

Look Before You Leap: Risk Adjustment for Managed Care Plans Covering Long-Term Services and Supports

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IN BRIEF

Many states are creating or expanding Medicaid managed long-term services and supports (MLTSS) programs to improve quality and control costs. To accomplish these goals, capitation rates paid to managed care plans should reflect the expected costs of care for the LTSS beneficiaries enrolled in these plans. This brief, supported through the West Health Policy Center, explains the role of risk adjustment in setting accurate, actuarially sound capitation rates for MLTSS plans, and the challenges in developing risk adjustment models that are suited to MLTSS programs. Risk adjusting MLTSS capitation rates to account for enrollees' functional and cognitive status may improve the accuracy of rates paid to each plan. However, risk adjustment is technically challenging, and the importance of using risk adjustment in MLTSS programs may vary based on state-specific program features, such as which population groups are enrolled, the benefits covered, whether enrollment is mandatory or voluntary, and the number and type of participating health plans. State officials should ensure they understand the benefits and challenges of adopting an MLTSS risk adjustment model for their programs.

Managed care has become an increasingly common delivery system for providing long-term services and supports (LTSS) to seniors age 65 and older and people under age 65 with disabilities who are eligible for Medicaid. The number of state Medicaid agencies that contract with managed care plans to provide LTSS has nearly tripled in the last 10 years, from eight states in 2006 to over two dozen states in 2016. The number of people enrolled in managed care programs covering LTSS nearly doubled from 916,000 in 2013 to 1.6 million in 2014.¹

In managed LTSS (MLTSS) programs, like other risk-based managed care programs, state Medicaid agencies pay fixed monthly capitation (per-person) rates to managed care plans, which are at financial risk for the costs of all contracted benefits provided to enrollees within the capitation amount. Federal law requires that Medicaid managed care capitation rates be "actuarially sound" (i.e., rates must be developed in accordance with generally accepted actuarial principles). Rates are judged to be actuarially sound if they reflect the expected costs of providing all covered benefits for each "rate cell" — categories that group enrollees by age, gender, eligibility category, and the region in which they live.² In addition, federal rules allow states to adjust rates based on enrollee health status, and most states do so for Medicaid managed care plans that cover medical care benefits, such as hospital, primary, and specialty care. But risk adjustment that specifically takes into account the expected costs of LTSS benefits based on enrollees' level of functioning or type of disability remains rare.³

This brief, supported through the West Health Policy Center, explains the role of risk adjustment in setting accurate, actuarially sound capitation rates for MLTSS plans, and the challenges in developing risk adjustment models that are suited to MLTSS. While risk adjustment is a key tool for setting equitable rates across plans, its importance may vary based on specific features of each state's MLTSS program (i.e., which population groups are enrolled, the benefits covered, whether enrollment is mandatory or voluntary, and the number and type of participating health plans). However, due to the technical complexity of risk adjustment and the difficulty of collecting reliable data on MLTSS enrollees' functional and cognitive status, state policymakers and Medicaid officials should take a close look at the costs and benefits of developing risk adjustment methods for MLTSS programs in their state before leaping into this challenging area.

Importance of Risk Adjustment to Managed Long-Term Care Supports and Services Rate Setting

Risk adjustment is a statistical method that accounts for differences in age, gender, health conditions, and other characteristics of a health plan’s enrollees in setting the payment rate for that plan (more information can be found in [Medicaid Rate-Setting for Managed Long-Term Services and Supports: Basic Practices for Integrated Medicare-Medicaid Programs](#)).⁴ By accounting for the expected cost of providing services needed by each plan’s enrollees, risk adjustment of capitation rates is an important tool for states to avoid overpayment to plans whose enrollees are healthier than average, and underpayment to plans whose enrollees are sicker than average. It also reduces the incentive for health plans to “cherry-pick” (i.e., intentionally seeking to enroll healthier beneficiaries to earn more profit) or stint on care for high-need enrollees to avoid losses. Risk adjustment is frequently used in state Medicaid programs covering medical care, such as hospital, physician, and specialty services, and several national risk adjustment models exist to adjust rates by age, gender, and health conditions — variables that are strongly correlated with expected health care costs. These models, however, do a poor job accounting for the main drivers of LTSS costs: physical and cognitive impairment. Seniors and people with disabilities have a wide variety of conditions and levels of functional impairment, both of which determine how much and how often they need assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs).^{5,6}

