessment records, state officials said it would be helpful to know which data elements are most important for rate-setting and risk-adjustment purposes. This would help them limit the number of data fields to link, making risk adjustment more manageable. When developing a new approach to rate setting or risk adjustment, states should consider the extent to which current information technology or data systems can support new rate-setting approaches; the need for new or modified information technology systems; how long any changes to data collection processes would take to implement; and how much such changes would cost. State, managed care plan, and provider capacity to collect and report reliable functional assessment data should also be considered.

Experiences of State Leaders

New York and Wisconsin are both using sophisticated risk-adjustment approaches to set MLTSS program rates. Both states have linked functional assessment data with managed care plan encounter data and have developed risk-adjustment models to better reflect the varying risk of individuals enrolled in different managed care plans. Both states have found that functional data, particularly ADLs and IADLs, along with certain neurological diagnosis codes (e.g., Alzheimer's disease/dementia, Parkinson's disease, and paralysis including hemiplegia, paraplegia, and quadriplegia) significantly improves the predictability of expected costs, generating R-squared values² between 35 percent and 50 percent.

STATE APPROACHES TO MLTSS PROGRAM RISK ADJUSTMENT

New York

New York has four MLTSS programs that target Medicaid beneficiaries who require a nursing home level of care: (1) Managed Long Term Care (MLTC); (2) Medicaid Advantage Plus (MAP); (3) Fully Integrated Duals Advantage (FIDA); and (4) PACE. The MLTC program is the only MLTSS program that is mandatory for certain populations;³ the rest are voluntary. In November 2014, approximately 140,000 individuals, including adults with physical disabilities and frail elders, were enrolled in these programs.⁴ Each of the four MLTSS programs include all Medicaid long-term care services, including nursing home services, but vary on the inclusion of acute services and the level of integration with Medicare. For MLTC and MAP, most physical health services, behavioral health services, and prescription drugs are carved out. PACE and FIDA offer a comprehensive benefit package that includes acute care and both are coordinated with Medicare. For each program, the base capitation rate (before risk adjustment) is calculated for

each region by blending together all LTSS costs including nursing home and HCBS. While historically over 95 percent of MLTSS enrollees resided in the community, the portion of nursing home residents enrolled in MLTSS is expected to increase as New York phases in mandatory MLTSS enrollment across the state. New York contracts with 38 different managed care plans, with 86 percent⁵ of the enrollment concentrated in New York City.

New York uses the same risk-adjustment model for the MLTC, FIDA, and PACE programs. MAP is not currently risk adjusted. Risk adjustment is applied to all LTSS, plus a small number of select ancillary services such as dental, durable medical equipment, vision, and transportation. Acute care services are not included in the risk-adjustment model. The model incorporates functional data collected from the state's uniform assessment system (UAS-NY) — the functional assessment tool used to determine eligibility for most of the state's home and community based waiver programs. The initial assessment is performed by local district staff or the enrollment broker, while ongoing assessments are performed at least semi-annually by the managed care plans. The model uses demographic data as well as information collected from the UAS-NY functional tool in nine key areas: (1) functional status (i.e., ADLs, IADLs); (2) health conditions; (3) cognition; (4) communication and vision; (5) mood and behavior; (6) disease diagnoses; (7) continence; (8) treatments and procedures; and (9) skin conditions. The risk model includes 24 different variables. Some of the model's variables have changed over time, primarily due to changes in plan data reporting, as well as the transition to the new UAS-NY functional assessment tool. The variables and associated cost weights are also expected to change as the MLTSS programs expand to include new populations and services.

Wisconsin

Wisconsin has three voluntary MLTSS programs that target Medicaid beneficiaries who require a nursing home level of care: (1) Family Care; (2) Family Care Partnership; and (3) PACE. More than 44,000 individuals, including adults with physical or developmental disabilities and frail elders, are enrolled in these three programs. Each of the programs covers all Medicaid long-term care services, including nursing home services, but vary in which acute care services are included and the level of integration with Medicare. Wisconsin's base rate is calculated by blending together all LTSS costs for both nursing home and HCBS. Currently, about 20 percent of Wisconsin's MLTSS enrollees reside in an institution and 80 percent reside in the community. Wisconsin contracts with eight different managed care plans in 13 different geographic regions.

