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Resource Paper

Rate Setting for Medicaid Managed Long-Term Supports and Services: *Best Practices and Recommendations for States*

Richard Kronick, PhD
University of California San Diego

Karen LLanos, MBA
Center for Health Care Strategies

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Executive Summary

Although Medicaid managed long-term supports and services (MLTS)[1] is growing in interest among states, in 2004 only 2% of Medicaid beneficiaries with long-term support and service needs, were enrolled in risk-based programs.[2] There are many challenges that must be overcome if MLTS is to grow into a mainstream product;[3] developing rate-setting systems that are supportive of program goals is one of the key requirements for successful implementation of MLTS.

In late 2006, Richard Kronick from the University of California-San Diego and the Center for Health Care Strategies (CHCS) surveyed 10 Medicaid managed long-term supports and services programs,[4] as well as representatives from the national Program of All Inclusive Care for the Elderly (PACE) office and the Centers for Medicare and Medicaid Services (CMS) to gain a better understanding of the methods used to set rates for MLTS programs.

This report describes rate-setting considerations for MLTS programs, highlights key findings, and provides suggestions for areas in which further development of rate-setting methods would advance the field. Our key findings are:

- After Medicaid MLTS programs have been operating for a few years, states should consider rebasing rates using experience from program contractors, rather than relying, on expenditures in home and community-based services (HCBS) waiver programs.

- Long-term care utilization and expenditures vary significantly among community-based nursing home-eligible beneficiaries, with some requiring much more care than others. MLTS rate setting should, where possible, recognize this heterogeneity by adjusting reimbursement for the functional status (and other characteristics) of enrolled beneficiaries. Developing a system of risk adjustment for functional status (RAFS), as an analog to the diagnostic risk adjustments that are used in acute care, could facilitate the growth of MLTS programs.

- MLTS rate setting should create meaningful financial incentives to encourage health plans to help beneficiaries remain in community settings. Making contractors financially responsible for beneficiaries when they transition into a nursing facility may be the most likely method of accomplishing this goal.

- As programs mature, states should develop methods of recognizing (and paying for) the long-term supports and service needs of community-based beneficiaries who are not yet

[1] "Long-term supports and services" is a general term describing a wide range of medical, behavioral, nursing, custodial, social, supportive, and community services provided over an extended period of time for people who are chronically ill.
[2] L. Palmer and S.A. Somers. *Integrating Long-term Care: Lessons from Building Health Systems for People with Chronic Illnesses, a National Program of the Robert Wood Johnson Foundation*. Center for Health Care Strategies, October 2005.
[3] P. Saucier, B. Burwell, and K. Gerst. *The Past, Present and Future of Managed Long-Term Care*. Thomson/MEDSTAT and University of Southern Maine, Muskie School of Public Service, April 2005.
[4] The 10 states surveyed were: Arizona, California, Florida, Maryland, Massachusetts, Minnesota, New York, Texas, Washington, and Wisconsin. However, during the period in which this paper was written Maryland made the decision not to pursue the implementation of an MLTS program. As a result, the majority of this paper highlights MLTS programs in nine states.

at nursing home level of care, so that they can remain independent and delay or prevent costly institutionalizations.

- Diagnostic risk adjustment of the acute care portion of the capitation in Medicaid MLTS is a sensible approach, but an issue of secondary importance to states. In most states, beneficiaries with long-term support and service needs are dual eligibles, and the acute care portion of the rate for Medicaid is typically relatively small.

- Because virtually all beneficiaries over 65 as well as many people with disabilities under age 65 are nearly universally covered by Medicare, integration of acute and long-term care for this population ideally calls for the blending of Medicare and Medicaid financing. Among the many obstacles to accomplishing this integration is the requirement that Medicaid capitation rates be determined solely based on the cost of providing Medicaid-covered services rather than other cost-effective services that could enable beneficiaries to remain in the community. States are able to provide this type of flexibility when funding is blended or integrated across Medicare and Medicaid.

Medicaid MLTS provides states with the opportunity to support frail beneficiaries living in the community and delay or prevent them from being placed in a nursing facility. However, this group of beneficiaries has a diverse range of health needs and functional capacity. States must find ways to design programs and develop rate-setting processes that address that heterogeneity.

The purpose of this exploratory paper is to describe the rate-setting systems currently being used by MLTS programs, highlight the major decisions states must make in setting rates for these programs, and summarize the lessons from these experiences. In the concluding section, observations about rate-setting areas that merit further consideration are presented. The underlying intent of this analysis of MLTS payment methodologies is to spark discussion and generate new ideas for building reimbursement methodologies that accurately reflect the health and long-term supports and service needs of Medicaid beneficiaries.

Introduction

In 2004, only about 2% of Medicaid beneficiaries with long-term support and service needs were enrolled in risk-based programs;[5] the majority of this population was in a fee-for-service (FFS) delivery system. Today, a growing number of states are considering managed long-term supports and services (MLTS) programs to increase access to care for their beneficiaries and control rising Medicaid expenditures. Long-term supports and services account for approximately 32% of total Medicaid expenditures.[6] Virtually every state Medicaid director is concerned with determining how to use public money wisely to purchase high quality long-term supports and services to serve a growing number of older people as well as younger people with disabilities.

In addition to the Program of All Inclusive Care for the Elderly (PACE)[7] that now enrolls approximately 15,000 beneficiaries in 20 states,[8] a wide range of MLTS programs have been implemented in Arizona, California, Florida, Massachusetts, Minnesota, New York, Texas, Washington, and Wisconsin. Some of these programs are designed to integrate acute and long-term care services (or, at least funding streams) for dual eligibles (Minnesota Senior Health Options and Disability Health Options, Massachusetts Senior Care Options, New York's Medicaid Advantage Plus, and the Wisconsin Partnership programs). Others were designed primarily as Medicaid-only long-term care programs, with the main goal of improving the delivery of MLTS services to community-based beneficiaries (Arizona Long Term Care System, Texas Star+Plus, Wisconsin Family Care, New York Managed Long-Term Care Plan, Washington Medicaid Integration Partnership, and the Florida Nursing Home Diversion waiver).

There are two major potential advantages to Medicaid MLTS compared to Medicaid FFS. First, Medicaid managed care can facilitate the development of systems of care that support frail people in the community and delay or prevent nursing facility[9] placement. In many states, home and community-based service (HCBS) providers are encouraged through financial incentives to deliver as many services as possible to the limited number of people served by the program. Since HCBS providers are not at-risk for nursing facility costs, they do not benefit financially by keeping their clients out of nursing facilities, or suffer any financial penalty if their clients move into nursing facilities. Most forms of Medicaid MLTS attempt to change this by putting a managed care entity at-risk for at least a portion of nursing facility care, thus creating more incentives for HCBS providers to serve people in the most appropriate community setting rather than in a nursing facility.

A second potential advantage of Medicaid MLTS is that it can provide a vehicle to integrate acute and long-term care, which should lead to improvements in the quality and efficiency of care for people in need of long-term supports and services. However, because almost all elderly people, and many frail people with disabilities, are covered by Medicare for acute care services,

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[5] L. Palmer and S.A. Somers, op. cit.
[6] Saucier, et al., op. cit.
[7] Program of All Inclusive Care for the Elderly (PACE) is a capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. Accessed at: **http://www.cms.hhs.gov/pace/**
[8] Accessed at: National PACE Association **http://www.npaonline.org/website/download.asp?id=1740**
[9] For the purposes of this paper, the term *nursing facility* and *nursing home* are used interchangeably.

achieving the second goal inevitably requires integration of Medicaid and Medicare financing streams. Further, there are many policy, regulatory, administrative, and political barriers to achieving this ideal integration.

Despite the quality improvement and cost savings potential of Medicaid MLTS, risk-based long-term care programs remain a niche product in a limited number of states. Obstacles to growth include "complex program design issues, consumer and provider resistance to managed care, contradictory payment incentives between Medicare and Medicaid, cumbersome regulatory requirements, and a dearth of managed care organizations with the expertise and willingness to assume risk for a broad range of Medicaid and Medicare-covered benefits, including long-term care services."[10] Additionally, although in part a chicken-and-egg problem, the lack of clearly demonstrated benefits to both states and beneficiaries of MLTS programs has contributed to the relatively slow adoption of these programs.

