

# Risk Mitigation Strategies in Medicaid Managed Long-Term Services and Supports Programs: Options for States

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## IN BRIEF

States with Medicaid managed long-term services and supports (MLTSS) programs must set actuarially sound capitation rates that do not over- or under-pay health plans for the costs of the services they provide. This brief — supported through the West Health Policy Center — explores challenges in rate setting for MLTSS programs, including: predicting the portion of community-dwelling enrollees versus enrollees residing in institutional settings, developing accurate managed care savings assumptions, and anticipating enrollees' unmet needs for long-term services and supports (LTSS). The brief also examines state approaches to mitigate risk, including risk adjustment, risk sharing, risk pools and reinsurance, to more equitably re-distribute or adjust for risk that is not otherwise accounted for in the base MLTSS rate-setting methodology. These approaches can help to better protect states and managed care plans from adverse risk and uncertainty and support managed care plans' ability to provide high-quality LTSS in the most cost effective care setting.

States are increasingly moving the delivery of Medicaid long-term services and supports (LTSS) from fee-for-service (FFS) to managed care models. But because managed long-term services and supports (MLTSS) is a relatively new construct, states, actuaries, and managed care plans have limited experience in setting rates for these programs. In an MLTSS model, states pay plans a fixed, monthly capitation (per person) rate for which the plans provide LTSS to Medicaid enrollees. The plans assume the risk for the cost of covered services, incurring losses if the cost of the services exceeds the monthly payments or retaining profit if the cost of services is less than the total payments.

Federal rules require states to establish capitation rates in accordance with actuarial standards of practices, which means the rates should include all reasonable, appropriate, and attainable costs for the populations and services covered by the managed care contract.<sup>1</sup> However, several issues involved in setting rates for MLTSS plans may expose the plans to unsustainable financial risks. For example, in voluntary MLTSS programs, the portion of community-based versus institutional enrollees may be difficult to predict and will change from year to year. In addition, when setting rates for new MLTSS programs, managed care assumptions (i.e., savings assumed to occur when services are managed instead of provided via unmanaged fee for service delivery) may be overly optimistic in the first year or two of program implementation. Lastly, there might be significant unmet need for LTSS in the enrolled population that was not anticipated in the rate development process.

This brief — supported through the West Health Policy Center — explores challenges in rate setting for MLTSS programs that may result in risk to the state of paying more than it should, or risk to plans in getting paid less than is appropriate to cover the actual costs of necessary services. It also describes the most common financial risk mitigation strategies that states have employed to protect both the state from overpayment and managed care plans from excessive financial losses. States developing MLTSS programs can use this information to design programs that protect them and participating plans from incurring risks that may jeopardize program stability and sustainability.

## Challenges in Managed Long-Term Care Supports and Services Rate Setting

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MLTSS capitation payment rates are set prospectively and rely on a series of actuarial assumptions to predict future costs. MLTSS rate methodologies generally start with the historical claims or encounter data that are most reflective of the population and services covered by the managed care contract. Actuaries then apply a series of adjustments and actuarial assumptions to these data, such as trend analysis (i.e., projecting the change in utilization or costs from the historical period to the rating period), program changes, managed care savings, and other non-benefit expenses to develop the capitation payment rates.<sup>2</sup> Because the MLTSS capitation rates are set prospectively, actual costs may be different than expected for a variety of reasons, including: differences in the projected mix of community-based and institutional residents; overly aggressive or conservative trend and/or managed care savings assumptions; unmet need; changes in the acuity of the enrollees; or enrolling a disproportionate number of high-cost, high-need enrollees.

### Mix of Community and Institutional Enrollees

Typically, MLTSS populations include residents in institutional settings such as nursing facilities (NFs) or intermediate care facilities for people with intellectual or developmental disabilities and community-based enrollees who qualify for the state's home- and community-based services (HCBS) waiver programs. To incent managed care plans to increase the use of lower cost community-based LTSS as an alternative to more costly institutional LTSS, the Centers for Medicare & Medicaid Services (CMS) encourages states to pay a single, blended capitation rate that combines both institutional and home- and community-based LTSS.<sup>3</sup> Blended rates are generally developed by creating separate capitation rates for institutional residents and HCBS eligible enrollees and then combining or "blending" the rates based on an estimate of the proportion or "mix" of individuals that are expected to be enrolled in the managed care plan. Developing the proper target mix of HCBS and institutional enrollees is a critical assumption in the development of the blended rate. For the blended rate to be actuarially sound, both the base rate component and the mix assumption need to be reasonable, appropriate, and attainable; otherwise, there is risk to the state of overpayment or risk of underpayment to managed care plans.

