Managed Long Term Services and Supports (MLTSS)

Unique actuarial considerations

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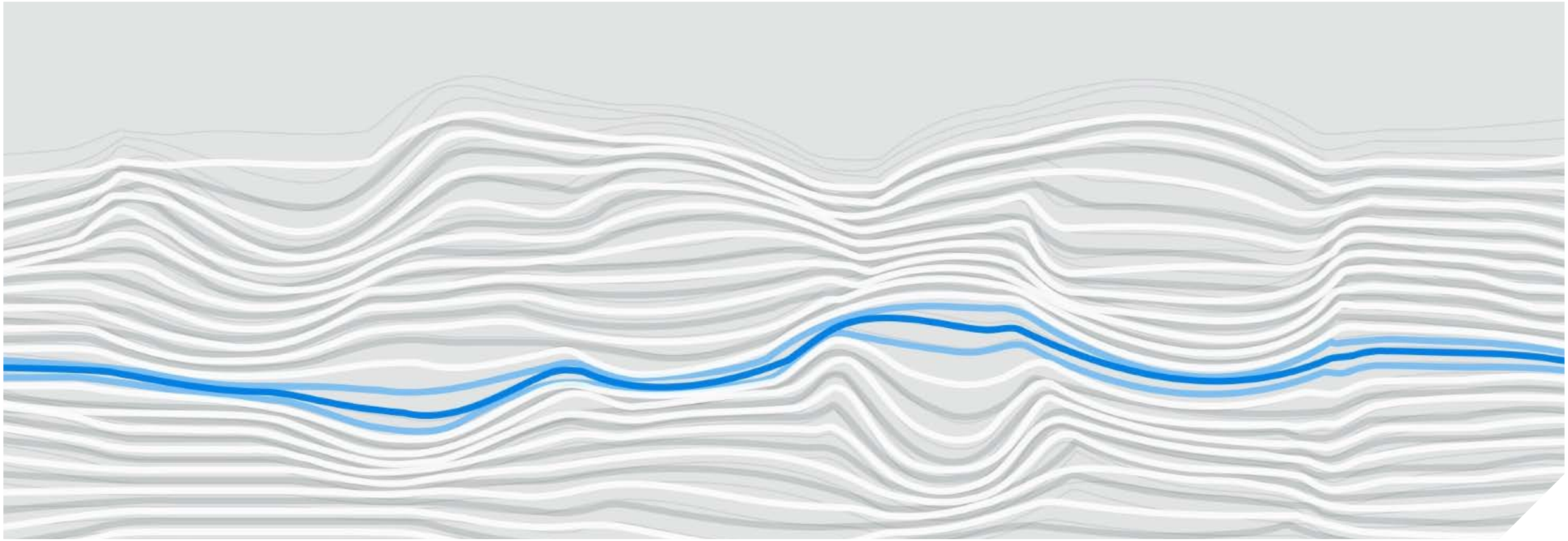
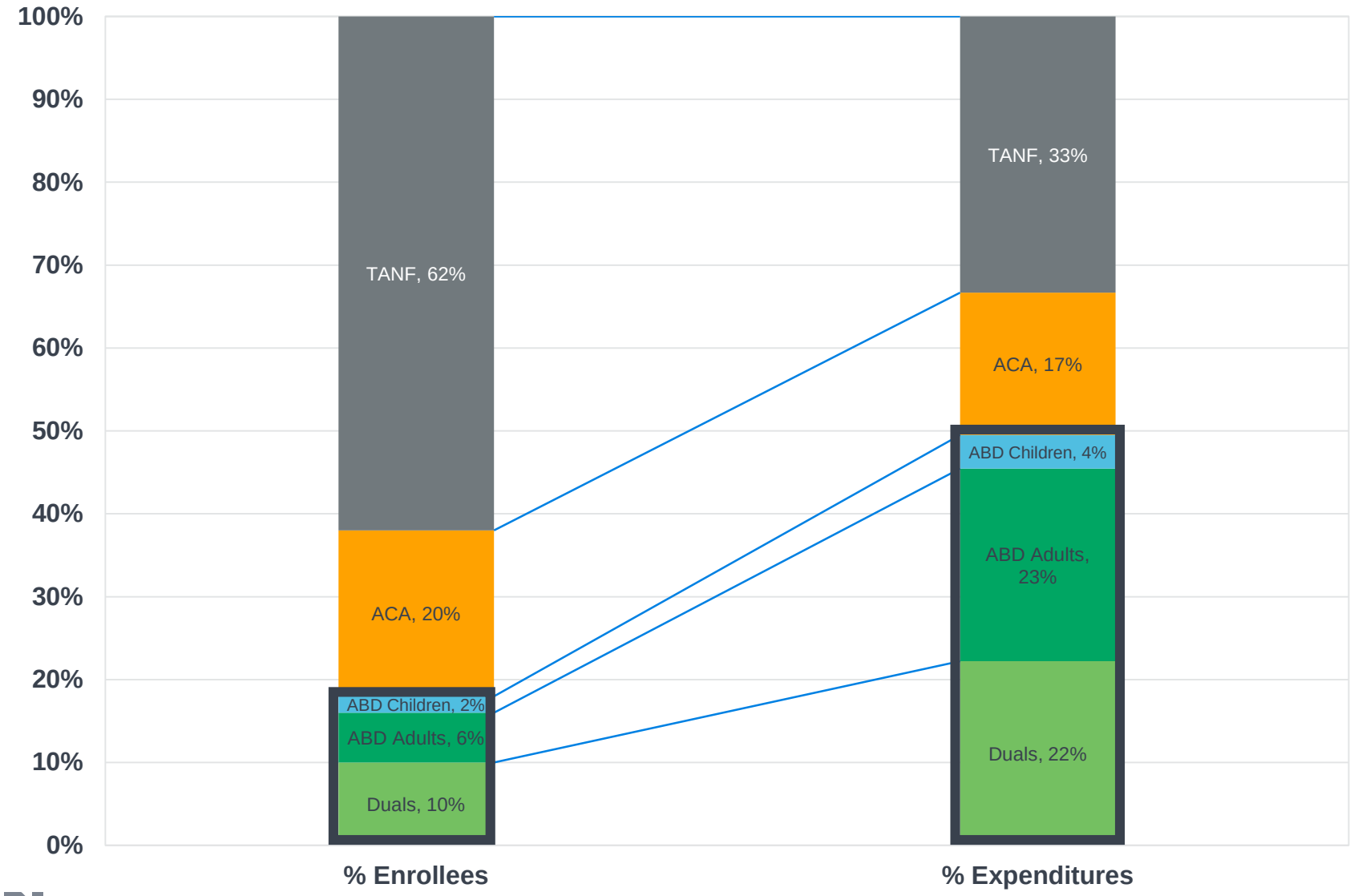


“Typical” state Medicaid population



- Costs for long term services and supports (LTSS) will continue to grow in absolute $s and as a % of Medicaid expenditures as the population ages

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Agenda

Note: Values in this presentation are for illustrative purposes only. They do not reflect a specific state's Medicaid program.

Generating savings in MLTSS

Manage acute care, ie. non-LTSS covered services

	% of Medicaid Expenditures	
Population	**LTSS**	**Non-LTSS**
ABD Children	15%	85%
ABD Adults	20%	80%
Dual eligibles	90%	10%

- Generating savings within non-LTSS covered services is similar to TANF and ACA populations, eg. reduce inpatient admissions/readmissions and emergency department visits
- Managing acute care can help reduce or delay need for LTSS
- For dual eligibles, acute care savings are more likely to materialize by integrating Medicare and Medicaid services
  - Medicaid expenditures for non-LTSS are relatively small because Medicare is usually primary and covers most non-LTSS

Generating savings in MLTSS

Provide care in the most cost effective setting

	% of Enrollees		
Population	**No LTSS**	**HCBS**	**Institutionalized**
ABD Children	90%	6%	4%
ABD Adults	80%	15%	5%
Dual eligibles	60%	20%	15%
Annual LTSS expenditures per recipient (illustrative)	**$0**	**$18,000**	**$60,000**

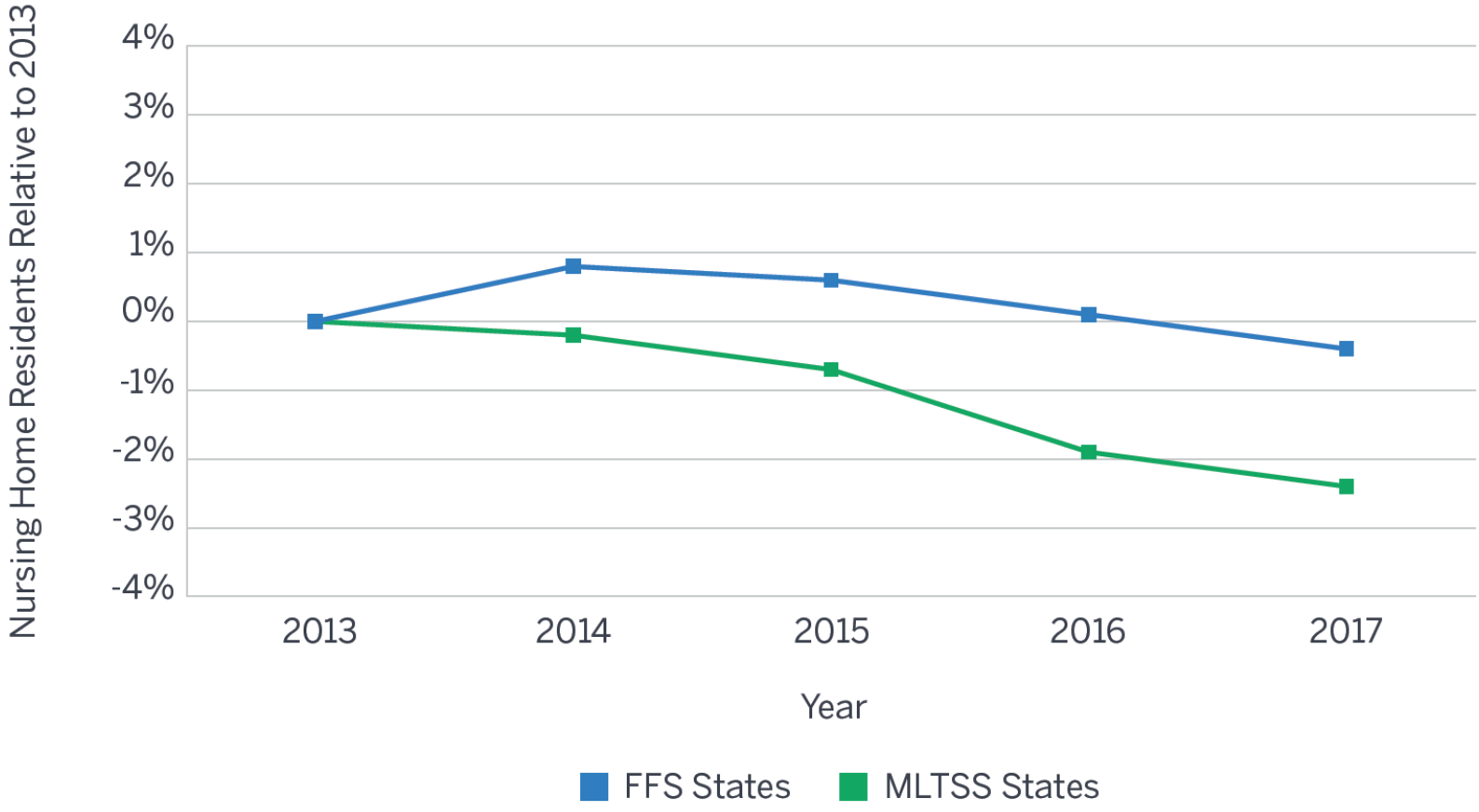
- Slow progression to more expensive settings, ie. diversion

- Facilitate movement from more to less expensive settings, ie. conversion

- Including all care settings in managed care may incentivize health plans to encourage use of more cost-effective settings as appropriate
- Enrolling members prior to need for LTSS and promoting continuous enrollment in managed care may slow progression to more expensive settings
- Patient liability for cost of LTSS can materially impact Medicaid net cost, especially for dual eligible

Generating savings in MLTSS

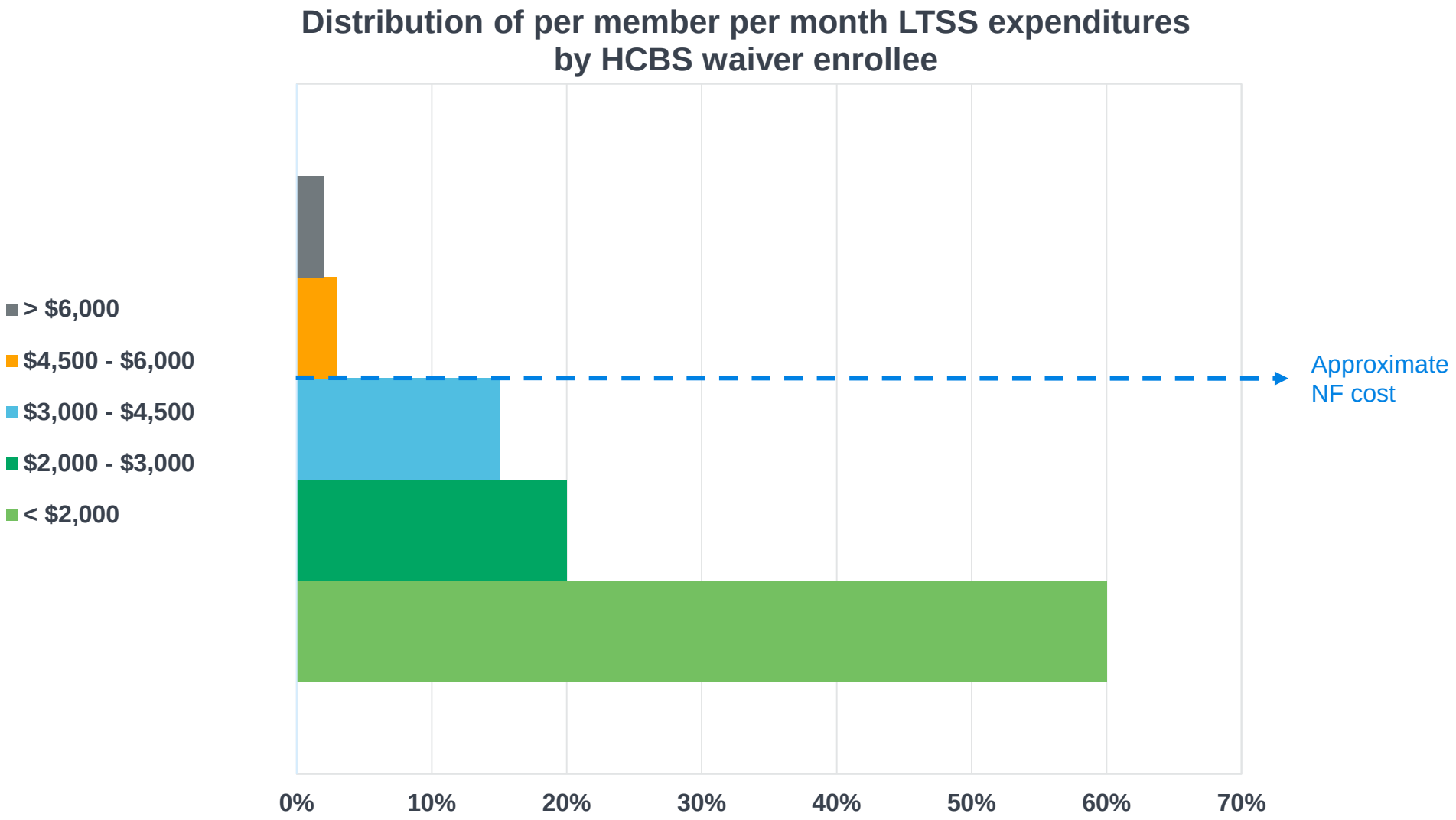
Provide care in the most cost effective setting



Source: Johnson, N., Keeley, A. M., & Khan, A. (2018, August 21). A comparison of nursing home usage in states with and without Medicaid Managed LTSS. Retrieved from http://us.milliman.com/insight/2018/A-comparison-of-nursing-home-usage-in-states-with-and-without-Medicaid-Managed-LTSS/

Generating savings in MLTSS

Optimize care plan efficiency



MLTSS capitation rate development

LTSS services

Examples of LTSS services
Professional assistance with activities of daily living
Assistance with housekeeping, cleaning, meal preparation, and personal care needs
Nursing services
Assisted living services
Nursing home services
Habilitation services
Intermediate Care Facilities for Individuals with Intellectual Disabilities

- Services are often approved for the beneficiary as part of a waiver
- Low hourly wage workers provide many services, so minimum wage increases impact costs
- Workers are often in short supply
- Once an enrollee is receiving services per care plan, limited savings opportunities in both utilization and unit costs

MLTSS capitation rate development

Other unique considerations

Alignment with policy objectives or program goals

- Self-directed care
- Individual budgets
- Covered populations

Creating incentives for MCOs

- Ensure appropriate setting of care
- Address social determinants of health
- Leverage family caregivers and natural support networks

Non-benefit expenses

- Care management and coordination expenses are higher than other populations
- Interaction with area agencies

- Covered services may differ by waiver
- Availability and quality of data
- Types of acuity adjustments if using experience from another program, eg. NF duration mix

MLTSS capitation rate development

Examples of rate cell structures

- **Blended/institutional HCBS rates**
  - Arizona, Illinois, Kansas, Ohio, Tennessee, Wisconsin, Virginia
- **Distinct rates by care settings, some with incentives to encourage community settings**
  - Florida, Minnesota, South Carolina, Texas

Note: States typically differentiate rate cells by Medicare eligibility and geographic area.

Sources: https://www.chcs.org/media/MLTSS-Rate-Setting_Final1.pdf, https://www.mathematica-mpr.com/our-publications-and-findings/publications/medicaid-ratesetting-for-managed-longterm-services-and-supports-basic-practices-for-integrated

Incentive examples

- Bonus for transitioning/ maintaining a nursing home resident in the community
- Delay payment of nursing home cap rate (or pay a reduced cap rate) when a member transitions from HCBS
- Bonus for increased number or % of HCBS participants in a year
- Quality measures, eg. assessments and care plans

MLTSS capitation rate development

Example of blended rate with rebalancing

Subpopulation	LTSS Capitation Rate	% Population	Target % Population
HCBS recipient	$ 1,500	74%	75%
Institutionalized	$ 5,500	26%	25%
Blended capitation rate		$2,540	**$2,500**

1.6% reduction in blended capitation rate due to target rebalancing

- MCOs need to hit target mix to achieve target margins
- MCOs can achieve better than target margins by achieving a better mix than target
- Considerations for setting target mix
  - Frequency of updating
  - Realistic target
  - Raising the bar year to year
  - Regional versus statewide
  - MCO-specific versus same
  - Variation by rate cell
  - Capacity to meet HCBS demand
  - Waiver enrollment availability

Risk adjustment in MLTSS

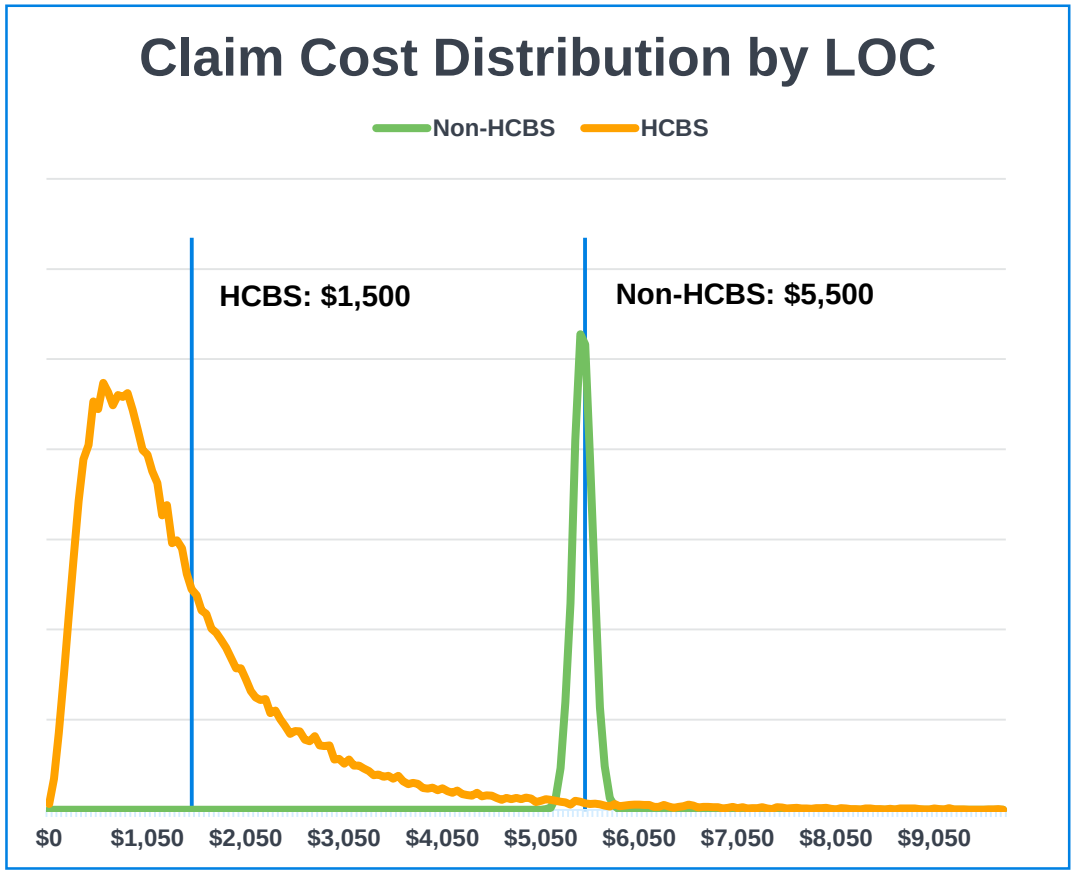
Role of risk adjustment in MLTSS rate setting

- Ties capitation revenue to MCOs' enrollment profiles
  - Recognizes differences in member service needs
- Reduces selection bias and the impact of member steering
- Aligns capitation revenue with program goals
  - Incentive to improve efficiency and quality of care
  - Incentive to delay nursing facility admission by providing the most cost effective care that is appropriate for a given member

Risk adjustment in MLTSS

Types of risk adjustment algorithms used in MLTSS

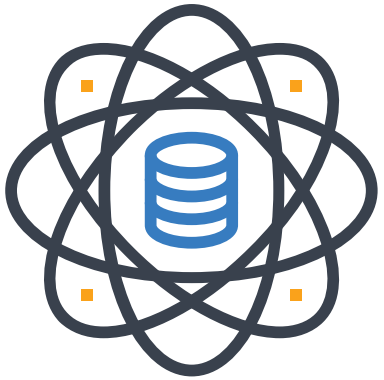
- **Location of Care (LOC) models**
  - Program capitation rates are developed separately for institutionalized (Non-HCBS) residents and HCBS recipients
    - HCBS capitation rates may be further divided based on the member's waiver category or historical utilization patterns
  - Capitation rates are blended based on MCO's specific distribution among LOCs
  - Some incorporate incentives to delay NF admissions or transition members to the community
  - Does not account for risk differences for members in the same LOC



Risk adjustment in MLTSS

Types of risk adjustment algorithms used in MLTSS

- **Functional based risk adjustment**
  - Uses assessment data to measure the relative level of service need for each individual
    - High quality, consistently coded assessment data is strongly correlated with LTSS service costs
  - Model agnostic to location of care
    - Provide incentive to improve efficiency and quality of care
    - Provide incentive to delay nursing facility admission
  - Model complexity can vary greatly
    - Simple models may only include ADL and MI/DD conditions
    - Complex models incorporate more specific measures and interaction terms
    - Model complexity is largely dependent on the quality of data



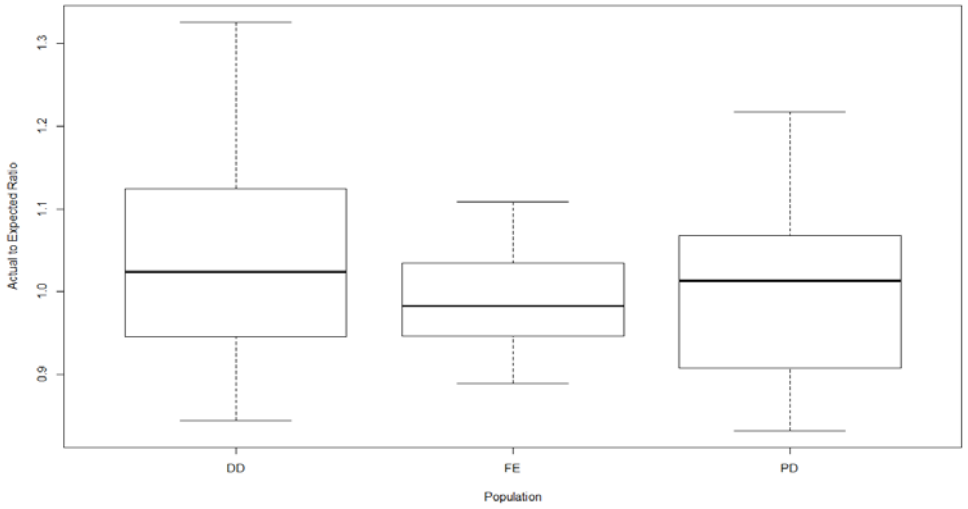
Risk adjustment in MLTSS

Wisconsin MLTSS risk adjustment model

- Functional based model used to risk adjust MLTSS capitation payments for over 15 years
- Separate models developed for specific populations (developmentally disabled, physically disabled, and frail elderly)
- Incorporates information collected from functional screen system
  - Type of living situation
  - Level of assistance required for each ADL/IADL
  - Diagnostic classes
  - Frequency of health related services
  - Behavioral traits (wandering, self-injurious, etc.)
- Models used for MCO benchmarking and program evaluation

Population	Model R^2	Variables Included
Developmentally Disabled	52.3%	48
Physically Disabled	49.7%	37
Frail Elderly	37.4%	31

Distribution of A-to-E Results By MCO / Region



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Risk adjustment in MLTSS

Challenges of functional based risk adjustment models

Assessment data

- Who is responsible for administration?
- Are functional screens coded consistently?
- How frequently are beneficiaries rescreened?

Program maturity

- Model accuracy decreased if developed using data from the first years of managed care

High cost recipients

- Like acute care risk adjustment, model under-predicts costs for very high cost members
- Additional risk mitigation may be necessary

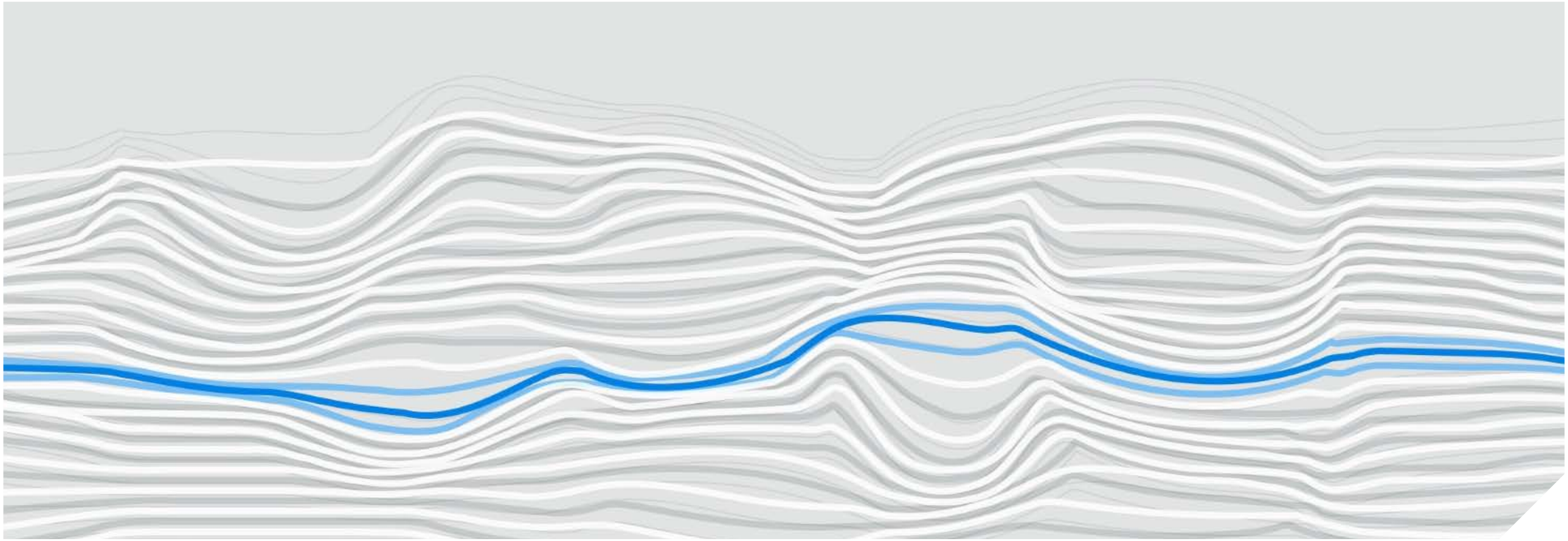
Transparency

- Additional reporting and documentation may be necessary for MCOs to review results

Case study: Risk adjustment disruption in Wisconsin's LTC program

Grant Cummings,
Wisconsin Dept. of Health Services

16 JULY 2019



Background

- Family Care serves frail elders and persons with physical or developmental disabilities
- There are 5 Family Care managed care organizations (MCOs), all local to Wisconsin
- Care management is considered a service and is subject to extensive contract requirements
- MCOs have medical loss ratios around 95%

Long Term Care Functional Screen (LTCFS)

- The LTCFS is used to determine a member's functional eligibility for Family Care

- The LTCFS contains hundreds of items about functional needs, conditions, and diagnoses

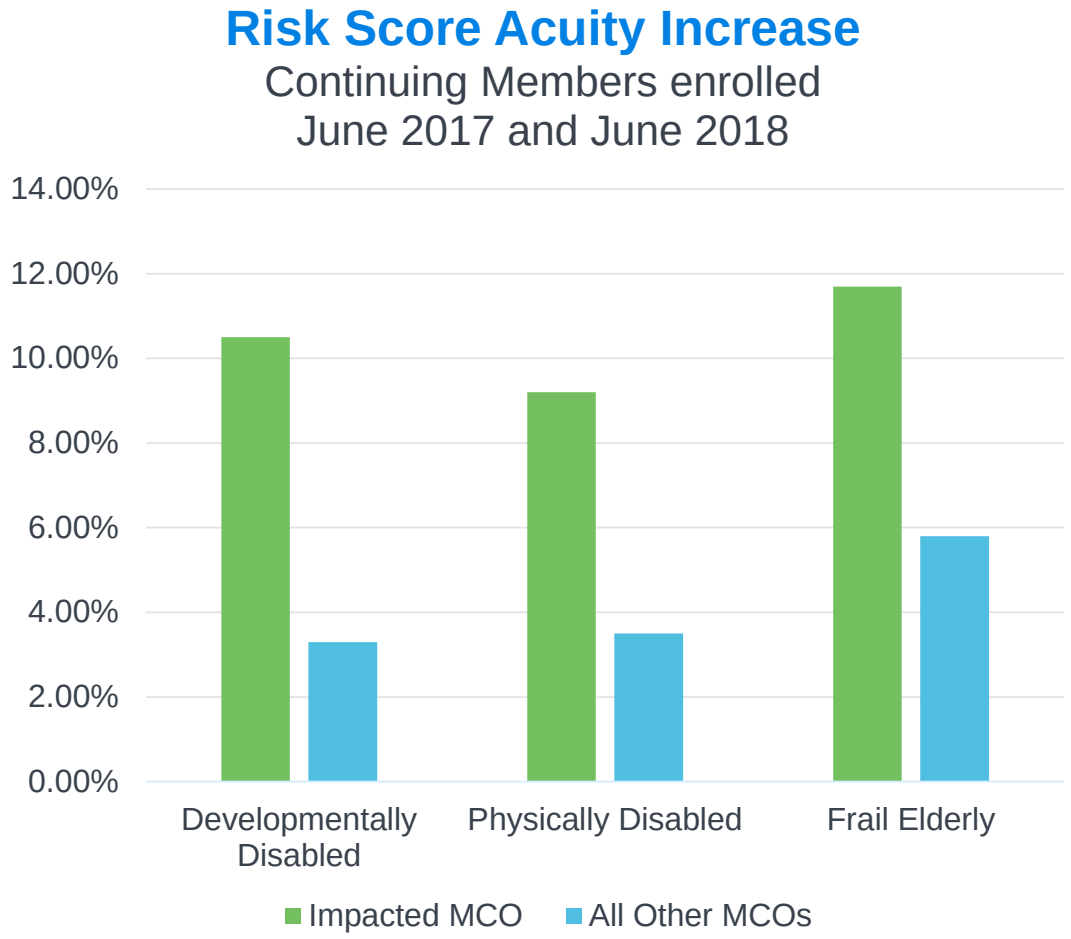
- Aging and Disability Resource Centers administer the first screen and MCOs administer all subsequent screens

Risk adjustment

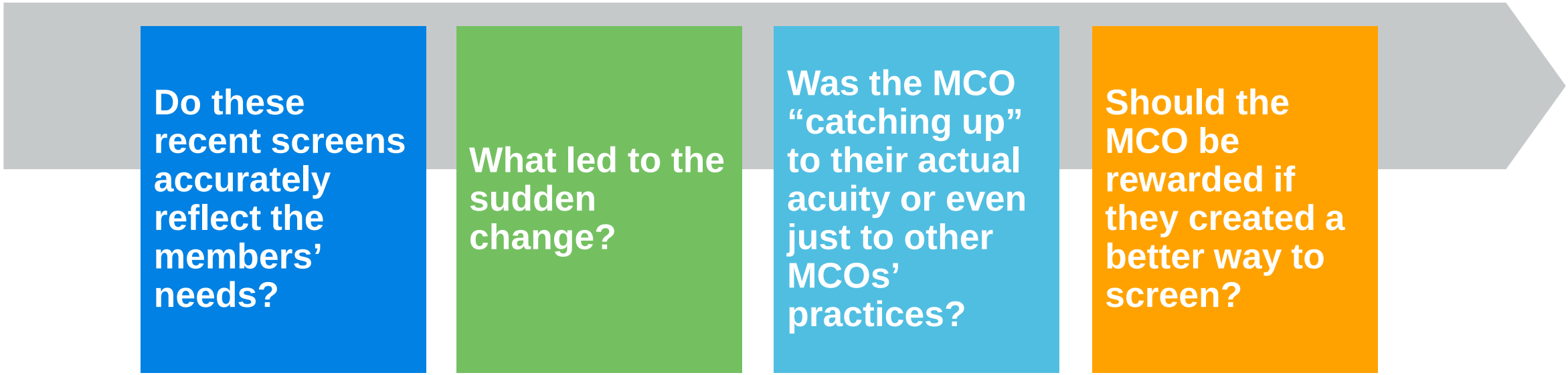
- Milliman develops a model to predict member costs using variables from the LTCFS
- Single biggest adjustment in rate development
- Both the 3 year historical acuity trend and each MCO's most recent acuity trend have been used in rate development

Unexpected acuity change

- One MCO's acuity increased materially more than other MCOs
- The MCO's acuity increase would have increased State expenditures by $34 million
- The acuity change was discovered in August 2018 after DHS estimated MCOs' financial positions under preliminary rates
- This was one month before preliminary rates were to be shared with MCOs and 4 months before rates were to be finalized



Many questions to address



The interim solution

- DHS and Milliman reduced the MCO's acuity trend by 3.5 percentage points
  - The reduction was half of their above-average performance
- DHS needed time to review but also needed to provide the MCO a rate to use for the statutorily required business plan submission

Multi-faceted review

- DHS reviewed changes in the percentage of each MCO's population that had the LTCFS elements used in risk adjustment
- DHS held multiple meetings with the MCO
- DHS program staff pulled screens to review the accuracy of the changes and compared the screens against care plans and assessments

Findings

- The percentage of the MCO's population with specific functional needs increased more rapidly than other MCOs'
- The increases were in:
  - Overnight care and supervision
  - Mental health diagnoses
  - Severe offensive behaviors
- Half of the acuity increase was connected to overnight care and supervision
- Changes to DHS screener training were clarifying that more people should be identified as needing overnight care and supervision

Findings

Continued

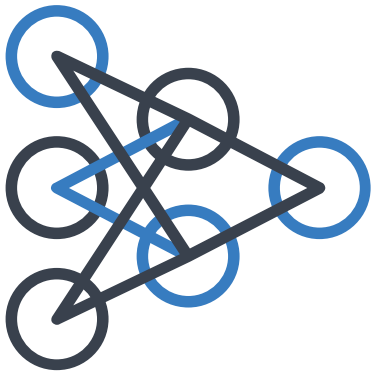
- The MCO had formed in a merger and had consolidated policies across the 3 parent organizations when screens began to increase
- The MCO retrained screening staff
- The MCO began running internal consistency checks on all screens each quarter and informed managers of inconsistencies that needed review
- The MCO shared that service costs and care teams' perceptions of acuity were not increasing at the same rate as the measured acuity on the screens
- DHS program staff reviewed a limited number of screens, but found all changes were supported by other documentation
  - DHS does not have the resources to do a comprehensive audit and independently re-screen the members

Final CY 2019 rates

- The downward adjustment to the MCO's acuity remained in the final rates
- The acuity change was not reflective of changes in costs
- A single change in an MCO's processes should not result in such a significant increase in State expenditures
- DHS was still reviewing the available information

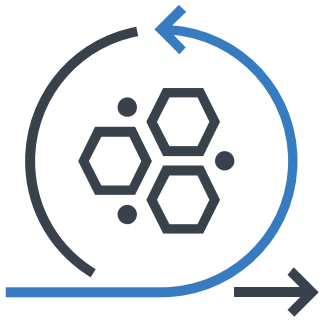
Impact on CY 2020 rates

- Other MCOs noticed the rate increase and updated their screening practices
- The screens from the MCO in question would redistribute funds away from the other MCOs
- State expenditures could increase again if the June 2019 screens showed another large increase



Remedies for CY 2020 rate development

- DHS and Milliman are reviewing 5 years' of screen data to identify variables that should not be used in risk adjustment
- DHS rate staff and program staff are working more closely to identify recent training efforts and LTCFS fields subject to MCO interpretation
- DHS decided to use the historical acuity trend for all trend adjustments and only use June screens for a budget neutral risk adjustment



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Thank you

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