All three MLTSS programs in Wisconsin use the same risk-adjustment model for the LTSS component of the rate. For the Family Care Partnership and PACE, the acute care component of the rate is separately risk adjusted based on the Hierarchical Coexisting Condition (HCC) risk-adjustment model (also used by the Centers for Medicare & Medicaid Services (CMS) to risk adjust Medicare Advantage capitation rates). The LTSS risk-adjustment model incorporates functional data collected from Wisconsin's Long Term Care Functional Screen, the functional assessment tool that is used to determine eligibility for the state's home- and community-based waiver services. The initial assessment is performed by Aging and Disability Resource Center enrollment staff. Assessments are subsequently performed at least annually by the managed care plans. The model uses information from the functional tool in eight areas: (1) ADLs; (2) IADLs; (3) medical diagnoses; (4) health-related services; (5) target group; (6) overnight care; (7) communication and cognitive abilities; and (8) behavioral/mental health needs. Three separate risk-adjustment models were developed to reflect the different needs of each of the major population groups: adults with physical disabilities; adults with developmental disabilities; and frail elders. The current risk models include between 38 and 67 variables and combinations of variables. Model variables and cost weights are reviewed and updated every year.

Challenges Associated with Diversity of MLTSS Enrollee Characteristics

The diversity of the populations enrolled in MLTSS programs, and the potential for certain managed care plans to enroll more people with higher needs and subsequently higher costs, explains states' interest in risk adjusting capitation rates paid to each plan. Risk adjustment reduces the incentive for plans to cherry-pick lower-cost enrollees or deny needed care to higher-cost enrollees because it allows plans that enroll higher-cost enrollees to receive higher payment for those individuals. Adding functional status information to MLTSS risk-adjustment models may help to more accurately predict costs for people with different types of health conditions, and types and severity of disability.

Existing data on MLTSS enrollees provides some information on risk differences across populations, but using past years' claims and costs data to build risk-adjustment models also has limitations. For example, physical health conditions have different effects on the level of need for assistance with ADLs or IADLs. The severity of conditions can also vary over time; for example, some people experiencing traumatic brain injury may recover physical or cognitive functions, while others may have permanent impairments. Interactions between physical health conditions and behavioral health needs can increase the need for medical care and LTSS. Secondary disabilities may not be reflected in claims history. For example, many Medicare-Medicaid enrollees in the financial alignment demonstrations have been found on initial assessment to have severe mental illness (SMI) that was not indicated in their claims history.⁶ A need for durable medical equipment or home modifications may suddenly arise as a result of a fall or appear incrementally — perhaps first as a need for grab bars in the bathroom, but then later as a need for renovation of a whole house. Variation in the trajectories of disease and disability also raise questions about how frequently to assess for changes in the need for assistance.

Wisconsin's risk-adjustment model takes into account the need for assistance with ADLs and IADLs. The state has found that adding ADL/IADL scores to the model has increased its predictive accuracy by as much as 20 to 25 percent. But Wisconsin analysts have noticed the model is less accurate for people with the greatest LTSS needs and very high-costs, so the state has added a reinsurance program to protect managed care plans from the financial risk of caring for these high-cost outliers. Additionally, for people with intellectual/developmental disabilities *and* behavioral health conditions, and people with traumatic brain injury, the state finds that it is difficult to predict how much supervision is required. Some of these individuals may have challenging behaviors or other conditions that drive LTSS costs above what would be predicted by the risk-adjustment model. Traditional ADL scores are not as useful as they are for frail older adults, given the heterogeneity of individuals within each of these groups. When looking at the population overall, however, cost projections are fairly accurate. Wisconsin's risk-adjustment models predicted costs for the entire population that were just 0.3 percent higher than actual managed care plan payments in 2013, and within about one percent in 2014.

The *Medicaid MLTSS Rate-Setting Initiative* asked state participants whether costs incurred in legacy waiver programs were useful predictors of costs in a successful MLTSS program. Wisconsin found that Family Care had per member per month (PMPM) costs that were a third less than those of its legacy waiver program, based in part on limitations in the waiver program. For example, the legacy waiver programs were operated by individual counties that could not negotiate rates with providers as effectively as the current MLTSS plans, due to the small number

of members they were serving and a smaller geographic reach. Wisconsin's current MLTSS plans cover multiple counties and have higher membership. This allows the MLTSS plans to negotiate better rates and seek out the most efficient providers. MLTSS plans are also able to better leverage data, right-sizing services to members through the use of more sophisticated algorithms and data analytic tools.