For some MLTSS programs, particularly new or voluntary programs, the mix of HCBS and institutional enrollees can be difficult to predict. Further, these so-called "mix percentages" can be affected by factors outside of the plans' control such as changes in eligibility and assessment criteria, eligibility expansions or reductions, changes in the state plan or waiver services, changes in or elimination of HCBS waiting lists, or state rebalancing programs such as Money Follows the Person initiatives that help long-term institutional residents return to the community. Mix percentages can also vary from plan-to-plan resulting in winners and losers. If the same blended rate is paid across all plans, or the mix percentage is fixed for a period of time, managed care plans may have incentives to cherry-pick lower cost HCBS beneficiaries over higher cost institutional beneficiaries.

### Managed Care Savings Adjustments

When states set rates for new MLTSS programs, they often expect to achieve savings through improved care management and care coordination. Savings may be assumed for reductions in unnecessary hospitalizations, emergency room use, or institutional admissions. If the savings are overly optimistic in the first year or two of program implementation or the MLTSS program was not implemented as originally planned, then the managed care plans bear the financial risk.

A significant potential source of savings in MLTSS programs comes from rebalancing—increasing the number of beneficiaries served in the community and reducing long-term institutionalizations. Often, the community and institutional mix percentage used to calculate the blended rate includes an "aspirational assumption" above and beyond the current mix that can be achieved in the prospective contract period.

For example, if the current mix is 50 percent HCBS enrollees and 50 percent institutional enrollees and the assumption is that MLTSS plans should be able to increase the proportion of HCBS enrollees by two percentage points, the rates would be blended based on the expected target mix of 52 percent HCBS and 48 percent institutional costs. This aspirational target provides a strong financial incentive for plans to meet or beat the mix percentage assumption included in the rate. However, if actual results are worse than expected, or the target is not realistic, the managed care plans bear the risk.

## Unmet Need

For new MLTSS programs, there may be unmet need for LTSS services among individuals who enroll in managed care. For example, the state may have extensive waiting lists for its HCBS programs that limit the number individuals who can receive LTSS in the community under the existing FFS program, but no longer apply in the MLTSS program. Or, if the state plan covers personal care services, individuals using these services are not using other HCBS if they had been assessed and determined eligible for an HCBS waiver program. Additionally, annual re-assessments now performed by managed care plans can result in expanded services that may have been more limited under the state's prior tool/process or managed care plans may offer an expanded network of certain service providers that increase access, resulting in increased utilization and costs. The potential unmet needs of both existing and new members is difficult to predict, but can pose a significant financial risk to managed care plans in the initial years of the MLTSS program.

## Changes in Acuity

As the population mix enrolled in MLTSS shifts towards more enrollees who reside in the community away from institutional settings, the acuity and risk profile of both HCBS enrollees and institutional residents will change accordingly. As individuals are able to remain in the community longer and receive the necessary services and supports as they age, their LTSS costs are likely to increase. Similarly, as unnecessary institutionalizations decrease, enrollees requiring long-term, nursing facility stays are also more likely to be more complex with higher needs that will increase per person costs to institutions over time. As a result, the component LTSS costs for LTSS enrollees in both settings may increase with the change in acuity. If these changes in acuity are not properly recognized in the rate setting, the capitation rates may be understated.

## Enrollees with High Outlier Costs

Managed care plans are at risk for all enrollees, including some very expensive individuals (e.g., enrollees who require certain biotech drugs; are diagnosed with hemophilia, traumatic brain injury, Von Willebrand's disease, Gaucher's disease or certain high-cost behavioral health conditions; or are dependent on ventilators, among other conditions). This could be a concern for some plans, especially smaller plans that do not have the financial reserves to protect them in the event that the plan enrolls a disproportionate number of high cost outlier enrollees.

## Risk Mitigation Strategies

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States use four types of tools to address the challenges in setting accurate MLTSS capitation rates: risk adjustment; risk sharing; risk pools; and reinsurance. Risk adjustment is often used by states to adjust for differences in risk between managed care plans and must be budget neutral to the state.<sup>4</sup> However, risk adjustment does not protect managed care plans from all of the inherent uncertainties of prospective rate setting. Therefore, other risk mitigation techniques such as risk sharing, risk pools, and reinsurance can be used in lieu of or alongside risk adjustment to offer additional protections to the state and managed care plan. Risk mitigation strategies can also be used to attract new managed care plans to the market, particularly smaller provider-based plans that may be more risk averse. The following section describes each strategy, and its benefits and challenges.