There are at least two major challenges for Medicaid programs purchasing managed long-term supports and services:

- An "institutional bias" that results in beneficiaries, despite their preferences, residing in nursing facilities; and

- Long-term care services and acute care services are, with few exceptions, not well coordinated or integrated, which creates problems for both quality and efficiency. The integration challenge is particularly difficult because a majority of Medicaid beneficiaries receiving long-term supports and services are dual eligibles, whose acute care expenditures are largely paid for by the Medicare program.

In the list of obstacles cited by the 2005 study, *The Past, Present and Future of Managed Long-Term Care,*[11] concern about the adequacy of Medicaid MLTS rate-setting methods was not mentioned as an impediment to the spread of MLTS. However, from discussions with state Medicaid officials, it is apparent that concerns about the ability to craft viable reimbursement systems contributes to the slow pace of Medicaid MLTS adoption. To the extent that state Medicaid programs are not confident that they can implement payment systems that will help accomplish programmatic goals, and if providers are not confident that they will be reimbursed adequately, then it will be difficult to expand Medicaid MLTS.

The purpose of this exploratory paper is to describe the existing rate-setting systems used by Medicaid MLTS programs, highlight the major decisions states must make in setting rates for Medicaid MLTS, and summarize the lessons from the states interviewed. The concluding section presents observations about rate-setting areas that merit further consideration. The underlying goal of this analysis is to generate new ideas for developing reimbursement models that can support the growth of MLTS for Medicaid beneficiaries throughout the United States.

[10] Saucier, et al., op. cit.
[11] Ibid.

Methodology

In late 2006, Richard Kronick, University of California-San Diego, and CHCS surveyed Medicaid MLTS programs and representatives from CMS and PACE, to gain a better understanding of the methods used to set rates in these types of programs. Kronick and CHCS conducted telephone interviews with Medicaid program managers within each state that has implemented a non-PACE MLTS program, and reviewed rate and payment structures as well as other tools (e.g., functional screens) used to set rates. Appendices A and B summarize the information that was gathered on MLTS rate-setting practices. The major findings and lessons from the analysis are presented below.

Key Findings and Recommendations

In assessing the advantages and disadvantages of alternative approaches to rate setting, it is important to understand the two primary goals of rate-setting systems. The first goal is to guarantee that Medicaid programs pay the "right" amount to program contractors[12] – enough, but not too much – to ensure that contractors can deliver high quality services to beneficiaries. Typically, the "right" amount also means no more than would be paid under a FFS model. The second goal is to provide incentives for behaviors that Medicaid programs would like to reward or change. Given the environment in which Medicaid programs function, a major constraint – but also an opportunity – is that providers who benefit from the current system (e.g., nursing facilities), must get something out of the new system, especially if they are in the position to impede movement to a new system. The key issues states must resolve in setting MLTS rates include:

1. *Determining and updating the base rate for Nursing Home Certifiable (NHC) beneficiaries receiving services in the community;*
2. *Adjusting the base rate depending on service need;*
3. *Adjusting the rate for beneficiaries in nursing facilities;*
4. *Adjusting the rate for beneficiaries who are not NHC;*
5. *Adjusting the rate for the Medicaid acute care portion of the rate; and*
6. *Interaction (if any) with Medicare payment.*

The following sections of the paper address these key issues, provide examples of approaches taken by state programs, and highlight best practice recommendations.

[12] For the purposes of this paper, the term *contractor* and *health plan* are used interchangeably.

Determining and Updating Base Rates

Overview

There are a variety of methods that states use to establish and update base rates for nursing home certifiable beneficiaries receiving services in the community. The states highlighted in this report vary broadly in both the methods used to determine the base rates paid to health plans and in the strategies used to update these rates over time.

Determining the Base Rate

With the exceptions of PACE and Arizona's Long-Term Care System (ALTCS), most MLTS programs determine the initial base rate for NHC beneficiaries living in the community based on the cost of beneficiaries enrolled in HCBS-waiver programs. Most enrollees in MLTS programs are NHC beneficiaries who live in the community, and, if the managed long-term supports and services program did not exist in that state, many of the beneficiaries would receive services through an HCBS waiver. Therefore, it makes sense to calculate the cost of these beneficiaries based on the HCBS waiver and to use that cost to develop the initial rate for the MLTS program.

In contrast, PACE programs in most states use a comparison group that includes both institutionalized and HCBS beneficiaries. In most cases, PACE rates are heavily weighted toward the experience of institutionalized beneficiaries, who typically comprise the majority of recipients at a nursing facility level of care. Because reimbursement for nursing facility residents is generally significantly higher than reimbursement for similarly impaired beneficiaries living in the community, PACE rates are significantly higher than the rates used in other MLTS programs that target beneficiaries living in the community.

Unlike other states, Arizona does not set rates administratively, but asks potential contractors to submit bids based on anticipated utilization and expenditures. The final rate is negotiated based on the bids that the state receives from the contractors. Florida is also an exception. In Florida, HCBS experience is used to set rates, but a 30% upward adjustment is assumed to reflect greater service expectations in the Nursing Home Diversion waiver (the MLTS program in Florida), than in the HCBS waivers.

Updating the Base Rate

Most MLTS programs update the base rate either by applying a trend factor to the initial rate or basing the update on an analysis of recent HCBS experience (i.e., cost and utilization data). However, Wisconsin's MLTS program, Family Care, uses a different approach to calculate rates over time. The state collects information from contractors on the services used by beneficiaries enrolled in the program, and estimates rates based on relatively recent program data. Contractors' experiences (i.e., expenditures) are averaged across all of the program's contractors to compute the average payment rate.

Two other MLTS programs, Arizona and New York, also incorporate contractor experience in setting the long-term care portion of the rates. However, unlike Wisconsin's approach,

contractor experience is not averaged. Rather, in these two programs the rates are negotiated based on the cost experience of each contractor.

Suggested Approach (Updating the Base Rate)

As an MLTS program matures, it is reasonable to expect that patterns of care and expenditures for beneficiaries will be quite different from the expenditures of beneficiaries on HCBS waivers.[13] As a result, it makes sense to update rates over time using utilization and expenditure data for MLTS beneficiaries, although there are a variety of obstacles to successfully using contractor experience to set rates. Basing rates on MLTS experience (rather than on the experience of beneficiaries in HCBS waivers) can help ensure that rates are adequate and appropriately reflect program utilization and expenditures.

Key Considerations for States: Rebasing Rates Based on Program Experience

1. ***What can states do to gather reliable information on utilization and expenditures?*** If states use encounter data on a more frequent basis, then the potential for these data to be reliable increases. For example, most states require contractors to submit encounter data; however, few states use these data to set rates.

2. ***Should states base rates for a particular health plan on the health plan's individual experience or on the combined (average) experience of all health plans?***

   The decision to set rates using either an *individual* contractor's experience or the *average* of the experience across all contractors will influence the incentives for health plans to be efficient in their delivery of service. Recognizing individual contractor's experiences will protect contractors whose enrollees are more likely to need nursing home-level care as opposed to HCBS-level care. Using the experience of individual contractors, however, may also have the negative consequences of reducing the incentive to substitute HCBS for nursing facility level of care. Further, basing the rate for a health plan on its own experience attenuates the efficiency-enhancing incentives that using the capitation method is designed to create. For example, if a contractor spends more money, or allows more beneficiaries to enter nursing facilities, it will likely recoup much of the extra spending in a subsequent year.

   Basing the rate for each health plan using only their own experience, as is done in Arizona and New York, can result in a more accurate rate calculation that reduces the likelihood of excess profits and losses. If a state has not implemented a risk-adjusted payment system protecting contractors that attract high-risk clients, then basing rates on individual contractor experience may be a reasonable approach. Further, Arizona and New York do not automatically recognize all of the contractor costs, but rather compare costs for each contractor to norms that are derived from the average experience across all contractors, and

[13] Service utilization and expenditures in Medicaid MLTS programs might be different from those in HCBS waivers for at least three reasons: (1) managed care organizations, may (if given the flexibility by the states) make different decisions about the need for services than would be made by an HCBS care planner; (2) if the MLTS is voluntary, the beneficiaries in MLTS may be different than the group in HCBS; and (3) if the HCBS program had a waiting list but the MLTS does not, the population served by the MLTS might be quite different from the group served by the HCBS waiver.

may disallow costs that are far from the norm. The comparison of contractor costs to industry norms limits the ability of contractors to recoup additional costs, and maintains some incentives for efficiency.

3. ***Does periodic rebasing simply perpetuate FFS incentives, in which health plans get paid more if more expensive care is provided? Does it unfairly penalize health plans with reduced rates if they are able to create efficiencies in the system?***
   As discussed above, if rebasing is done at the industry level (using the combined contractor's experience), incentives for efficiency are strong. To the extent that the MLTS program reduces utilization and expenditures, states might choose to leave some of the savings with the health plan(s) to encourage further investments in the development of community-based systems of care.

4. ***How should states address case management costs?***
   Most states set an allowance for administrative costs as a percentage of premium. This raises the question of whether case management costs should be considered as a part of administrative costs, or whether case management costs should be considered when calculating the service portion of the premium. Because case management is a vital service that MLTS contractors are expected to provide, considering case management as a service, and not as an administrative cost, makes sense. The downside for states is that defining case management as a service may lead to increased costs. States will want to carefully track case management expenses and may want to limit the percentage of premium allowed for case management.

5. ***How should states deal with costs for services that are not included in the state plan amendment?***
   According to current CMS rules,[14] expenditures for services that are not traditionally covered by Medicaid cannot be included in rate determination, even if an at-risk plan has determined that these services will improve the quality of life at an acceptable cost (or, perhaps, even save money). This rule is problematic, since it could discourage health plans from providing quality-improving, efficiency-enhancing care. Unless or until this rule is changed, a reasonable response would be for the state to calculate the value of services that are not included in the state plan, and then informally make an adjustment elsewhere in the rate-setting process (i.e., making a slight upward adjustment (in their calculation) to the inflation factor or other feature of the rate setting system) to ensure that at-risk contractors are not discouraged from providing beneficial services.

Adjusting the Base Rate Depending on Service Need

Overview

States should consider how, if at all, to adjust the nursing home certifiable base rate to reflect the heterogeneity of service need among nursing home certifiable beneficiaries living in the community. Nursing home certifiable beneficiaries vary widely in their level of need. Some

[14] Federal Rule: 42 CRF, §438.6(c) (4) (ii) Actuarial soundness.

NHC beneficiaries have extensive long-term support and service needs, while others can remain in their communities with more moderate levels of long-term supports and services. The variation in need is related to several factors, including: the level of functioning, (e.g., beneficiaries unable to perform any activities of daily living (ADLs) or instrumental activities of daily living (IADLs) without assistance need more help than those with fewer ADL and IADL deficiencies); the extent of cognitive impairment and behavioral difficulties; and the availability of informal support.

MLTS payment systems vary widely in responding to the heterogeneity of need among NHC beneficiaries. Two states – Wisconsin and Florida – make explicit payment adjustments based on beneficiary characteristics. Two other states – Arizona and New York – use a negotiated rate process that implicitly pays more to contractors serving higher-need beneficiaries (to the extent that utilization and expenditures are higher for these contractors than for those serving lower-need beneficiaries). Other programs, including those in Massachusetts, Minnesota, Texas, and Washington, as well as the PACE program, pay the same rate to all contractors within a geographic area, thus do not adjust payments based on the characteristics of the beneficiaries enrolled in a given health plan.

Wisconsin Family Care uses a sophisticated approach to adjusting payments that addresses heterogeneity among NHC beneficiaries. The state gathers an extensive amount of information about the beneficiary using a web-based functional screen.[15] The state then uses regression analysis to estimate the relationship between client characteristics (i.e., level of care, specific ADLs, count of IADLs, and specific communication, cognition, and behavioral issues) and expenditures. The functional screen is used, along with information on the distribution of client characteristics for each contractor, to determine a risk-adjusted rate.

A somewhat similar method of adjusting rates based on beneficiary need is used in the Florida Nursing Home Diversion waiver. However, Florida and Wisconsin's methods differ in that Wisconsin conducts the regression analysis based on the experience of beneficiaries enrolled in the Family Care program – that is, the program for which capitated payments are made. Florida, on the other hand, conducts the analysis on beneficiaries enrolled in the Aged and Disabled Adult (ADA) waiver[16] and the Assisted Living for the Elderly (ALE) waiver,[17] which both predate the Nursing Home Diversion program for which capitated payments are risk adjusted. The relationships among beneficiary characteristics and expenditures are not as strong among beneficiaries in Florida's ADA and ALE waiver programs as among Wisconsin Family Care beneficiaries. This may, in part, be because the set of services provided through the Florida waivers are more limited than in the Wisconsin Family Care program.

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[15] Wisconsin's Functional Screen. Accessed at **http://dhfs.wisconsin.gov/LTCare/FunctionalScreen/index.htm**

[16] Aged Disabled Adult Waiver Program (ADA Waiver) provides home and community-based services for individuals 60 years old or older or ages 18 to 59 and determined disabled according to Social Security standards; meet SSI, or Medicaid waiver assistance income and asset requirements; meet nursing facility level of care criteria; and are enrolled in the waiver. Accessed at: **http://ahcaxnet.fdhc.state.fl.us/nhcguide/alternatives.shtml#AssistedLivingfortheElderlyWaiverProgram**

[17] The Assisted Living for the Elderly (ALE) waiver program is a statewide home and community-based services program for individuals who reside in qualified Assisted Living Facilities. To be eligible for ALE waiver services, an individual must be age 65 and older or be ages 60 to 64 and be determined disabled according to Social Security standards; meet nursing facility level of care criteria; meet SSI or Medicaid waiver assistance; and meet one or more criteria including: require assistance with four or more ADLs; require assistance with three ADLs plus supervision, or administration of medication. Accessed at: **http://ahcaxnet.fdhc.state.fl.us/nhcguide/alternatives.shtml#AssistedLivingfortheElderlyWaiverProgram**

As MLTS programs mature, it will likely be advantageous to state Medicaid programs, health plans, and beneficiaries in need of long-term supports and services, to adjust rates to reflect the heterogeneity of needs among NHC beneficiaries. Adjusting rates based on the functional status and other characteristics of enrollees will ensure that beneficiary needs are met and protect health plans that serve a disproportionate number of high-need beneficiaries. Further, rates that are adjusted based on functional status will protect Medicaid programs if the MLTS program expands to serve additional community-based beneficiaries who were not previously receiving HCBS services. These newly served beneficiaries may have lower levels of need than beneficiaries previously served by HCBS waivers; and a functional-status based payment will not simply assume that they are average. Reflecting this understanding, Medicaid program staff in each of the states interviewed expressed interest for the development of methods that would allow them to adjust rates based on level of enrollee need.

Suggested Approach

It is clear to us, and to most of the Medicaid program staff with whom we consulted, that the development and implementation of robust "risk-adjustment" tools for beneficiaries in need of long-term supports and services may facilitate the growth of MLTS programs. There are, however, some environments (e.g., programs with only a few contractors, with few concerns about differential risk selection, and with a relatively stable population of beneficiaries) in which not accounting for the heterogeneity of need among the NHC population is a satisfactory approach to determining rates. However, it seems likely that a rate-setting approach that more closely aligns payments with expected service need may facilitate the development of delivery systems that achieve MLTS program goals.

Key Considerations for States: Adjusting Rates Based on the Functional Characteristics of Nursing Home Certifiable Beneficiaries

1. ***How can states collect reliable and valid information on functional status and other characteristics?***
   When a health plan payment is adjusted based on the diagnoses of beneficiaries, the quality and quantity of diagnostic information changes significantly. If health plans are paid based on the ADL and other characteristics of beneficiaries, then the accuracy and completeness of that information will improve over time. The fairest approach, both to assure equity across health plans and to minimize "functional-status creep," is to have personnel who are independent of the contractors conducting the functional assessments – that is, to have state agency personnel or a third-party under contract to the state perform all of the assessments. If the state allows contractors to perform the assessments, then clear, standardized instructions should be provided, and some system of auditing will be needed.

2. ***Are there enough similarities in expenditure patterns (and in the relationships between beneficiary characteristics and expenditure patterns) across states that a set of national weights could be developed, or would each state inevitably want to develop their own state-specific weights?***
   It appears that the relationship between functional status and HCBS expenditures varies substantially across states. As described above, the relationships seem to be stronger in the Wisconsin Family Care program than in Florida's Assisted Living for the Elderly waiver or

Aged and Disabled Adult waiver. Similar analyses conducted on Connecticut[18] HCBS participants in the 1990s found results closer to the Florida experience, with modest relationships between ADLs and expenditures, while analyses conducted on California[19] beneficiaries receiving in-home supportive services found results more like Wisconsin, with relatively strong relationships between ADLs and expenditures. There are both empirical and normative questions here – it might be that in some states (e.g., Connecticut and Florida) there is not a strong relationship between ADLs and expenditures, but that most stakeholders agree there should be. If that were the case, then a set of national weights might be plausible. A variant is that national weights could be developed and states with relatively weak relationships between ADLs and expenditures could blend those weights with a non-risk-adjusted rate to "dampen" the effect of risk adjustment.

3. ***Is the information on beneficiaries' characteristics collected by states similar enough (across states) that a relatively uniform "Risk Adjustment for Functional Status" (RAFS) system could be developed?***
   Rick Kronick and CHCS spent several months speaking with states to assess the type of functional assessment information that is currently available. While there are differences in the information that is available, it appears there may be enough commonalities in the data collected to allow for the development of a RAFS system. Nonetheless, states would still have to do some "tweaking" to the RAFS system to reflect their individual state environments.

4. ***How (if at all) should states acknowledge the availability of informal support from family members or friends in the payment system?***
   In several waiver programs it appears that beneficiaries who have more informal support receive fewer waiver services than those with less informal support. Neither Wisconsin's nor Florida's risk-adjustment system accounts for the impact of informal supports. A RAFS system probably should not consider the availability of informal supports. States should, however, consider the attitude of certain groups within their beneficiary population toward institutionalization of family members. For example, certain racial and ethnic groups may be more likely to provide informal supports to their frail and elderly family members in the home in order to avoid nursing facility placement. Thus, including informal supports in the payment system could create inequities if some health plans disproportionately serve beneficiaries from racial or ethnic groups who may have more access to informal support services. This potential inequity is worth noting and may warrant further analysis.[20]

Adjusting the Rate for Beneficiaries Living in Nursing Facilities

Overview

One of the major rationales for implementing MLTS programs is to create incentives and opportunities to support beneficiaries living in the community and to delay or prevent nursing

[18] R. Kronick and T. Gilmer. *Final Report: Development of Risk-Adjusted Payment Methods for the Connecticut Lifelong Care Project*. Prepared for the Connecticut Department of Social Services, 2000.
[19] R. Kronick and T. Gilmer. *Final Report: Risk Adjustment for In-Home Support Services Users in Alameda County*, January 2001.
[20] States could develop incentive systems to reward plans for maintaining or increasing the availability of informal support.

facility placements. States range widely in the extent to which they provide strong financial incentives to keep beneficiaries out of nursing facilities. Wisconsin, Florida, and the PACE programs provide the strongest incentives to avoid institutionalization. Health plans in these programs are fully responsible for nursing facility care and do not receive a payment adjustment when a beneficiary enters a nursing facility. In Arizona and New York, there also is no payment adjustment when a beneficiary enters a nursing facility. However, in subsequent years the rates in these two states adjust upward in response to increased expenditures in the base year.

Minnesota's Senior Health Options (MSHO) and Massachusetts's Senior Care Options (SCO) programs use incentives that fall in the middle of that range or continuum. In Minnesota, contractors are paid an actuarially determined "nursing facility add on" for potential nursing home placements for all non-institutional members and are at risk for 180 days of nursing home costs for any placement made from the community. When a member is placed in the nursing home, the nursing home add-on payment to the contractor ceases, and the contractor must cover that cost out of previously paid revenues. After the 180 days of contractor liability is satisfied, the nursing home is paid directly by the state at fee-for-service rates, but the beneficiary remains enrolled for other services. Massachusetts uses a similar approach, but the rate adjusts upward after three rather than six months of payment at the community-level rate. Massachusetts also has a transitional rate for beneficiaries who move from nursing facilities into the community. To achieve a positive policy objective, contractors get paid at the higher nursing facility rate for a period of time after the beneficiary transitions from the nursing facility into the community. At the other end of the continuum, the financial incentives in Texas Star+Plus and Washington's Medicaid Integration Partnership (WMIP) programs are not as robust. Beneficiaries are disenrolled from the Texas program four months after entering a nursing facility. Similarly, beneficiaries are disenrolled from the Washington program six months after nursing facility placement.

Massachusetts, Texas, and Washington contractors have modest financial incentives to support high-need individuals in the community. Health plans are required to pay for the first few months of nursing facility placement, but they are paid by the Medicaid program at a community rate rather than the nursing facility rate. When caring for frail beneficiaries for whom community-based costs are likely to be high, the financial advantage of keeping beneficiaries living in the community is likely to be small and short-term. From a financial perspective, it seems that health plans in these states may have more of an incentive to allow a very high-need individual to transition into a nursing facility, rather than making heroic efforts to keep him/her living in the home. One reason this may be true is because these states do not use functional status data to risk-adjust payments for NHC beneficiaries living in the community and thus use rates that may not capture the potentially higher costs of these individuals. A high-need beneficiary in the community is likely to use more care than is covered in a capitation rate that has not been risk adjusted based on functional status. As a result, some health plans may have more of an incentive to let high-need beneficiaries enter a nursing facility. In this scenario, the health plans would be responsible for nursing facility expenditures between three and six months, and then be relieved of financial responsibilities – either because the beneficiary is disenrolled from the health plan (e.g., Texas and Washington) or because the capitation rate has been adjusted to a nursing facility-level rate (e.g., Massachusetts).

Suggested Approach

In MLTS programs that primarily enroll community-based beneficiaries, it makes sense to hold contractors responsible for beneficiaries regardless of where the care is provided. In most states, one of the major goals of MLTS programs is to improve and invest in community-based systems of care and to increase the number of beneficiaries served in the community. It is safe to assume that even with moderate financial incentives to keep beneficiaries in the community, health plans would respond accordingly.

In MLTS programs that are just starting up, health plans may need protection from lifetime responsibility of nursing facility care, and, during start-up phases, it may make sense for states to provide this protection (as Washington has done in the WMIP). However, if MLTS programs start with this sort of protection, it makes sense to move, over time, to greater contractor responsibility for nursing facility care. Although well-intentioned contractors can be expected, at least initially, to support beneficiaries in the community even in the absence of strong financial incentives, over time the financial incentives are likely to drive behavior, and for this reason states should align financial incentives to support community living.

If an MLTS program does use strong financial incentives to keep beneficiaries living in the community, then the state should also consider a method of adjusting rates that incorporates variations across health plans in the expected probability of nursing facility placement. That is, if some health plans attract beneficiaries who are at higher risk of nursing facility placement, then the payment should adjust accordingly.

In Florida, the state uses a "nursing home placement add-on" that recognizes that some beneficiaries will transition into nursing facilities and that their health plans will be responsible for nursing facility costs. The add-on is based on the number of years that the health plan has been participating in the Nursing Home Diversion program. The length of time a health plan has been a contactor with the program is used as a proxy for the probability of nursing home placement. This approach assumes that transitions to nursing facilities will be more frequent among the program's more "mature" health plans. For example, a health plan that has been with the program for two years will receive an add-on of $263 per enrollee per month. On the other hand, a health plan that has been in the program for five years receives an add-on of $603 per month to cover the anticipated additional costs of paying nursing facility rates for members who are expected to transition to nursing facilities.

Although Florida's approach is sensible, it may make more sense to base the add-on rate on the length of time a beneficiary has been enrolled in the program (or has been NHC), rather than the length of time that the health plan has been a contractor with the program. The probability of nursing facility placement is likely to depend on factors such as: how long the beneficiary has been NHC; level of frailty; age; housing; HCBS availability; and/or the availability of informal supports. Investigation of the relationship between these factors and the likelihood of nursing facility placement as well as the development of an adjustment system to reflect this relationship would improve the ability to put contractors at-risk for nursing facility placements.

The approach taken in Wisconsin implicitly adjusts for the probability of nursing home placement. The payment weights from the functional screen's regression model incorporate adjustments for factors such as ADL deficiencies. The payment weights are estimated using the experience of beneficiaries enrolled in the program. To the extent that older beneficiaries or

those who are frailer are more likely than others to become nursing facility residents, then the payment weights for these characteristics (e.g., ADLs) will reflect the expected additional costs of being placed in a nursing facility. One factor that is not included in the regression model, but that might be predictive of nursing home placement is the beneficiary's length of enrollment in the MLTS program. It is possible that beneficiaries who have been enrolled for longer periods of time in Family Care have a higher probability of transitioning to a nursing facility than beneficiaries with shorter enrollment periods. States should consider including the amount of time that a beneficiary has been NHC as a factor in their risk-adjustment formula.

Adjusting the Rate for Beneficiaries who are Not Nursing Home Certifiable

Overview

A potential benefit of MLTS programs is that health plans may be able to provide long-term supports and services that may improve the quality of life, slow the rate of functional deterioration, and reduce hospitalizations for beneficiaries who are not yet NHC. The ability of health plans to provide more coordinated long-term supports and services than FFS can provide depends, in part, on whether some of those services (e.g., personal care and adult day health) are available as state plan services and also on the approval process, both under the state plan and as part of the MLTS program. For example, if health plans are expected to provide a substantial volume of long-term supports and services to beneficiaries who are not NHC, then this expectation should be reflected in the rate-setting process. Massachusetts has a separate rate for beneficiaries who are not yet NHC, but who have Alzheimer's disease or a chronic mental illness. The state chose to create a separate payment rate for Alzheimer's because a diagnosis of this disease is an indicator of need for MLTS among beneficiaries who do not meet NHC criteria. By providing a higher payment rate to health plans that serve beneficiaries with these diagnoses, the state creates incentives to attract these types of higher-need beneficiaries who are not yet NHC into the MLTS program.

Texas is an example of an MLTS program with a community "well" capitation payment that allows health plans to provide limited amounts of long-term supports and services to beneficiaries who live in the community, but are not NHC. Personal care and adult day health are state plan services and are not restricted to beneficiaries who are NHC. Reimbursement in the community "well" rate cell for dual eligibles in Texas Star+Plus is approximately $150 per month, of which approximately $100 per month is allocated for community long-term services. Health plans can use these funds to provide long-term supports and services to beneficiaries who are not NHC, but who may need these types of supports and services. Unlike Massachusetts, which provides health plans with an incentive in the form of a different payment rate to serve non-NHC beneficiaries who need long-term services and have Alzheimer's disease, Texas addresses this issue through the capitation rate.[21]

[21] Texas uses the Chronic Illness and Disability Payment System to adjust the acute care portion of the capitation ($150 per month). To the limited extent that diagnostic information is useful in predicting long term care needs, the rate is partially adjusted for MLTS needs.

Suggested Approach

There is substantial variation across states concerning the extent to which community-based long-term supports and services are covered as state plan services or under HCBS waivers. Similarly, there is also variation across states in the rules used to determine service levels for beneficiaries who are not NHC. As such, it is difficult to suggest just one approach.

It is important for all states to clearly communicate to contractors the expectations concerning the delivery of MLTS to non-NHC beneficiaries and to develop payment systems that support these expectations. A challenge is that most states collect diagnostic and prescription drug information for beneficiaries who are not NHC, but do not collect functional status data for this population. This lack of information makes it difficult to adjust payments for long-term supports and services in a systematic way (the Massachusetts Alzheimer disease and chronic mental illness rate cells circumvent this problem). Alternatively, states can survey a sample of health plan enrollees on a variety of health-related issues, similar to those addressed in the Health Outcomes Survey (HOS) that CMS conducts on Medicare beneficiaries, and adjust payments accordingly.[22] The types of topics addressed in the HOS survey include pain, emotional health, physical health, durable medical equipment, and limitations with completing certain basic activities. However, states that use this survey approach should note that this is a very difficult population to survey, as described in Anthony Tucker's 2006 report examining the need for support for activities of daily living among Maryland's Community Choice-eligible population.[23]

Adjusting the Medicaid Acute Care Portion of the Rate

Overview

In most states, a majority (typically 80% or more) of MLTS beneficiaries are dual eligibles.[24] For dual eligibles, the acute care portion of the Medicaid rate is typically in the range of $50-$200 per month.[25] This is a small enough amount (relative to the total payments that most MLTS health plans receive) that applying diagnostic risk adjustment to the acute care portion of the rate is not likely to have much effect on health plan incentives to encourage or discourage high-need beneficiaries from enrolling. However, even if diagnostic risk adjustment of the acute care portion of the rate for dual eligibles is not a high priority, doing so is likely to result in more equitable payments.

For states that have implemented diagnostic risk adjustment in managed acute care, a relatively straightforward extension of that process will allow diagnostic risk adjustment to the acute care portion of the rate for MLTS beneficiaries. Washington and Texas each use the Chronic Illness and Disability Payment System (CDPS) to adjust their managed acute care rates as well as the

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[22] The Medicare Health Outcomes Survey (HOS) is an outcome measures tool used in Medicare managed care. Accessed at: **http://www.hosonline.org/**

[23] A. Tucker. *A Survey of Functional Status to Support Community Choice Rate Setting and Program Assessments*. Center for Health Program Development and Management, University of Maryland, Baltimore County. July 2006 Accessed at: **www.chpdm.org/StudyFindingsTemp1.htm**

[24] Arizona is an exception. Arizona covers large numbers of beneficiaries under-65 with physical disabilities in ALTCS, and many of these beneficiaries are Medicaid-only.

[25] Minnesota is an exception. The base rate for community "well" (that is, not NHC) beneficiaries is in the range of $600 per month.

acute care portion of the Medicaid managed long-term care rate. CDPS is a diagnostic classification system that Medicaid programs can use to make health-based capitated payments for Temporary Assistance to Need Families (TANF) and Medicaid (non-duals) beneficiaries with disabilities. MLTS programs that are integrated with Medicare can relatively easily use the CMS Hierarchical Condition Category (CMS-HCC)[26] model to adjust the acute care portion of the capitation. The Wisconsin Partnership Program uses the CMS-HCC approach to adjust the capitation rate. For Medicaid-only beneficiaries, however, the acute care portion of the rate is much larger; therefore a diagnostic adjustment of this portion of the rate, using a method such as CDPS or CMS-HCC, is desirable.

Suggested Approach

Unless a state is already using diagnostic risk adjustment for acute care services, there is generally not enough money at stake in the acute care portion of the Medicaid rate for dual eligibles to warrant the time and expense needed to implement diagnostic risk adjustment. In states with substantial numbers of Medicaid-only (as opposed to dual eligible) beneficiaries in MLTS, the desirability to use a system such as CDPS or CMS-HCC to perform diagnostic risk adjustment increases. However, it should be noted that the length of time it takes to implement diagnostic risk adjustment depends on the quality of the state's diagnostic data as well as its Medicaid management information system.

Interaction with Medicare Payment *(if any)*

Overview

The strongest rationale for "managing" long-term supports and services is that it may facilitate the integration of Medicare acute and long-term care. It makes sense to assume that if one group of providers or health plans has clinical and financial responsibility for the entirety of a beneficiary's care and use of resources, then better decisions can be made about the care of that individual. Further, it also makes sense to assume that this may lead to increases in HCBS services provided (above the level provided in waivers or under a state plan), investments in case management, and, potentially, increased payments to nursing facilities to provide preventive services aimed at reducing hospitalizations and institutionalizations. As a result, many states are searching for ways to account for Medicare in determining payment rates for dual eligible beneficiaries.

Despite the potential advantages of integrating Medicaid managed long-term supports and services with managed Medicare acute care, these integrated approaches face a wide range of hurdles to success, including rate-setting challenges. For example, a Medicaid health plan that wants to act as a Medicare Advantage Special Needs Plan (SNP), is required to submit a Medicare Advantage bid that is based on the cost of supplying Medicare-covered services. The process of identifying of Medicare-covered services (as distinct from Medicaid-covered services) is difficult and requires substantial administrative effort.

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[26] Set of Hierarchical Condition Categories (HCC) is designed to pay health plans an adjusted payment to account for care for the health plan's most ill beneficiaries. Risk-adjustment factors include: age, sex, Medicaid status, and disability. Accessed at: **http://www.thecodingsource.com/BusinessServices.html**

A second difficulty with Medicare payments to fully integrated plans is that under current regulations, with the exception of the PACE plans, there is limited adjustment in payments to reflect the greater frailty of beneficiaries (the CMS-HCC system adjusts payments for diagnoses, but not directly for functional status). For fully integrated SNPs that exclusively or primarily enroll beneficiaries at nursing facility level of care, this is likely to be a problem. CMS is continuing to conduct research on how best to adjust payments for "frailty," and successful resolution of this problem is important for the viability of fully integrated plans that target NHC beneficiaries.

