

Considerations for a National Risk-Adjustment Model for Medicaid Managed Long-Term Services and Supports Programs

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IN BRIEF

Risk adjusting capitation rates paid to health plans helps ensure more equitable payments to each plan based on expected costs of its enrollees. Several risk-adjustment models exist for plans providing medical services, but currently there is no standardized risk-adjustment model for Medicaid managed long-term services and supports (MLTSS) programs. The development of a standardized, nationally available MLTSS risk-adjustment model for state Medicaid agencies could reduce the burden on states to establish their own models and facilitate comparisons about the key drivers of long-term services and supports (LTSS) costs within and across states. Creating a standardized model requires comparable data on functional status – one of the most important drivers of LTSS costs – across states and managed care plans. Research and collection of comparable, reliable functional status data are critical to the development of a national MLTSS risk-adjustment model for adaptation and use by state Medicaid agencies.

As more states establish Medicaid managed long-term services and supports (MLTSS) and integrated Medicare-Medicaid programs, they confront many challenges in setting capitation rates that accurately reflect beneficiaries' risk level and long-term services and supports (LTSS) use. States that participated in the [Medicaid MLTSS Rate-Setting Initiative](#), coordinated by the Center for Health Care Strategies, Mathematica Policy Research, and Airam Actuarial Consulting and made possible by the West Health Policy Center, explored key issues related to MLTSS rate setting, including developing and improving risk-adjustment models using functional status data and designing risk mitigation approaches for very high-cost individuals.

State officials encountered several challenges to developing risk-adjustment models for MLTSS programs, particularly the lack of standardized data on enrollees' functional status that could be linked to cost data. In addition, many states lack the necessary resources to develop risk-adjustment models, which require extensive data linking and statistical analysis. A standardized, national risk-adjustment model for LTSS based on the type and severity of enrollees' functional impairment, which is a key driver of LTSS cost, could help to reduce the burden on states of trying to develop their own home-grown models. States across the country would have the option to use this standardized approach, tailored as necessary to reflect different state program features and circumstances.

This brief examines considerations in developing a nationally available risk-adjustment model for MLTSS programs that can be used by states across the country. It also explores research needed to develop a robust model that predicts expected LTSS costs as accurately as possible.

Key Benefits and Challenges of a National Model

Many states base risk-adjustment models for Medicaid managed care rate setting on enrollees' use of medical services to ensure better alignment of capitation-based payments with the health risks of the population enrolled and minimize selection bias. States may choose from a number of national models to predict variation in the use and cost of medical care services across plans and programs. However, these

models do not accurately predict LTSS costs, which are driven primarily by the type and level of functional impairment, such as the need for assistance with activities of daily living (ADLs) or instrumental activities of daily living (IADLs). While a few states have developed state-specific MLTSS risk-adjustment models that incorporate functional assessment data, developing these models is resource and data intensive and requires ongoing refinement to account for changes in the program and populations enrolled (more information can be found in [Building Managed Long-Term Services and Supports Risk-Adjustment Models: State Experiences Using Functional Data](#)).¹

A standardized risk-adjustment model for LTSS could help: (1) reduce the burden on states of creating and maintaining their own models; (2) identify common cost drivers for the major population subgroups that use LTSS; (3) facilitate comparisons across states, managed care plans, and providers on quality and performance metrics; and (4) support alternative payment models to advance state value-based purchasing strategies in LTSS.

Developing a standardized, national risk-adjustment model for LTSS populations entails several challenges. Unlike the standardized national assessment tool for nursing home residents, the Minimum Data Set (MDS), there is no common tool for assessing functional status of people using home- and community-based services (HCBS) across states and managed care plans. The lack of a standardized tool makes it difficult to obtain comparable data on functional impairment levels and analyze their association with costs in a standardized way. The level of detail collected in the assessment data often varies from state to state and even across HCBS waiver programs within a state.² Furthermore, functional assessment data may not be captured electronically and many states record the assessment results only on paper.³

The Centers for Medicare & Medicaid Services (CMS) has supported efforts to develop standardized functional assessment processes and tools for HCBS programs within each state and is currently working with six states to test a common functional assessment tool for use in LTSS programs.⁴ However, research is needed to assess how different variables and definitions of functional and cognitive impairment correlate with LTSS use and costs, and whether other drivers of LTSS costs, such as the use of natural/family supports or social determinants, should be considered in rate setting and risk adjustment.