## Risk Adjustment

MLTSS risk adjustment models often range in complexity from those that adjust only for the proportion of community and institutional residents to those that use a sophisticated, complex algorithm to adjust for a person's functional, cognitive, and behavioral needs (see [Building Managed Long-Term Services and Supports Risk-Adjustment Models: State Experiences Using Functional Data](#)).<sup>5</sup>

Many states use a simple form of risk adjustment to address the variation in the current mix of HCBS and institutional users in each MLTSS managed care plan (i.e., the mix percentage). For example, Tennessee pays a blended rate for enrollees who qualify for institutional level of care that is based on each managed care plan's projected mix of HCBS and NF users during the contract year. The mix percentage is fixed for the twelve-month contract period to encourage plans to at least maintain, or even increase, the use of community-based LTSS and reduce unnecessary institutionalizations. Plans that can increase HCBS use will earn more profit. The mix percentage is reset each year by plan and region and is budget neutral to the state.<sup>6</sup>

Simple risk adjustment models serve to mitigate the risk of selection bias across plans due to differences in the mix of where enrollees live and receive services, and result in more equitable payments among managed care plans. However, care should be taken not to adjust the mix too frequently, which would undermine the financial incentives inherent in blended rates. For example, Virginia initially adjusted the mix percentage every 90 days for its Commonwealth Coordinated Care financial alignment demonstration for beneficiaries dually eligible for Medicare and Medicaid since the mix of HCBS and NF enrollees varied significantly by plan and was changing continuously as enrollment increased across the state. The state later changed the policy to adjust the mix percentage every 180 days as the enrollment stabilized across plans.<sup>7</sup>

## Risk Sharing

In risk sharing, a risk corridor is established by setting upper and lower bounds for gains and losses. The state typically retains full or partial responsibility for total costs that exceed a certain predetermined, upper threshold. However, if a managed care plan's actual costs are below the lower threshold, the plan must rebate all or a portion of the excess amount to the state.

Risk sharing can provide both upside and downside protection to the state and the managed care plan when the risk of the population enrolling in the MLTSS program is uncertain, as is common in new programs. For example, Kansas offered risk sharing to managed care plans in the first several years of its Medicaid managed care program, KanCare. Once enrollment stabilized and the KanCare program matured, the state eliminated its risk sharing program and introduced risk adjustment to address variations in medical conditions for its acute care population across the three contracted managed care plans. However, Kansas continues to use a more limited risk corridor for persons with intellectual disabilities to address managed care plan concerns over potential selection bias that traditional medical risk adjustment approaches could not fully address.

Arizona has a longstanding MLTSS program but continues to use a form of risk sharing around the mix of individuals who use HCBS and NF assumed in the rate. Arizona pays a blended rate based on an assumed mix percentage that is set at the beginning of the contract year. At the end of the year, Arizona compares the actual percentage of HCBS and NF users to the expected ratio. If the actual mix is above or below one percentage point of the expected ratio, the underpayment/overpayment is shared equally between the state and the plan.<sup>8</sup>

While there are several benefits to a risk sharing program, it can be administratively burdensome to the state to establish parameters, collect data, and calculate and reconcile amounts. Contract specifications regarding how this process will work should be spelled out upfront. In addition, under risk sharing, state budgets for MLTSS are less predictable and may be strained if the state is required to pay additional funding to the managed care plan that was unanticipated. Reconciliation of the expenditures can also take

as much as a year or more, as it requires a sufficient level of claims run out that can impact managed care plan cash flow.

## Risk Pools

Risk pools are another form of risk mitigation that are often used to cover unanticipated costs for a small number of high-risk, high-cost individuals. All managed care plans contribute to risk pools in exchange for coverage against the risk of enrollees' incurring very high costs. In recent years, risk pools have become more popular due, in part, to the fact that they are budget neutral to the state and can be funded by withholding a portion of the capitation payment. Wisconsin, for example, uses a high-cost risk pool for enrollees with physical or developmental disabilities who have LTSS costs in excess of \$225,000. The high-cost risk pool is designed to cover up to 80 percent of costs above \$225,000 for each individual. A per member per month (PMPM) amount is withheld from the capitation payment, and at the end of each contract year, a settlement is performed that determines the payout for each managed care plan based on each plan's percentage of total costs above \$225,000 in the contract year.<sup>9</sup>