If states try to rebase their long-term care rates using the experience of contractors, such rebasing may be challenging for programs in which a single contractor is receiving capitated payments from both Medicare and Medicaid. To the extent that contractors increase expenditures on long-term supports and services and reduce utilization of acute care services, Medicaid payments will increase, and acute care savings will accrue to some combination of contractors, beneficiaries, and the Federal Treasury. One possible solution to this problem would be to consider contractor experience in providing both Medicare and Medicaid-covered services, subtract the Medicare capitation received from the contractor revenue needs, and base the Medicaid rates on the difference between the total revenue needs and the Medicare reimbursement. However, this approach is not permitted by CMS regulations which require Medicaid rates to be based on the costs of supplying Medicaid covered services. Additionally, this approach would also put states potentially at-risk for fluctuations in Medicare reimbursement rates.

Suggested Approach

New York is making progress in this area by requiring health plans to provide information on the utilization and expenditures of Medicare covered services (see Appendix C). The state developed a template that organized its Medicare and Medicaid payment data. As part of the bidding process for the state's integrated Medicaid Advantage program, the state requires health plans to submit information included in their Medicare Advantage bids, essentially following the format of the Medicare Advantage Bid Pricing tool. The capitation rate calculation sheet includes the following:

- Categories of service;
- Proposed medical capitation;
- Administration;
- Medicare surplus
- Medicaid surplus/reserves; and
- Enrollee premium to be paid by Medicaid (if applicable).

By requiring heath plans to complete the pricing tool as part of the bid process, the state is able to identify potential duplication of funding and services between Medicaid and Medicare. In addition, integrating the bid rate information allows the state to better align incentives to the health plans.

Although there are many reasons that states will understandably be unwilling to go at-risk for Medicare payment decisions, states might consider the option (referenced in the overview of this section) at least as a theoretical approach. That is, a state could determine, based on contractor experience, the total cost of delivering care to beneficiaries in integrated Medicare-Medicaid

programs, subtract the capitation payments received from Medicare, and then base the Medicaid portion of the rate on the remaining expenditures. This approach puts states at-risk for variations in the adequacy of Medicare Advantage payments; if Medicare payments are too low, or the growth rate of Medicare Advantage payments is too constrained over time, Medicaid programs would end up being responsible for expenditures. However, if Medicare payments are too low, then the integrated programs are unlikely to be viable in any case. Another potential barrier to this approach would be obtaining approval for the rates from the Medicaid side of CMS, since the Medicaid rates would be based, in part, on the relationship between the cost of Medicare-covered services and the amount of Medicare Advantage payment for those services.

It is even more difficult to align incentives in MLTS programs that are not integrated with Medicare, such as Wisconsin Family Care, Texas Star+Plus, Washington's WMIP, Florida's Nursing Home Diversion waiver, and ALTCS in Arizona. In these programs states make payments for Medicaid-covered services for dual eligibles that are primarily enrolled in long-term care. Dual eligible beneficiaries may be enrolled in Medicare SNPs, regular Medicare Advantage plans, or in Medicare FFS. If dual eligible MLTS beneficiaries are also in Medicare FFS, there is little chance of integrating acute and long-term care, and any savings in reduced acute care expenditures will not accrue to the Medicaid program or to the MLTS plan. If beneficiaries are in Medicare Advantage plans, then savings in reduced acute care expenditures will be largely captured by the health plan. State and federal policymakers should work toward solutions that permit gain sharing so that all stakeholders have incentives to improve the quality of both acute and long-term supports and services.

Conclusion

State officials who are considering implementing MLTS programs for nursing home-eligible beneficiaries are faced with a complex set of rate-setting decisions. This report highlights the experiences of several leading states in designing rate-setting approaches for MLTS programs. As states embark on developing or refining the rate-setting process for their MLTS programs, they should consider the following:

- After Medicaid MLTS programs have been operating for a few years, states should consider rebasing rates using experience from program contractors, rather than relying on expenditures made in HCBS waiver programs.

- Long-term supports and services utilization and expenditures vary significantly among community-based nursing home certifiable beneficiaries, with some requiring much more care than others. MLTS rate setting should, where possible, recognize this heterogeneity by adjusting reimbursement for the functional status (and other characteristics) of enrolled beneficiaries. Development of a system of Risk Adjustment for Functional Status, as an analog to the diagnostic risk adjustments that are used in acute care, would facilitate the achievement of MLTS program goals.

- MLTS rate setting should create meaningful financial incentives to encourage health plans to maintain beneficiaries in community settings. Making contractors financially responsible for beneficiaries when they transition into a nursing facility may be the most likely method of accomplishing this goal.

- As programs mature, states should develop methods of recognizing (and paying for) the long-term supports and services needs of community-based beneficiaries who are not yet at nursing facility level of care.

- Diagnostic risk adjustment of the acute care portion of the capitation Medicaid MLTS is a sensible approach, but an issue of secondary importance to states. In most states, MLTS beneficiaries are dual eligibles, and the acute care portion of the rate for Medicaid is typically relatively small.

- Because virtually all beneficiaries over 65 as well as many people with disabilities under age 65 are nearly universally covered by Medicare, integration of acute and long-term care for this population ideally calls for the blending of Medicare and Medicaid financing. Among the many obstacles to accomplishing this integration is the requirement that Medicaid capitation rates be determined solely based on the cost of providing Medicaid-covered services rather than other cost-effective services that could enable beneficiaries to remain in the community. States are able to provide this type of flexibility when funding is blended or integrated across Medicare and Medicaid.

MLTS programs provide states with the opportunity to support frail beneficiaries living in the community and delay or prevent them from being placed in institutions. However, due to the broad spectrum of health needs and functional status associated with this clinically complex population, states must find ways to design programs and develop rate-setting processes that address the heterogeneity of their needs. In an effort to support state's work in this area, CHCS is continuing to work with Rick Kronick to assess the need and feasibility of developing a risk-adjusted rate-setting methodology based on functional status data.

Appendix A: *Program Overview*

Overview of Programs [aa, bb, cc]									
State	Program Implementation				Geography		Eligibility		
	Program Name	*Implementation Date*	*Title XIX Authority*	*Is the program integrated with Medicare?*	*Limited*	*Statewide*	*Non-Dual Eligible*	*Dual Eligible*	*Elderly*
Arizona	Arizona Long Term Care System	1989	1115	NO		X	X	X	X
California	Senior Care Action Network Health Plan	1985	1115	YES	X			X	X
Florida	Nursing Home Diversion Program	1988 (first county)	1915 (a)/(c)	NO	X			X	X
Massachusetts	Senior Care Options Program	2004	1915(a)	YES		X (statewide authority, but not statewide yet)	X	X	X
Minnesota	Minnesota Senior Health Options	1997	1915 (a)/(c)	YES		X	X	X	X
	Senior Care Plus	2005	1915 (b)/(c)	NO		X (statewide expansion 2007)	X	X	X
New York	Managed Long-Term Care Program	1998	1915(a)	NO	X		X	X	X
	Medicaid Advantage Plus	2007	1915(a)	YES	X			X	X
Texas	STAR+PLUS	1998	1915 (b)/(c)	NO	X		X	X	X
Washington	Medicare-Medicaid Integration Project	2005	SPA	NO	X			X	X
	Washington Medicaid Integration Partnership	2005[dd]	SPA	YES	X		X	X	X
Wisconsin	Family Care	2000 (first county)	1915 (b)/(c)	NO	X		X	X	X
	Wisconsin Partnership Program / PACE	1999	1115	YES	X		X	X	X

[aa] Chart reflects 2006 data supplied by states.
[bb] Only nine states are highlighted. Maryland made the decision not to pursue implementation of an MLTS program, and therefore is not included in these charts.
[cc] Chart Legend: DD= developmentally disabled, ICF= intermediate care facility, ISN= intensive skilled nursing, LOC= level of care, NF=nursing facility, NHC= nursing home certifiable, SNF=skilled nursing facility, SPA=state plan amendment.
[dd] Long-term care began in 2006.

Overview of Programs [ee, ff, gg]								
State		Enrollment					Plans to Expand or Modify Program	
	Program Name	*Mandatory*	*Voluntary*	*Are beneficiaries required to be NHC?*	*Total # of beneficiaries in program*	*Estimated # NHC beneficiaries enrolled in program (living in community & NF)*	*Yes*	*No*
Arizona	Arizona Long Term Care System	X		YES	42,783 (18,310 are DD) (FY 2006)	42,783	Plans to add consumer-directed care, transitional services, & spouses paid as caregivers	
California	Senior Care Action Network Health Plan		X	NO	68,000 (FY 2005-2006)	18,000 (FY 2005-2006)		Federal S/HMO[hh] demo expired 12/2007. State plans to convert Medicaid portion of SCAN to Medi-Cal managed care & Medicare portion of SCAN to SNP.
Florida	Nursing Home Diversion Program		X	YES	9,038 (FY 2005-2006)	9,038 (FY 2005-2006)		
Massachusetts	Senior Care Options Program		X	NO	7,000	2,200		
Minnesota	Minnesota Senior Health Options		X	NO	35,000	23,000		NO
	Senior Care Plus	X		NO	1,100	300	YES (statewide expansion)	
New York	Managed Long-Term Care Plan		X	YES	18,918	18,918	YES	
	Medicaid Advantage Plus		X	YES	0	0	YES	

[ee] Chart reflects 2006 data supplied by states.
[ff] Only nine states are highlighted. Maryland made the decision not to pursue implementation of an MLTS program, and therefore is not included in these charts.
[gg] Chart Legend: DD= developmentally disabled, ICF= intermediate care facility, ISN= intensive skilled nursing, LOC= level of care, NF=nursing facility, NHC= nursing home certifiable, SNF=skilled nursing facility, SPA=state plan amendment.
[hh] Social health maintenance organization.

Overview of Programs [ii, jj, kk]								
State		Enrollment					Plans to Expand or Modify Program	
	Program Name	*Mandatory*	*Voluntary*	*Are beneficiaries required to be NHC?*	*Total # of beneficiaries in the program*	*Estimated # NHC beneficiaries enrolled in program (living in community and NF)*	*Yes*	*No*
Texas	STAR+PLUS	X		NO	152,000	8,840	Expanded 2/2007 to additional service delivery areas increasing enrolled population from 60,000 to 152,000	
Washington	Medicare-Medicaid Integration Project		X	NO	69 (monthly avg)			
	Washington Medicaid Integration Partnership		X	NO (must meet the facility LOC)	2,700 (monthly avg)	196		
Wisconsin	Family Care		X[ll]	NO (vast majority of beneficiaries are NHC; small group is below NH LOC)	10,231	NHC: 9,673 Non-NHC: 558	Goal of expanding managed long-term care options statewide over the next 5 years	
	Wisconsin Partnership Program / PACE		X	YES	WPP: 2,256 PACE: 759	All are NHC	Goal of expanding managed long-term care options statewide over the next 5 years	

[ii] Chart reflects 2006 data supplied by states.
[jj] Only nine states are highlighted. Maryland made the decision not to pursue implementation of an MLTS program, and therefore is not included in these charts.
[kk] Chart Legend: DD= developmentally disabled, ICF= intermediate care facility, ISN= intensive skilled nursing, LOC= level of care, NF=nursing facility, NHC= nursing home certifiable, SNF=skilled nursing facility, SPA=state plan amendment.
[ll] The only way to get HCBS services in counties where Family Care operates is through Family Care Program (although PACE and WPP are also available in Milwaukee county).

Appendix B: *Rate Structure Information*

Medicaid Rate Structure Overview [mm, nn, oo]						
State	*Program Name*	*Name of Actuary*	*What comparison group used to set capitation rates?*	*Risk Adjustment within NHC population*	*Rate Cells/Rating Categories*	*Are separate rates by level of care used?*
Arizona	Arizona Long Term Care System	In-house	Rate based on experience of health plan enrollees	Based on contractors' experiences	Historically rate cells are defined by contract type. In FY 2007, separate capitation rates for (1) Dual; (2) Non-Dual; (3) Acute Care only; and (4) Prior Period Coverage, were developed.	Blended capitation rate
California	Senior Care Action Network Health Plan	In-house	Rate based on managed care data for aged/disabled/LTC dual eligible population	Age, gender, and geography	Dual eligible	NO
Florida	Nursing Home Diversion Program	Milliman	Aged/Disabled Adult Services & Assisted Living for Elders waivers[pp]	Frailty level and other NF placement add-on factors (*Assessment Rating Factor*)	One rate cell is used for all beneficiaries	NO
Massachusetts	Senior Care Options Program	Mercer	FFS Medicaid population	Clinical status, setting of care, and geography	(1) Community Other; (2) Community Alzheimer's Disease; (3) Community NHC; (4) Institutional Tier 1; (5) Institutional Tier 2; (6) Institutional Tier 3	YES
Minnesota	Minnesota Senior Health Options	Milliman	FFS waiver for HCBS portion	Age, gender, waiver status, institutional status, Medicare status, region, or county	Multiple rate cells	YES
	Senior Care Plus					
New York	Managed Long-Term Care Program	Mercer	Rate based on experience of health plan enrollees	Based on contractors' experiences	<65 and 65+	NO
	Medicaid Advantage Plus					

[mm] Chart reflects 2006 data supplied by states.
[nn] Only nine states are highlighted. Maryland made the decision not to pursue implementation of an MLTS program, and therefore is not included in these charts.
[oo] Chart Legend: DD= developmentally disabled, ICF= intermediate care facility, ISN= intensive skilled nursing, LOC= level of care, NF=nursing facility, NHC= nursing home certifiable, SNF=skilled nursing facility, SPA=state plan amendment.
[pp] 30% upward adjustment made to waiver experience reflects greater severity and greater service expectations.

Medicaid Rate Structure Overview [qq, rr, ss]						
State	*Program Name*	*Name of Actuary*	*What comparison group used to set capitation rates?*	*Risk Adjustment within NHC population*	*Rate Cells/Rating Categories*	*Are separate rates by level of care used?*
Texas	STAR+PLUS	In-house and Deloitte Touche	LTC portion of capitation rate based on HCBS waiver	Risk adjustment (CDPS) is made only to the acute care portion of rate	(1) Other Community Care Medicaid Only; (2) Other Community Care Medicaid/ Medicare; (3) Community Based Alternatives Medicaid Only; (4) Community-Based Alternatives Medicaid/Medicare	NO
Washington	Medicare-Medicaid Integration Project	Milliman	LTC portion of capitation rate based on HCBS waiver	Age, gender, and geography (CDPS used for acute care portion of rate)	(1) Nursing Facility Residents; (2) Community Option Program Entry System members; (3) Other Eligible Members	NO
	Washington Medicaid Integration Partnership	Milliman	FFS claims	Age, gender, and geography (CDPS used for acute care portion of rate)	(1) Nursing Facility Residents; (2) Community Options Program Entry System Members, Medicaid Personal Care Program, Division of DD, and Nursing Facility Residents; (3) Other Eligible Members	NO (planning to risk adjust based on CARE assessment)
Wisconsin	Family Care	Pricewaterhouse Coopers	Encounter data from Family Care program	Functional screen-based regression model	(1) Comprehensive LOC; (2) Intermediate LOC	YES
	Wisconsin Partnership Program / PACE	Pricewaterhouse Coopers	Blend of Nursing Facility FFS and HCBS FFS population	Different intensity levels of NF care stratify the LTC component of rate; functional screen-based regression model being phased-in. HCC used to risk adjust the primary/acute component of rate.	(1) ICF and SNF LOC; (2) ISN LOC	YES

[qq] Chart reflects 2006 data supplied by states.
[rr] Only nine states are highlighted. Maryland made the decision not to pursue implementation of an MLTS program, and therefore is not included in these charts.
[ss] Chart Legend: DD= developmentally disabled, ICF= intermediate care facility, ISN= intensive skilled nursing, LOC= level of care, NF=nursing facility, NHC= nursing home certifiable, SNF=skilled nursing facility, SPA=state plan amendment.

Medicaid Rate Structure Overview [tt, uu, vv]

State	Program Name	What is the rate? (in most cases, only select rates are listed)	Is acute care included in the capitation?	Is contractor experience used to update rates?	Are there competing contractors in a region?	Are contractors at full or limited risk for nursing facility care?	Is payment adjusted for NF placement?
Arizona	Arizona Long Term Care System	w/Medicare: $2,839 w/o Medicare: $5,226 *(average)*	YES	YES (contractor specific)	YES	Full-risk	Rate is adjusted in subsequent years based on experience
California	Senior Care Action Network Health Plan	Aged: $99; Disabled: $93; LTC: $3,208 *(average across counties)*	YES	NO	NO	Limited to two months	No, NF coverage limited to two months
Florida	Nursing Home Diversion Program	$1,809	YES	NO	YES	Full-risk	No, but rate is adjusted based on # of years a provider is in the program
Massachusetts	Senior Care Options Program	Community Settings of Care (dual eligible Boston): $155 (Other); Alzheimer Disease/Chronic Mental Illness: $605; NHC: $2,701; Institutional Settings of Care: $6,339 (Tier 2)	YES	NO	YES	Full-risk[ww]	Yes, after 3 months
Minnesota	Minnesota Senior Health Options	Dual-Institutionalized: $220-$440; Community Duals, Non-Wavier: $534-$769; Community Duals, Waiver: $1,363-$1,949	YES	YES (for acute care portion, but not LTC care portion)	YES	Limited to 6 months (beneficiary stays in the plan)	Yes
	Senior Care Plus				NO		
New York	Managed Long-Term Care Program	$1,700 to $5,000	NO	YES (contractor specific)	YES	Full-risk	No, rate is adjusted in subsequent years
	Medicaid Advantage Plus	State did not provide rates	YES	YES	YES (in the future)	Full- risk	NO

(continued next page)

[tt] Chart reflects 2006 data supplied by states.
[uu] Only nine states are highlighted. Maryland made the decision not to pursue implementation of an MLTS program, and therefore is not included in these charts.
[vv] Chart Legend: DD= developmentally disabled, ICF= intermediate care facility, ISN= intensive skilled nursing, LOC= level of care, NF=nursing facility, NHC= nursing home certifiable, SNF=skilled nursing facility, SPA=state plan amendment.
[ww] No return to fee-for-service. NHC community category includes first 3 months at-risk and beneficiary stays in health plan.

Medicaid Rate Structure Overview [xx, yy, zz]							
State	*Program Name*	*What is the rate? (in most cases, only select rates are listed)*	*Is acute care included in the capitation?*	*Is contractor experience used to update rates?*	*Are there competing contractors in a region?*	*Are contractors at full or limited risk for nursing facility care?*	*Is payment adjusted for NF placement?*
Texas	STAR+PLUS	Medicaid-Only Other Community Care: $836; Medicaid-Only Community-Based Alternatives: $3,696; Dual Eligible Other Community Care: $145; Dual Eligible Community-Based Alternatives: $1,304 (average rate of 2 plans in Harris county)	YES	NO	YES	Limited to 4 months (consecutive months are not required). Beneficiaries are then disenrolled.	Yes, after 4 months
Washington	Medicare-Medicaid Integration Project	$1,509 *(average across all rate cells)*	YES	NO	NO	Limited to 36 months (beneficiaries are then disenrolled)	Yes, after 36 months
	Washington Medicaid Integration Partnership	$704 *(average across all rate cells)*				Limited to 6 months	Yes, after 6 months
Wisconsin	Family Care	Comprehensive LOC: $2,094 *(average of counties)*; Intermediate LOC: $691	NO	YES	NO	Full-risk	No, but uses functional status risk-adjustment system with higher rate paid for people at higher acuity.
	Wisconsin Partnership Program / PACE	SNF/ICF: $3,122 *(average across health plans)* ISN: $4,661 *(average across health plans)*	YES	NO	NO	Full-risk	NO

[xx] Chart reflects 2006 data supplied by states.
[yy] Only nine states are highlighted. Maryland made the decision not to pursue implementation of an MLTS program, and therefore is not included in these charts.
[zz] Chart Legend: DD= developmentally disabled, ICF= intermediate care facility, ISN= intensive skilled nursing, LOC= level of care, NF=nursing facility, NHC= nursing home certifiable, SNF=skilled nursing facility, SPA=state plan amendment.

Appendix C: *Excerpt from New York State Template for Obtaining Selected Medicare Advantage Bid Data*

Schedule C1
Capitation Rate Calculation Sheet
Premium Group: 18-64 M&F

			Medicare[1]			Medicaid		
#	Category of Service	Amount of Copay	Utilization PMPY	Unit Cost	PMPM Cost	Utilization PMPY	Unit Cost	PMPM Cost
			a	b	c	d	e	f
1	Inpatient Hospital - Acute				$ -			
2	Inpatient Mental Health				$ -			
3	Inpatient Mental Health Days in Excess of 190 Day Lifetime Limit							$ -
4	Skilled Nursing Facility				$ -			
5	Skilled Nursing Facility Days in Excess of 100 Per Benefit Period							$ -
6	Home Health (Excluding Home Health Aides)				$ -			$ -
7	Home Health Aides				$ -			$ -
8	Personal Care							$ -
9	Primary Care Physician				$ -			
10	Chiropractic Services				$ -			
11	Outpatient Surgery				$ -			
12	Ambulance				$ -			
13	Durable Medical Equipment, Prosthetics & Supplies				$ -			
14	Diagnostic Testing				$ -			
15	Hearing Services				$ -			
16	Dialysis				$ -			
17	Vision Care				$ -			
18	Part B Drugs				$ -			
19	Other Part B				$ -			
20	Health & Education				$ -			
21	Emergency Room	$50			$ -			$ -
22	Outpatient Mental Health	$20			$ -			$ -
23	Outpatient Rehabilitation/Therapy	$10			$ -			$ -
24	Outpatient Substance Abuse	$20			$ -			$ -
25	Podiatry	$10			$ -			$ -
26	Specialty Care (Including Urgent Care)	$10			$ -			$ -
27	Dental							$ -
28	Private Duty Nursing							$ -
29	Transportation - Non Emergency							$ -
30	Nutrition							$ -
31	Medical Social Services							$ -
32	Personal Emergency Response Services							$ -
33	Adult Day Health Care							$ -
34	Social and Environmental Support							$ -
35	Social Day Care							$ -
36	Home Delivered and Congregate Meals							$ -
37	Proposed Medical Capitation (Copay Adjusted)				$ -			$ -
38	Administration (from Schedule G)				$ -			$ -
39	Surplus/Reserves[2]							$ -
40	Proposed Capitation/Revenue Requirement				$ -			$ -
41	Enrollee Premium To Be Paid By Medicaid (if applicable)[3]							
42	**Total Capitation**				$ -			$ -
43	Combined Medicare & Medicaid Capitation							$ -

[1] Medicare Utilization and Unit Costs - Derive from Worksheet 2, Part II, columns (m) - (o) and Worksheet 3, col g, of the Plan's CMS Bid. Note proposed Medicare Medical Capitation (line 37, col c) has been reduced by the cost sharing amounts in lines 21..26, col f.

[2] Medicare Surplus - Extract from Worksheet 4, line x, column g, of the Plan's CMS Bid.
Medicaid Surplus/Reserves - 2% of Proposed Capitation, line 40, col f.

[3] Enrollee Premium To Be Paid By Medicaid - Derive from Worksheet 6, Section III, Part C, line 6 of the Plan's CMS Bid.

1

Appendix D: *Related Resources*

Integrated Care Program Design, Rate Setting, and Risk Adjustment: A Checklist for States. Center for Health Care Strategies, June 2006. **http://www.chcs.org/usr_doc/ICP_TA_Tool.pdf**

Saucier P., Burwell B. and Gerst K. *The Past, Present and Future of Managed Long-Term Care*. Thomson/MEDSTAT and University of Southern Maine, Muskie School of Public Service, April 2005.

Tucker A. *A Survey of Functional Status to Support Community Choice Rate Setting and Program Assessments*. Center for Health Program Development and Management, University of Maryland, Baltimore County. July 2006. **www.chpdm.org/StudyFindingsTemp1.htm**

Tucker A., Burton L., and Weiner J. *A Comparison of Alternative Risk Adjustment Methods to Set Capitation Payments for S/HMO II and "Dual Eligible" Medicaid/Medicare Populations*. Johns Hopkins University, Health Services Research and Development Center for the University of Maryland Baltimore County, Center for Health Program Development and Management. February, 2001.

Verdier J.M. *Medicare Advantage Rate Setting and Risk Adjustment: A Primer for States Considering Contracting with Medicare Advantage Special Needs Plans to Cover Medicaid Benefit*. Center for Health Care Strategies, October 2006.

Wisconsin Department of Health and Family Services: functional screen information. **https://www.dwd.state.wi.us/desltc/**.