MLTSS enrollees with different needs can require different levels of care management, and states take different approaches to setting the portion of the MLTSS payment rate devoted to these services. Minnesota has found that people with SMI can have very high care management needs and often benefit from having a case manager who specializes in serving this population to deliver targeted case management (a billable service) and also to serve as the care coordinator for the enrollee (an administrative function of the plan). While having the same individual provide related services may result in less confusion for the enrollee and can increase administrative efficiencies, it can create challenges for allocating and reporting care management costs between medical and administration, and even between Medicare and Medicaid when the model is integrated. Tennessee's experience has taught it that managed care plans need tools to manage costs in addition to care management, such as expenditure caps and benefit limits. Complicating the issue, as Medicare has begun to cover care coordination with a Complex Care Management payment, states wondered if they are duplicating payments for care management for dually eligible enrollees.⁷

Although the heterogeneity of the MLTSS population can be overwhelming, and data may not be available to examine every source of variation, it is still important to focus on key drivers of differences in enrollee costs and aim to improve accounting for differences rather to hold out for a "perfect" model. State participants in the *Medicaid MLTSS Rate-Setting Initiative* agreed that rate setting should not try to address all outliers since there are other mechanisms, such as reinsurance and stop-loss provisions, to deal with these cases. Questions remain about whether cost drivers differ for dually eligible individuals and Medicaid-only populations, and how to account for efficiencies and quality outcomes that accrue when a plan is responsible for covering a comprehensive benefit package of medical care and LTSS versus one that is limited to LTSS.

Additional Research Questions

Several important policy questions related to rate-setting and risk-adjustment models will require additional research:

- Should the use of natural supports and family caregivers factor into rates?
- How can payment incentives be used to drive quality and outcomes in MLTSS?
- Should social determinants of health be considered in rate setting, and how can this best be accomplished?

1. Natural supports and family caregivers

The availability of unpaid family caregivers and natural supports can have a significant impact on costs. For that reason, managed care plans have an incentive to tap natural support networks and provide respite and other supports to family caregivers when it can reduce the overall cost of care. States can also allow family members to be paid caregivers. But the consensus among

states participating in the *Medicaid MLTSS Rate-Setting Initiative* was that rate-setting and risk-adjustment methodologies should not take into account unpaid caregiver support because there is no way to fairly account for differences. Following are potential policy questions for further analysis:

- What are the best strategies to take advantage of family caregiver supports and reduce overall LTSS costs?
- What are the best ways for states and managed care plans to identify the availability of appropriate paid and unpaid caregivers to help meet the individual's needs?
- What resources and supports do family caregivers need to remain engaged in providing care on an on-going basis?
- Under what circumstances does it make economic sense for health plans to pay family caregivers for some or all of the support services they provide?
- How can self-direction and individual budgets be incorporated into the care plan to encourage the most cost effective use of supports and services, including paid or unpaid family caregiver supports?

2. *Quality, outcomes and incentives*

To drive better value in MLTSS programs, states recognize the need to measure and monitor quality and outcomes and reward managed care plans that have achieved the state's performance targets. Pay-for-performance programs provide financial opportunities beyond rate setting to incent managed care plans to meet policy goals, achieve quality targets and outcomes, or drive change throughout the delivery system. Pay-for-performance rewards managed care plans and providers for achieving certain pre-defined targets or measures by providing incentive payments outside of the capitation payment. Payments can also be funded by withholding a portion of the capitation and allowing plans to "earn" it back if certain metrics are achieved. CMS allows for up to five percent of the capitation rate to be paid as quality incentives. Following are potential policy questions for further analysis:

- What are the appropriate measures to evaluate quality and outcomes in MLTSS? Which measures should be tied to pay-for-performance incentives?
- Do bonuses or withholds provide stronger incentives to managed care plans and/or providers?
- What other non-financial strategies are most effective in achieving quality and outcome targets (e.g., public reporting, auto-assignment algorithm)?
- Can functional data and risk adjustment be used to measure quality and outcomes more equitably and identify areas for improvement?
- Are there other quality levers – besides focusing on transitions out of nursing facilities – that can keep people from entering an institution in the first place?

3. Social determinants of health

Social and economic conditions, such as whether an individual has safe and affordable housing, employment, good nutrition, social supports, transportation, and access to education and information in their language or at an appropriate reading level, can significantly impact a person's health risk. Addressing the social determinants of health and improving a person's quality of life have the potential to reduce future health care costs and improve outcomes.

Following are potential policy questions for further analysis:

- How can the rate-setting process be used to incent innovative approaches for managed care plans and providers to support social determinants of health?
- What managed care plan and provider strategies have been most effective in improving a person's quality of life while reducing LTSS and other health care costs?
- What data should be used to measure and monitor the effects of policy and interventions on the social determinants of health, and how can that data be accessed?
- What variables that influence the social determinants of health are most predictive of future LTSS costs and resource needs?
- Which social variables should be considered/not be considered for inclusion in a rate-setting or a risk-adjustment model?

Conclusion

Developing and refining MLTSS payment rates requires attention to the basics (e.g., having accurate and timely data, establishing appropriate rate cells, etc.) as well as consideration of more advanced approaches such as when and how to risk adjust rates and how to leverage other payment policies in conjunction with payment rates to achieve policy goals. States at the forefront of MLTSS rate setting face common challenges, including linking functional assessment data to encounter and claims data and building models that account for the diversity of MLTSS program enrollees.

Over the coming months, the *Medicaid MLTSS Rate-Setting Initiative* will develop technical guidelines for states that go beyond the basics of MLTSS rate setting. The guidelines will offer actionable approaches and synthesize common elements that most states would tackle when developing an advanced MLTSS methodology that incorporates functional assessment and other data. The guidelines will cover lessons from states' experiences with testing and applying new approaches to rate setting and risk adjustment, and steps to take when using functional assessment data for risk adjustment. They will also discuss strengths and weaknesses of sources of functional status data, how to collect and access these data, and cautions or considerations when using the data in rate setting and risk adjustment, including information on the degree to which certain data elements predict cost. The technical tool will be released in 2016, along with a webinar highlighting its findings and implications for states with various types of MLTSS programs.

Appendix 1: Overview of State MLTSS Programs and Risk-Adjustment Approaches^b

STATE/ PROGRAM(S) ^c	REGION	ENROLLMENT ^d	PROGRAM DESIGN, BENEFITS AND POPULATIONS ^e	RISK ADJUSTMENT FOR LTSS USING FUNCTIONAL STATUS	USE OF LTSS RATE CELLS
Arizona^f MLTSS (Arizona Long Term Care System (ALTCS)) <i>Established 1989</i>	Statewide	Mandatory ALTCS: 57,178; ALTCS enrollees in aligned MLTSS plans/D-SNPs: 8,997	<ul style="list-style-type: none"> Aligned MLTSS/Dual Eligible Special Need Plan (D-SNP) platform.^g ALTCS plans cover all Medicaid benefits (primary, acute, LTSS, prescription drugs, and behavioral health) and Medicare services for enrollees who choose to be in aligned plans. Serves children, individuals with disabilities, individuals with intellectual/developmental disabilities (I/DD), and adults over age 65. 	No	Yes. For each geographical service area and plan, based on Medicare eligibility, use of LTSS.
Kansas MLTSS (KanCare) <i>Established 2013</i>	Statewide	Mandatory Approximately 35,000 enrollees	<ul style="list-style-type: none"> Comprehensive Medicaid managed care program; benefits include all Medicaid acute, behavioral health, and LTSS. Serves children, individuals with disabilities, individuals with I/DD, and adults over age 65. 	No	Yes. Blended rate based on mix of HCBS waiver and NF enrollment for elderly and physically disabled. Separate rate cells by age group for I/DD.
Massachusetts Capitated model financial alignment demonstration (One Care) <i>Established 2013</i>	Limited to 9 of 14 counties	Voluntary (and some passive enrollment) 12,366 enrollees (not all use LTSS)	<ul style="list-style-type: none"> The capitation rate includes all Medicare and Medicaid benefits and some additional Medicaid benefits including diversionary behavioral health services, vision, dental and expanded community based services. Serves individuals with disabilities, including individuals with I/DD who are between the ages of 21-64 at the time of enrollment. 	No. However, rating categories are a determinant used to establish the capitation rates. The rating categories are initially determined based on the member’s claims history. The rating category may be adjusted to reflect ongoing needs based on functional status data captured by plans during initial and ongoing assessments.	Yes. Rate cells include: community other; behavioral health (high, very high); and LTSS needs in community (high, very high) and residing in institution for 90+ days.

^b Many of the same considerations discussed in this paper are relevant to PACE, but PACE programs are not a primary focus of the *Medicaid MLTSS Rate Setting Initiative*.

^c Several participating project states (KS, MA, TX, TN, VA and WI) have PACE programs.

^d If not otherwise indicated, dates of enrollment figures were from the most recent available data provided by state participants upon review of the figures in December 2015.

^e P. Saucier and B. Burwell. “Population Groups Enrolled in Managed Long Term Services and Supports.” Truven Health Analytics, July 2012. Available at: <http://www.medicare.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltss-populations.pdf>.

^f In March, 2014, CMS awarded planning grants to nine states, including Arizona and Minnesota, to test quality measurement tools and demonstrate e-health in Medicaid community-based LTSS. The grant program, known as Testing and Experience Functional Tools (TEFT), is designed to field test an experience survey and a set of functional assessment items, demonstrate personal health records, and create a standard electronic LTSS record.

^g An aligned D-SNP/MLTSS integrated platform refers to an arrangement by which states with MLTSS programs require the managed care entities offering MLTSS to offer Medicare health services through companion D-SNPs covering the same geographic area. States with MLTSS programs can also choose to contract only with D-SNPs that have companion MLTSS plans.

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Massachusetts MLTSS/D-SNPs (Senior Care Options (SCO)) <i>Established 2003</i>	Limited to 11 of 14 counties	Voluntary 39,102 (7/2015)	<ul style="list-style-type: none"> Integrated Medicare-Medicaid care based on aligned MLTSS/D-SNP platform. All Medicare and Medicaid benefits, including acute care, behavioral health, and LTSS. Serves individuals over age 65 eligible for MassHealth Standard. 	No, but uses functional status data captured from initial and ongoing assessments to assign members to rating categories. Adjustments made as necessary after additional assessment.	Yes. Based on location (Boston vs. other); community vs. institutional setting; dual status (Medicaid only or Dually Eligible); and level of need within community and institution.
Minnesota^d MLTSS/D-SNPs (Minnesota Senior Health Options (MSHO)) <i>Established 1997</i>	Statewide	Voluntary 35,251 (12/2015)	<ul style="list-style-type: none"> Integrated Medicare-Medicaid care based on aligned MLTSS/D-SNP platform for individuals over age 65. All Medicare and Medicaid benefits, including acute care, behavioral health, and LTSS (Elderly Waiver HCBS and 180 days of nursing facility care). Serves individuals over age 65. 	Yes. Uses functional status data for risk adjustment (# ADLs).	Yes, including metro vs. rural setting, add-on payments for NF-eligible individuals living community and Elderly Waiver enrollees; separate NF payment for residents who live in the community.
Minnesota MLTSS (Minnesota Senior Care Plus (MSC+)) <i>Established 2005</i>	Statewide	Mandatory 13,609 (12/2015)	<ul style="list-style-type: none"> Comprehensive Medicaid managed care program; benefits include all Medicaid acute, behavioral health, and LTSS (Elderly Waiver HCBS and 180 days of NF care). People mandatorily enrolled in managed care who are not in MSHO. Serves individuals over age 65. 	Yes. Uses functional status data for risk adjustment (# ADLs).	Yes, including metro vs. rural setting, add-on payments for NF-eligible individuals living in the community, and Elderly Waiver enrollees.
Tennessee MLTSS/D-SNPs (TennCare CHOICES) <i>Established 2010</i>	Statewide	Mandatory Approx. 30,000 enrollees use MLTSS	<ul style="list-style-type: none"> MLTSS/D-SNPs (TennCare CHOICES). Comprehensive Medicaid managed care program; benefits include all Medicaid acute, behavioral health, and LTSS. Serves adults with physical disabilities and adults over age 65. 	No	Yes. CHOICES 1 (NF services), 2 (NF-eligible; reside in community), and 3 (“at risk” for becoming NF-eligible); by dually eligible vs. Medicaid-only. Claims experience from members receiving care in NFs and NF eligible members residing in the community is used to develop per member costs based on where the member resides. These per member costs are blended based on regional MLTSS service setting patterns to create a single CHOICES rate paid for members in CHOICES 1 or CHOICES 2.
Texas Capitated financial alignment demonstration (Texas Dual Eligible Integrated Care Project) <i>Established 2015</i>	Limited to 6 counties	Voluntary; passive 55,000	<ul style="list-style-type: none"> All Medicare and Medicaid benefits, including acute care, behavioral health, and LTSS Serves individuals with disabilities and adults 65+ 	No	Yes. All members in the demonstration are dually eligible. Rates are set by service delivery area, and three risk categories (HCBS users, NF residents, and others receiving community care).

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Texas MLTSS/D-SNPs (STAR+PLUS) <i>Established 1998</i>	Statewide	Mandatory for adults; voluntary for children 280,000 dually eligible members and 235,000 Medicaid-only members	<ul style="list-style-type: none"> Requires MLTSS plans to offer D-SNPs in some counties Comprehensive Medicaid managed care program; benefits include all Medicaid acute, behavioral health, and LTSS; new nursing facility carve-in (March 2015) Serves children, individuals with disabilities, and adults 65+ 	No	Yes. Rates set by dually eligible vs. Medicaid-only; service delivery area; and 3 risk categories (HCBS users, NF residents, and others receiving community care).
Virginia Capitated financial alignment demonstration (Commonwealth Coordinated Care) <i>Established 2014</i>	Limited to select counties	Voluntary; passive 28,743	<ul style="list-style-type: none"> All Medicare and Medicaid benefits, including acute care, behavioral health, and LTSS for individuals under age 65. Serves individuals with disabilities, individuals with I/DD, and adults over age 65. Developing MLTSS program (planned launch in 2016-2017). 	No	One rate cell for LTSS users (NF and HCBS) adjusted biannually for relative distribution by plan.
Wisconsin MLTSS (Family Care) <i>Established 2000</i>	Expanding statewide	Voluntary 40,593	<ul style="list-style-type: none"> MLTSS program: covers all LTSS services in managed care, including nursing home care; Individuals enrolled receive acute, select behavioral health services, and prescription drugs via fee-for-service. Serves individuals with disabilities, individuals with I/DD, and adults over age 65. 	Yes. Uses multiple variables from assessment data to compute risk score.	Yes. For each MCO for each geographic region the MCO serves.
Wisconsin MLTSS/D-SNPs (Family Care Partnership) <i>Established 1996</i>	Limited to select counties	Voluntary 2,957 (12/2015)	<ul style="list-style-type: none"> Aligned MLTSS/D-SNP platform. Medicare and Medicaid benefits include acute care, prescription drugs, and LTSS. Serves individuals with disabilities, I/DD, and adults over age 65. 	Yes. Uses multiple variables from assessment data to compute risk score.	Yes. For each MCO for each geographic region the MCO serves.

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The Center for Health Care Strategies (CHCS) is a nonprofit health policy center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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ENDNOTES

- ¹ Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission. "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid." January 2015. Available at: https://www.macpac.gov/wp-content/uploads/2015/01/Duals_DataBook_2015-01.pdf.
- ² "R squared" is a statistical measure of a model's ability to match average predicted costs to actual.
- ³ New York's MLTC program is mandatory for individuals over the age of 21 who are: (1) eligible for both Medicaid and Medicare and need community-based long-term care services for more than 120 days; and (2) reside in New York City or Nassau, Suffolk, or Westchester counties.
- ⁴ New York State Department of Health. "2014 Managed Long-Term Care Report." Available at: https://www.health.ny.gov/health_care/managed_care/mltc/pdf/mltc_report_2014.pdf.
- ⁵ Ibid.
- ⁶ Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office. Personal communication.
- ⁷ J. Stone. "Medicare Chronic Care Management Services Payment: Implications for States Serving Dually Eligible Individuals." Integrated Care Resource Center, December 2015. Available at: http://www.integratedcareresourcecenter.net/PDFs/ICRC_Medicare_Chronic_Care_Mgt_Pmt.pdf.