Massachusetts included both a high-cost risk pool and a risk sharing arrangement in the first year of One Care—its financial alignment demonstration for Medicare-Medicaid enrollees. The high-cost risk pool covered costs that exceeded a certain level of spending on selected Medicaid LTSS, behavioral health, and dental services. Similar to Wisconsin, the risk pool was to be funded by withholding a portion of the capitation payment. At the end of the payment period, funds from the pool were to be allocated based on each managed care plan's portion of total costs above the threshold amount.<sup>10</sup> However, total costs in the Massachusetts One Care demonstration program across all plans were much higher than expected in the first year of the demonstration, so the risk pool was rescinded. Instead, the risk-sharing arrangement was used to cover part of the losses experienced by the participating plans.

Risk pools can also be used in MLTSS programs to retroactively adjust HCBS/institutional mix percentages assumed in a blended payment rate when the mix percentage is less predictable for each contracted managed care plan. New Mexico took this approach when it initially implemented its mandatory MLTSS program, Coordination of Long-Term Services (CoLTS) in 2008.<sup>11</sup> New Mexico opted to pay a blended rate for all enrollees needing a nursing home level of care, regardless of setting. However, while the mix percentage was predictable in the aggregate, it was less certain how the mix percentage would vary for each managed care plan, since the program was new. The state implemented a risk pool to protect the plans from any adverse selection risk and to reduce any incentive to cherry pick the lower-cost, community-based beneficiaries over the more costly nursing home residents. The risk pool was designed to be budget neutral to the state based on the relative HCBS/NF mix that actually enrolled with each managed care plan compared to the average assumed in the capitation rate development. The risk pool was eliminated after the first year of the program, once the enrollment for each managed care plan had stabilized.

Similar to risk sharing, reconciling the risk pool can be administratively burdensome to the state. States need to establish parameters, collect data, and calculate and reconcile amounts in a timely manner. Contract specifications should be developed upfront to avoid any ambiguity. To the extent that the state withholds a portion of the capitation rate to fund the risk pool, states should take care to ensure that the risk pool funds are retained in a separate account, apart from other state budget funds, so that the money can be dispensed at the time of reconciliation. As with risk sharing, the reconciliation process can take time to complete, impacting managed care plan cash flow.

## Reinsurance

Reinsurance can be used in combination with risk sharing or risk adjustment to better protect managed care plans from unexpected, high-cost claims associated with a single individual. Plans can purchase reinsurance from private reinsurers, but it is often very expensive, so some states act as the reinsurer by charging a premium (i.e., reducing the capitation payment) in exchange for providing reinsurance

protection. Unlike risk pools, which are budget neutral to the state, the state is at risk for costs that exceed the collected premium amounts. Reinsurance is not as common in MLTSS programs compared to acute care programs, since LTSS costs are fairly predictable. A few states, however, have found reinsurance to be an important risk mitigation tool for specific LTSS populations.

To attract managed care plans and mitigate their concerns about enrolling a disproportionate number of individuals with high cost conditions, Arizona developed a very robust reinsurance program for its MLTSS program. Arizona offers three different types of reinsurance to contracted plans: (1) regular reinsurance; (2) catastrophic reinsurance; and (3) transplant reinsurance. The regular reinsurance covers 75 percent of the costs of eligible services that exceed an annual deductible. The deductible amount varies between \$10,000 and \$30,000, depending on the size of the managed care plan and whether the enrollee is eligible for Medicare Part A. Costs above \$650,000 are covered at 100 percent. Separate catastrophic reinsurance covers beneficiaries receiving certain biotech drugs, individuals with hemophilia, enrollees diagnosed with Von Willebrand's disease, Gaucher's disease and enrollees with certain high-cost behavioral health conditions. There is no deductible for catastrophic reinsurance, and 85 percent of eligible reinsurance costs are covered by the state. Transplant reinsurance is available to partially reimburse managed care plans for the cost of care for an enrollee who receives a transplant that meets the reinsurance criteria and requirements.<sup>12</sup>

State-run reinsurance programs require states to provide detailed contract specifications regarding what is covered and not covered under the reinsurance agreement, and collect and review paid claims data to ensure appropriate reimbursement. Well-designed reinsurance programs require the managed care plan to retain some financial responsibility above the threshold, so that the plan continues to have the financial incentive to manage the care for that enrollee. State-run reinsurance pools may require a separate funding mechanism and budget so that reinsurance premiums are retained for future expenses rather than reverted to the state general funds.