Research and Analytic Issues

To develop an accurate, nationally available risk-adjustment model for MLTSS programs, several issues require research and analysis. The considerations outlined below would help inform the development of a model that has a high predictive ratio across states, based on the costs associated with diverse enrollee characteristics, including functional status.

1. Standardization of Functional Assessment Data Elements

To build a standardized risk-adjustment model for MLTSS programs, actuaries require data that is objective and consistent to analyze the association between functional status and related risks and costs. In its June 2016 Report to the Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) found wide variation in the functional assessment tools in use; at least 124 tools are in use across states, and many states use different tools for different population groups.⁵ In addition, in most states, managed care plans use their own assessment tools — which may or may not include domains required by the states — to develop care plans for beneficiaries. However, even in states that use tools with similar domains (e.g., health status, functional status, social supports, and other relevant factors), there can be considerable differences in how variables are defined and information is collected.⁶ For example, tools define and assess impairments for ADLs (e.g., mobility, eating, and personal care/hygiene functions) differently.⁷ As a result, it is difficult to make comparisons across tools, programs, and Medicaid populations to ascertain which characteristics drive costs.

CMS is currently working with six states to develop and test standardized functional assessment items for assessing community-based LTSS beneficiaries with differing disabilities. If these standardized functional assessment elements generate reliable data, they could be used to compare how the level of need for assistance with ADLs, IADLs, or other variables correlates with costs for different subgroups within the LTSS population across states. These elements could form the basis for identifying the standardized data elements needed for a national risk-adjustment model.

Adopting a uniform functional assessment tool across LTSS programs *within* a state would also help to compare costs for different types of MLTSS programs. To the extent the variables collected in each tool are common, it allows for comparisons of costs across different types of MLTSS programs, such as those covering only Medicaid LTSS, integrated Dual Eligible Special Needs Plans, financial alignment demonstrations, Programs of All-Inclusive Care for the Elderly (PACE), etc. However, developing a uniform assessment tool can be extremely time and resource intensive, particularly if a state combines existing tools from several waiver or other programs into one. For example, Minnesota is one of the few states that developed a uniform assessment tool, called MnCHOICES (see box) that merged three assessment tools for different populations into one.

Minnesota's Comprehensive Assessment Tool: MnCHOICES

Minnesota developed a comprehensive functional assessment and care planning tool, called MnCHOICES, which replaced three separate legacy tools: the Developmental Disability Screening; the Long-Term Care Consultation; and the Personal Care Assistance and Service Plan.⁸ MnCHOICES is web-based tool that is used for persons of all ages, disabilities and financial status. County lead agencies and tribes are using MnCHOICES, and managed care plans will begin using it soon. The advantages and challenges in the development of MnCHOICES are similar to those for the development of comparable functional data elements for use in a standardized risk adjustment model.



MnCHOICES was designed to provide equitable access to a broader range of services and supports for persons in need of LTSS by improving consistency in eligibility and service determinations across programs and populations. An electronic MnCHOICES Support Plan application, to be implemented in 2017, will populate information gathered during the assessment interview into a Community Support Plan (CSP).

State officials report that developing the uniform assessment tools was very time-consuming and expensive. Initial planning began in 2004, and after receiving state funding in 2009, it took another four years to build MnCHOICES in collaboration with staff from other divisions in the Minnesota Department of Human Services, counties, tribes, managed care plans, a stakeholder steering committee, and contractors. MnCHOICES was launched in November 2013 and implemented in 87 counties and two tribes by December 2014. The state had to overcome technology issues, which caused delays, work flow interruptions, and duplication in data entry. However, state officials believe the costs and delays are outweighed by efficiencies to be gained in using one tool for all LTSS programs, by more equitable eligibility determinations, and by the ability to create automated links between assessment and care plans.

2. Identification of Common LTSS Cost Drivers across Diverse State Programs

State Medicaid programs vary significantly in their eligibility criteria for LTSS, HCBS waiver benefits, and availability of community-based care and affordable housing, all of which may affect LTSS utilization and costs. Accounting for this variability makes the task of developing and operating a nationally available risk-adjustment model more complex. However, doing so is critical to ensure that a standardized model can be modified to reflect variation in state MLTSS program design, eligibility, and availability of services. This requires research on the extent to which these variables affect costs for different LTSS populations, and how they may impact cost weights. Studies could examine how LTSS cost drivers vary for persons with intellectual disabilities compared to persons with physical disabilities or frail seniors across states; how the

mix of institutionalized and community-based residents impact the risk model and cost weights; and how other characteristics that limit a person's ability to remain in the community lead to long-term institutionalization.

Balancing the number of variables to include in a national model is an important consideration given numerous differences in state LTSS program design. Too many variables and the model may be overly complicated to implement; too few might weaken the model's value. For example, it may be more feasible to develop a simple model based on a limited number of discrete variables than to develop a more predictive model based on a larger number of nuanced variables that may not be universally collected by states or plans.

3. Understanding Other Potential LTSS Cost Drivers

A nationally available risk-adjustment model should also consider including LTSS cost drivers other than functional and cognitive status. Following are two additional factors discussed by states participating in the *Medicaid MLTSS Rate-Setting Initiative*:

- Family/Other Unpaid Caregiving.** States and managed care plans have varying policies with regard to paying family caregivers for providing LTSS. In states that do not allow relatives or friends to be paid for providing services and supports, actual LTSS use and costs may be understated since information on services provided by unpaid caregivers would not be captured in claims, encounter, or functional assessment data. Moreover, as of 2012, only 15 states included an assessment of family caregiver needs in Medicaid HCBS client assessment tools, though many planned to do so in the future.⁹ For example, Wisconsin uses a Resource Allocation Decision (RAD) tool to authorize services for individuals enrolled in the Family Care and Family Care Partnership programs, based in part on an assessment of natural, family, and community supports, and their contribution to an overall care plan. Furthermore, the availability of unpaid caregivers can change, increasing LTSS costs even if there is no change in the beneficiary's overall LTSS needs.

Future research could examine the impact of varying types and amounts of paid and unpaid caregiving on the total cost of care for beneficiaries with different characteristics and level of need, and the short- and long-term net costs of providing more paid support to supplement or substitute for unpaid family caregiving. Rate-setting and risk-adjustment models may also consider the cost of respite care, training, and other services provided by states and managed care plans to relieve caregiver burden. These supports may reduce overall LTSS costs in the long term by delaying or avoiding institutionalization, but increase costs in the short term because of unmet needs of overburdened caregivers. In addition, studies are needed to examine potential inequities that could arise by incorporating family caregiving into rates. For example, plans should not be rewarded for enrolling individuals with family members who are willing and able to provide unpaid services that substitute for paid support, over enrollees who do not have such supports available.

Due to these uncertainties about costs and ethical concerns, 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. At this point, there is no fair method or sufficient research available to account for differences in costs among beneficiaries who do or do not have access to those supports. However, states should carefully monitor managed care plans to minimize any potential selection bias that could occur by targeting beneficiaries who have access to these additional supports, avoiding those who do not, or compelling families to provide unpaid care, in order to maximize profits.¹⁰

- Social Determinants of Health and LTSS.** Several social factors significantly impact health outcomes and drive LTSS costs. These factors include access to safe and affordable housing, employment, nutrition, social interaction, neighborhood safety, transportation, education level and access to information in languages other than English and at appropriate reading levels. Deficits in these areas can increase an individual's need for and costs of LTSS, and if not properly accounted for, may affect the financial

viability of managed care plans with disproportionate numbers of enrollees facing such challenges. Several groups, including the National Academy of Medicine and the National Quality Forum, are exploring how social determinants of health drive health costs and other outcomes for high-need individuals and how this data could be collected.¹¹ However, there is limited data on how social determinants affect differential need for and use of LTSS, and little or no research that demonstrates the relationship between social determinants and LTSS costs that could be used in a risk-adjustment model. Future research could fill this gap by identifying which factors have the greatest impact on needs and costs, to what extent, and the costs of interventions to address these risks.

Conclusion

As more states develop MLTSS and integrated Medicare-Medicaid programs, interest is likely to grow in the development of a standardized, nationally available risk-adjustment model for LTSS rates based on type or severity of functional disability, which states could adapt to meet their own needs. As part of this effort, defining functional assessment elements consistently could facilitate comparisons across states and managed care plans, improve the accuracy of the model, and reduce some state burden of creating their own tools. Additional research on common LTSS cost drivers across different subgroups of the MLTSS population, and how other factors affect LTSS use and costs, would also be valuable to inform this effort.

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*
- *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*
- *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 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/>.
- ² Medicaid and CHIP Payment and Access Commission (MACPAC). “Report to the Congress on Medicaid and CHIP. Chapter 4: Functional Assessments for Long-Term Services and Supports.” June 2016. Available at: <https://www.macpac.gov/publication/functional-assessments-for-long-term-services-and-supports/>.
- ³ Ibid.
- ⁴ For more information about the Testing Experience and Functional Tools (TEFT) grants, refer to: <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/grant-programs/teft-program.html>.
- ⁵ MACPAC, op. cit.
- ⁶ L. Ray, et al. “Memorandum Comparing Four States’ Comprehensive Assessment Systems.” UCLA Borun Center for Gerontological Research. May 9, 2013. p. 24. Available at: http://www.thescanfoundation.org/sites/default/files/usc-ucla-ucsf-memo_comparing_four_states_assessment_systems-10-30-2013.pdf.
- ⁷ G.L Atkins and B. Gage. “The Need to Standardize Assessment Items for Persons in Need of LTSS.” Washington, DC: Long-Term Care Quality Alliance, April 2014. Available at: <http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images/LTQA-The-Need-to-Standardize-Assessment-Items-4-14-1.pdf>.
- ⁸ Minnesota Department of Human Services. “Fact Sheet: MnCHOICES.” 2015. Available at: <https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6477-ENG>.
- ⁹ K. Kelly, N. Wolfe, M.J. Gibson, and L. Feinberg. “Listening to Family Caregivers: The Need to Include Family Caregiver Assessment in Medicaid Home- and Community-Based Service Waiver Programs.” #2013-13. Washington DC: AARP Public Policy Institute, 2013. Available at: <http://www.aarp.org/home-family/caregiving/info-11-2013/including-family-caregiver-assessment-in-medicaid-hcbs-waive-programs-AARP-ppi-ltc.html>.
- ¹⁰ E. Carlson. “Voluntary Means Voluntary: Coordinating Medicaid HCBS with Family Assistance.” Issue Brief. Justice in Aging, May 2016. <http://www.justiceinaging.org/wp-content/uploads/2016/05/Voluntary-Means-Voluntary-Coordinating-Medicaid-HCBS-with-Family-Assistance.pdf>.
- ¹¹ National Quality Forum Measure Applications Partnership Dual Eligible Beneficiaries Workgroup. “Draft Report.” June 13, 2016. Available at: http://www.qualityforum.org/Project_Pages/MAP_Dual_Eligible_Beneficiaries_Workgroup.aspx and National Academies of Sciences, Engineering and Medicaid. “Accounting for Social Risk Factors in Medicare Payment: Criteria, Factors and Methods.” Washington, DC: The National Academies. 2016. Available at: <https://www.nap.edu/catalog/23513/accounting-for-social-risk-factors-in-medicare-payment-criteria-factors>.