Some risk adjustment models have been developed to take into account functional impairment for enrollees with high LTSS needs. For example, since 2004 the Centers for Medicare & Medicaid Services (CMS) has used a risk adjustment model to adjust rates for the frailty of seniors eligible for nursing home level of care, who enroll in Programs of All-Inclusive Care for the Elderly (PACE). CMS uses a similar model to adjust rates for fully integrated dual eligible Special Needs Plans (FIDE SNPs), a type of Medicare Advantage plan that enrolls Medicare-Medicaid enrollees who need LTSS. Both models use information from self-reported physical and mental health functioning, sort enrollees into functional need categories based on difficulty in performing ADLs, and create a frailty adjuster that is added to the health risk scores for enrollees.⁸ Adding the frailty adjuster increases the models’ accuracy in predicting total health costs,⁹ but these models only adjust the Medicare portion of the capitation rate covering medical care, not the Medicaid-covered LTSS portion. To fill this gap, New York’s and Wisconsin’s Medicaid agencies developed risk adjustment models for their MLTSS programs. In both models a few key variables, primarily the level of need for assistance with ADLs and IADLs, were found to be highly predictive of LTSS costs. There are some differences in the two states’ models due to differences in populations enrolled or the way in which functional and cognitive status are assessed. New York, for instance, found that in addition to ADLs and IADLs, memory loss, incontinence, and some diagnoses were strongly correlated with LTSS costs.¹⁰ Wisconsin enrolls people with intellectual or developmental disabilities (I/DD) into MLTSS plans, as well as people under age 65 with physical disabilities and frail individuals age 65 and older, so it chose to develop different risk adjustment models for each group because it found that cost drivers varied among them.^{11,12}

Risk Adjustment in a Nutshell⁷

In Medicaid risk adjustment, a state uses data from Medicaid eligibility files and paid claims, including information about age, gender, clinical diagnoses, and other variables, to develop a predicted relative cost for each enrollee in the managed care plans in the state. The risk score for each enrollee is then aggregated into an overall score for each plan that reflects the expected cost of the plan’s enrollees, relative to the expected overall average cost per Medicaid enrollee in the state.

For example, if the average risk score for the overall Medicaid population is defined as 1.0, a healthy young man might receive a score of 0.4 based on his having relatively few indicators of high future costs. In contrast, a woman with a spinal cord injury who requires assistance outside the home might be scored at 1.5, and a senior with significant cognitive and mobility impairments who requires round-the-clock care might be scored at 2.3. A plan having an aggregate score of 1.2 for its enrollees would receive a 20 percent add-on to the state’s average monthly per-enrollee payments, while a plan with an aggregate score of 0.8 would receive an average per capita rate that was 20 percent below the average for the state.

Impact of State Program Differences on the Importance of Managed Long-Term Care Supports and Services Risk Adjustment

Despite its value in improving the predictive accuracy of capitation rates paid to each managed care plan, risk adjustment for type of disability and level of functioning that influences use of LTSS benefits remains uncommon in state MLTSS programs for a variety of reasons. Most state MLTSS programs now in operation began in the last few years; during the initial phase of implementation, Medicaid agencies tend to focus on critical things such as enrolling beneficiaries and ensuring that plans have adequate provider networks, which leaves little time and resources to develop their own risk adjustment models. Among states with more established programs, some enrolled just a few thousand beneficiaries (until recently), reducing the motivation to develop specialized risk adjustment models. Other states with long-standing and larger MLTSS programs, such as Arizona and Minnesota that serve tens of thousands of enrollees, could not effectively evaluate the need for risk adjustment models because they did not have reliable data on enrollees' functional and cognitive status — the primary drivers of LTSS costs — to analyze the association with costs.

In addition, differences in the way state MLTSS programs are designed can affect the importance of risk adjustment in setting fair and accurate capitation rates, as well as states' decisions to invest in developing a risk adjustment methodology. Following are MLTSS program design features and a discussion of how they influence the need for risk adjustment:

- **Heterogeneity of enrollees.** State Medicaid agencies are increasingly enrolling all four of the major LTSS beneficiary groups into MLTSS plans: (1) frail adults age 65 and older; (2) adults under age 65 with physical disabilities; (3) individuals with intellectual and developmental disabilities; and (4) children with disabilities. Of the 31 state MLTSS programs in operation in 22 states as of 2014, 26 enrolled more than one population group. Six programs enrolled all four target populations, 10 enrolled three population groups, and nine enrolled two groups.¹³ Plans generally serve all target populations enrolled in a program. The greater the diversity of beneficiaries enrolled in each plan, the more important risk adjustment becomes since each plan's mix of enrollees may have higher or lower levels of need and expected costs than the average. In states with programs narrowly targeted to one beneficiary group, risk adjustment is less important.
- **LTSS eligibility.** The heterogeneity of enrollees is also shaped by the level of need that qualifies beneficiaries for LTSS covered by managed care plans, since it influences the cost and utilization profile of enrollees. Nine of the 31 MLTSS programs in operation in 2014 limited enrollment to people who were certified to need an institutional level of care (LOC), as in home- and community-based services (HCBS) 1915c waiver programs. Six of the 31 MLTSS programs served individuals certified to need an institutional LOC as well as people who need some LTSS but do not meet an institutional LOC. However, more than half (16 of the 31 programs) enrolled people with or without existing LTSS needs, including individuals dually eligible for Medicare and Medicaid.¹⁴ Most of the programs in this last group are in states participating in demonstrations under CMS' Financial Alignment Initiative, whose enrollees are more heterogeneous in terms of cost and utilization patterns. The more diversity in enrollee needs, the greater the need to adjust rates to each plan to account for varying needs and expected costs based on the mix of enrollees in each plan.
- **Scope of benefits covered.** All state MLTSS programs cover both HCBS and institutional care, increasing the importance of risk adjustment to account for differences in the mix of each plan's enrollees who are at risk of institutional admission. If MLTSS programs only cover institutional care and excluded HCBS, the more predictable cost of institutional care lowers the importance of risk adjustment.

If a plan is only at risk for LTSS, and the state and/or plan does not control or have access to information about medical care, states can only develop a model to adjust for LTSS costs. However, states are increasingly requiring MLTSS plans to cover both medical care and LTSS for Medicaid-only/non-dually eligible enrollees. Among 19 MLTSS programs in 17 states that reported enrollment numbers as of July 2014, only three of the 19 programs covered only LTSS benefits to the exclusion of acute care benefits.¹⁵ When acute and LTSS benefits are combined and managed care plans are at risk for the entire spectrum of services, separate risk adjustment methodologies for each portion of the rate are generally desirable.

- **Size and number of contracting plans.** In general, the more people enrolled in a managed care plan, the lower the financial risk to the plan, since it can spread the risk across a larger population. Plans with few enrollees are at greater financial risk because a disproportionate number of high-cost enrollees can create large, unexpected financial losses. In addition, the more participating plans in a given region of the state, the greater the chance that one plan will enroll people who have a higher or lower need for LTSS than the others. Risk adjustment is more important, therefore, in states that contract with many local plans that enroll relatively few enrollees. This was one of the factors that drove New York to develop its risk adjustment model; the state contracts with more than 20 MLTSS plans, most of them in New York City, and most plans enroll fewer than 2,500 individuals. In addition to having fewer people across which to spread risk, small plans are vulnerable to risk volatility; they may be fine one year but incur very high costs the next year if more people need to enter nursing facilities. Delaware, which enrolled approximately 11,500 individuals in its MLTSS program in 2014, contracts with just two plans but both enroll about the same number of enrollees, so there is less chance that the two plans have very different risk profiles.
- **Mandatory versus voluntary enrollment.** In the majority of state MLTSS programs, enrollment in MLTSS is mandatory; that is, beneficiaries do not have the option of choosing to remain in fee-for-service to receive LTSS. The other programs allow voluntary enrollment; beneficiaries can choose to enroll in Medicaid managed care to receive LTSS or remain in fee-for-service.¹⁶ Risk adjustment is particularly important in programs that allow voluntary enrollment because it presents an opportunity for plans to cherry-pick or, conversely, experience adverse selection. In addition, if states allow beneficiaries to opt out of MLTSS, those who choose to do so many have very different cost profiles than those who opt in. Even in mandatory programs, adverse selection may occur if enrollees are given a period of time to select a plan of their choice, after which they are automatically assigned into a plan. These periods of voluntary enrollment present an opportunity for plans to cherry pick or for providers to steer members towards preferred plans with which they might have more favorable contracts or payment rate.¹⁷ Some states allow beneficiaries subject to mandatory MLTSS enrollment to choose self-direction or PACE as an alternative. If a substantial proportion of LTSS beneficiaries choose such options, risk adjustment is important to account for differences in enrollee characteristics and associated costs across these options.

Data Needed and Costs for Managed Long-Term Care Supports and Services Risk Adjustment

Despite the importance of risk adjustment to ensuring fair and accurate capitation rates paid to managed care plans, the development of a risk adjustment model for MLTSS can be costly. Resources are needed to collect reliable and accurate data on functional and cognitive level of need and validate the data. Resources are also required to link functional assessment with cost data, and continually upgrade and refine the risk adjustment model. Without sufficient investment in these activities, the benefits of MLTSS risk adjustment cannot be realized. Following are state considerations related to obtaining the data necessary to use functional status to set MLTSS capitation rates:

- **Diversity of functional assessment tools.** One of the biggest challenges to developing risk adjustment for MLTSS is collecting reliable and comparable data on enrollees' functional and cognitive status in a

format that can be used to adjust capitation rates for each plan. Currently, most states use a variety of assessment tools that differ across programs, plans, agencies, and target populations. Arizona and Texas, for example, have different assessment tools for different LTSS programs, enrolled populations, or points in time. While this need not be a barrier to the use of assessment data for risk adjustment, the greater the diversity of functional assessment tools in a state, the more difficult it will be to collect and organize the data in a standardized way. Some states have developed uniform assessment tools, which state-contracted assessors and MLTSS plans use to determine initial and ongoing eligibility for LTSS in all state programs,¹⁸ but collecting this data electronically and linking the information to claims, utilization, and other cost data has been difficult.

- **Collection and validation of functional assessment data.** The most reliable data on enrollees' functional and cognitive status data come from in-person assessments, conducted by trained assessors who are independent of managed care plans. (Independence helps avoid gaming that occurs when plan payment is tied to assessment results.) In-person assessments can be very costly, however, especially as the number of MLTSS enrollees grows, so states should consider whether to conduct such assessments for every enrollee or if a representative sample of enrollees will suffice. States can also obtain self-reported functional data from mail or telephone surveys with representative samples of enrollees in each plan, but people with cognitive disabilities or those with communication barriers — whose costs tend to be greater — are likely to be under-represented. Tennessee created a system for obtaining functional status data from every MLTSS enrollee that relies on a rigorous set of checks and balances. Though the system is costly, the state believes that accurately assessing an individual's level of need is worth the investment.¹⁹ Whether assessments are conducted via face-to-face visits or surveys, it is essential to have the data available electronically, with sufficient information to link it to cost data for each individual, and in file formats that allow such data linkages to be used in risk adjustment.
- **Commitment over time from staff or vendors with the right skills.** Developing a risk adjustment model can take considerable amount of time, and requires strong statistical skills and sophisticated data linking capability. To develop their risk adjustment models, New York and Wisconsin relied on a combination of in-house staff and actuarial consultants working together over many years. During this process, they also consulted with a variety of stakeholders, including managed care plans, clinicians, and consumer representatives.²⁰ Developing a model that adjusts for functional status is not a one-time activity. Just as CMS periodically revises the risk adjustment model for Medicare Advantage plans, states should plan for regular updates to their models based on changes in benefits, utilization, enrollee characteristics and needs, and other factors driving LTSS costs.

Conclusion

Risk adjustment is an important tool to help MLTSS programs ensure accurate and equitable capitation rates based on the expected costs of care for the individuals enrolled in each plan. It ensures that rates adequately reflect the functional and cognitive status of enrollees and that plans have the resources to meet enrollees' needs. It also helps to ensure the long-term financial sustainability of Medicaid MLTSS programs by paying no more, and no less, than the expected costs of each plan's enrollees. Risk adjustment cannot protect the state from very low cost cases, or managed care plans from very high-cost cases, due to limitations of the statistical methods used in most regression models. Consequently, additional risk mitigation methods are needed to address these outliers, such as reinsurance, risk corridors, and risk sharing (see [Risk Mitigation Strategies in Medicaid Managed Long-Term Services and Supports Programs: Options for States](#)).²¹ Doing MLTSS risk adjustment well also entails costs and challenges. State program managers and policymakers need to carefully assess the value of risk adjustment based on the diversity of populations enrolled, the size and number of participating managed care plans, whether enrollment is mandatory or voluntary, and the availability of sufficient resources before leaping into this challenging area.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It 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.

MEDICAID MANAGED LONG-TERM SERVICES AND SUPPORTS RATE SETTING RESOURCES

This brief is a product of CHCS' [Medicaid Managed Long-Term Services and Supports Rate-Setting Initiative](#), which is made possible by the West Health Policy Center to help states and other stakeholders advance rate-setting methods for MLTSS programs. Other resources on www.chcs.org, include:

- *Building Managed Long-Term Services and Supports Risk-Adjustment Models: State Experiences Using Functional Data*
- *Considerations for a National Risk-Adjustment Model for Medicaid Managed Long-Term Services and Supports Programs*
- *Developing Capitation Rates for Medicaid Managed Long-Term Services and Supports Programs: State Considerations*
- *Engaging Managed Care Plans in Rate Setting for Medicaid Managed Long-Term Services and Supports Programs*
- *Population Diversity in Medicaid Managed Long-Term Services and Supports Programs: Implications for Rate Setting and Risk Adjustment*
- *Strategies to Mitigate Risk in Medicaid Managed Long-Term Services and Supports Programs*
- *Trust but Verify: Tennessee's Approach to Ensuring Accurate Functional Status Data in its Medicaid Managed Long-Term Services and Supports Program*

ENDNOTES

¹ Centers for Medicare & Medicaid Services. "Medicaid Managed Care Enrollment and Program Characteristics, 2014." Prepared for the Centers for Medicare & Medicaid Services by Mathematica Policy Research, Spring 2016. Available at: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/data-and-systems/medicaid-managed-care/downloads/2014-medicaid-managed-care-enrollment-report.pdf>.

² United States Code of Federal Regulations. 42 CFR 438.2 and 438.4(b)(4). Available at: <http://www.ecfr.gov/cgi-bin/text-idx?SID=971b979a734829adc6182459b5cd6e9b&mc=true&node=20160506y1.29>.

³ Federal rules do not require state Medicaid agencies to risk adjust rates based on health status or other risks. But if states do use risk adjustment, it must be done in a budget neutral manner, such that there is "no aggregate gain or loss across the total payments made to all managed care plans under contract with the state." (42 CFR 438.5(a) and (b)(6)) See also CMS' 2016 Medicaid Managed Care rate guidance: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/2016-medicaid-rate-guide.pdf>.

⁴ M. Dominiak and J. Libersky. "Medicaid Rate-Setting for Managed Long-Term Services and Supports: Basic Practices for Integrated Medicare-Medicaid Programs." Mathematica Policy Research, July 2016. Available at: <https://www.mathematica-mpr.com/our-publications-and-findings/publications/medicaid-ratesetting-for-managed-longterm-services-and-supports-basic-practices-for-integrated>.

⁵ Activities of Daily Living include eating, bathing, toileting, getting dressed, and transferring from bed to chair; Instrumental Activities of Daily Living include housekeeping, transportation, and handling personal finances.

⁶ For a discussion of the diversity of the people with disabilities, see: J. Libersky and D. Lipson. "Population Diversity in Medicaid Managed Long-Term Services and Supports Programs: Implications for Rate Setting and Risk Adjustment." Center for Health Care Strategies, August 2016. Available at: <http://www.chcs.org/resource/population-diversity-medicaid-managed-long-term-services-supports-programs-implications-rate-setting-risk-adjustment/>.

⁷ Adapted from: "Health Policy Brief: Risk Adjustment in Health Insurance." *Health Affairs*, August 30, 2012. Available at: http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_74.pdf.

⁸ For example, the original frailty factors for the first model were 1.094, 0.340, 0.172, and -0.143 respectively, for counts of ADL difficulty 5-6, 3-4, 1-2, and 0. See: J. Kautter, M. Ingber, and G. Pope. "Medicare Risk Adjustment for the Frail Elderly." *Health Care Financing Review*, Vol. 30, No. 2 (2008) pp: 83—93.

⁹ G. Pope, J. Kautter, M. Ingber, et al. "Evaluation of the CMS-HCC Risk Adjustment Model: Final Report." Prepared for the Centers for Medicare & Medicaid Services by RTI International, March 2011. Available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/evaluation_risk_adj_model_2011.pdf.

¹⁰ New York State, Medicaid Managed Long-Term Care Risk Adjusted Rates. Summary of Methods for rates effective April 1, 2015.

¹¹ Wisconsin Department of Health Services Calendar Year 2015 Family Care Capitation Rates. Prepared by PricewaterhouseCoopers, December, 2014. Available at: <https://www.dhs.wisconsin.gov/files/fc2015capitationrates.pdf>.

¹² M. Dominiak and A. Bohl. "Building Managed Long-Term Services and Supports Risk-Adjustment Models: State Experiences Using Functional Data." Center for Health Care Strategies, August 2016. Available at: <http://www.chcs.org/resource/building-managed-long-term-services-supports-risk-adjustment-models-state-experiences-using-functional-data/>.

¹³ J. Kasten, D. Lipson, P. Saucier, J. Libersky, and C. Irvin. "Who Enrolls in State Managed Care Programs Covering Long-Term Services and Supports? Implications of State Variation in Enrollee Characteristics for a Cross-State Evaluation." Prepared for the Centers for Medicare & Medicaid Services by Mathematica Policy Research and Truven Health Analytics, August 2015. (Unpublished).

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ Nine of the 31 MLTSS programs operating in 22 states in 2014 allowed beneficiaries to "opt-out"; states automatically enroll beneficiaries into managed care organizations and they have a certain period of time to disenroll. This policy is also known as passive enrollment. Five of the 31 programs allow beneficiaries to "opt-in" by actively choosing to enroll in a MLTSS plan.

¹⁷ In New York, these periods of voluntary enrollment allowed certain plans to recruit healthier patients and collect improper payment. See: J. Libersky, C. Stepanczuk, R. Lester, K. Liao, and D. Lipson. "Medicaid Managed Long-Term Services and Supports: Themes from Site Visits to Five States." Mathematica Policy Research, Working Paper 44, March 2016. Available at: <https://www.mathematica-mpr.com/-/media/publications/pdfs/health/2016/mltss-wp44.pdf>.

¹⁸ C. Ingram, A. Lind, and B. Ensslin. "Uniform Assessment practices in Medicaid Managed Long-Term Services and Supports Programs." Center for Health Care Strategies, September 2013. Available at: http://www.chcs.org/media/Uniform_Assessment_in_MLTSS_9-6-13_FINAL.pdf.

¹⁹ For a description of Tennessee's system, see: J. Libersky. Trust but Verify: Tennessee's Approach to Ensuring Accurate Functional Status Data in Its Medicaid Managed Long-Term Services and Supports Program." Center for Health Care Strategies, August 2016. Available at: <http://www.chcs.org/resource/trust-verify-tennessees-approach-ensuring-accurate-functional-status-data-medicare-managed-long-term-services-supports-program/>.

²⁰ For more discussion of this process, see: M. Soper. "Engaging Managed Care Plans in Rate Setting for Medicaid Managed Long-Term Services and Supports Programs." Center for Health Care Strategies, August 2016. Available at: <http://www.chcs.org/resource/engaging-managed-care-plans-rate-setting-medicare-managed-long-term-services-supports-programs/>.

²¹ For more information on risk mitigation see: M. Dominiak. "Risk Mitigation Strategies in Medicaid Managed Long-Term Services and Supports Programs: Options for States." Center for Health Care Strategies, August 2016. Available at: <http://www.chcs.org/resource/risk-mitigation-strategies-medicare-managed-long-term-services-supports-programs-options-states/>.