## Conclusion

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An actuarially sound MLTSS rate-setting approach starts with base rates that account for all reasonable, appropriate, and attainable costs.<sup>13</sup> However, developing rate-setting assumptions that are reasonable, appropriate, and attainable while limiting the potential for selection bias and accounting for outliers can be a significant challenge for many states and their actuaries, both those with mature MLTSS programs as well as those that are new to MLTSS. To help address these challenges, states often use various risk mitigation strategies, including risk adjustment, risk sharing, risk pools, and reinsurance to more equitably re-distribute or adjust for risk that is not otherwise accounted for in the base MLTSS rate setting methodology. Together, these strategies can better protect states and managed care plans from adverse risk and uncertainty, while continuing to provide the right financial incentives to plans to better serve Medicaid's most frail and vulnerable beneficiaries in the most cost-effective care setting.

## 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](http://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](http://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*
- *Engaging Managed Care Plans in Rate Setting for Medicaid Managed Long-Term Services and Supports Programs*
- *Developing Capitation Rates for Medicaid Managed Long-Term Services and Supports Programs: State Considerations*
- *Look Before You Leap: Risk Adjustment for Managed Care Plans Covering Long-Term Services and Supports*
- *Population Diversity in Medicaid Managed Long-Term Services and Supports Programs: Implications for Rate Setting and Risk Adjustment*
- *Trust but Verify: Tennessee's Approach to Ensuring Accurate Functional Status Data in its Medicaid Managed Long-Term Services and Supports Program*

## ENDNOTES

<sup>1</sup> Actuarial Standard of Practice Number 49. "Medicaid Managed Care Capitation Rate Development and Certification." Actuarial Standards Board, March 2015. Available at: [http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049\\_179.pdf](http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf).

<sup>2</sup> 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/>.

<sup>3</sup> Centers for Medicare & Medicaid Services. "2016 Medicaid Managed Care Rate Development Guide." September 2015. Available at: <https://www.medicare.gov/medicaid-chip-program-information/by-topics/deliverysystems/managed-care/downloads/2016-medicare-rate-guide.pdf>.

<sup>4</sup> Federal rules do not require state Medicaid agencies to risk adjust rates, but if a state uses 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) See also CMS 2016 MMC rate guidance, <https://www.medicare.gov/medicaid-chip-program-information/by-topics/deliverysystems/managed-care/downloads/2016-medicare-rate-guide.pdf>.

<sup>5</sup> For examples of MLTSS risk adjustment models, see: 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/>.

<sup>6</sup> Personal email correspondence from TennCare. Note the risk adjustment was implemented in 2016 based on each managed care plan's projected mix percentage and the regional average mix. In CY2016, TennCare used a 75% / 25% weighting of managed care plan projected mix and regional mix.

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

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<sup>8</sup> Arizona Health Care Cost Containment System. “Contractor Operations Manual, 303—Home and Community Based Services Reconciliation: ALTCS.” Effective October 1, 2015; Revised October 27, 2015. Available at: <https://www.azahcccs.gov/shared/Downloads/ACOM/PolicyFiles/300/303.pdf>.

<sup>9</sup> State of Wisconsin Department of Health Services Calendar Year 2016 Capitation Final Rate Development for Family Care Program. Prepared by Milliman, December 2015. Available at: <https://www.dhs.wisconsin.gov/familycare/reports/fc-2016capitationrates.pdf>.

<sup>10</sup> MassHealth. “Demonstration to Integrate Care for Dual Eligible Individuals (One Care-CCA).” CY 2016 Final Rate Report. February 26, 2016. <http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/state-fed-comm/ma-cca-cy-2016-one-care-rate-report-2-26-16-final.pdf>.

<sup>11</sup> CoLTS was subsumed by the Centennial Care program in 2014.

<sup>12</sup> Arizona Health Care Cost Containment System. Reinsurance Policy Manual, October 1, 2015 <https://azahcccs.gov/PlansProviders/Downloads/Reinsurance/ReinsuranceProcessingManual1012015.pdf>

<sup>13</sup> Actuarial Standard of Practice Number 49. Medicaid Managed Care Capitation Rate Development and Certification. Actuarial Standards Board, March 2015. Available at: [http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049\\_179.pdf](http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf).