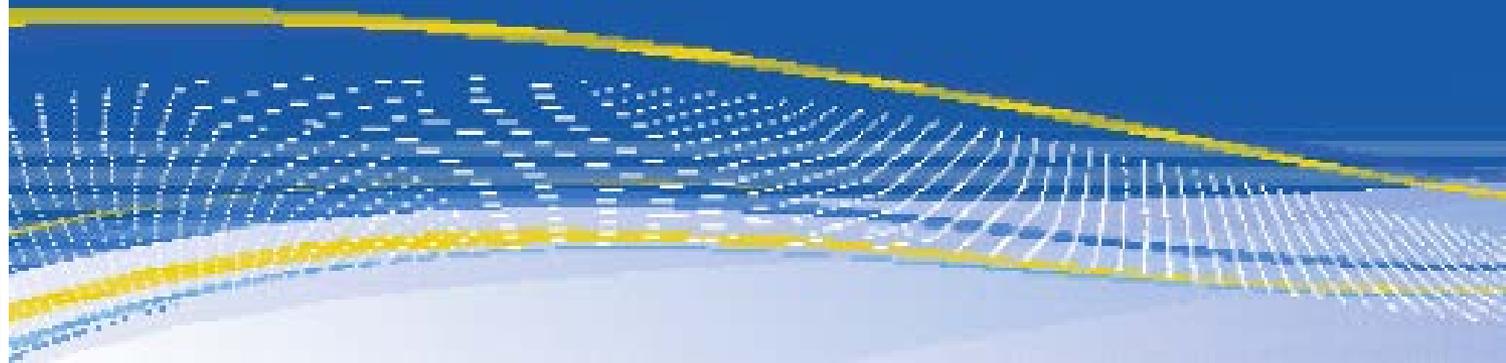




# Capitated Rate Setting for MLTSS Programs



Division of Long Term Services and Supports and  
Division of Managed Care Plans  
Disabled and Elderly Health Programs Group  
Center for Medicaid and CHIP Services



# Training Objectives

- Understand Medicaid Managed Long Term Services and Supports (MLTSS) rate setting objectives and federal requirements.
- Discuss the basic MLTSS rate setting approach.
- Discuss payment strategies to support policy goals and promote community-based LTSS over institutionalization.
- Discuss risk mitigation strategies and related contractual provisions.

# MLTSS Rate Setting Objectives

- Develop a capitation rate that:
  - Meets all federal and state regulatory requirements, including **actuarial soundness** requirements in 42 CFR 438.4.
  - Follows CMS Medicaid Managed Care Rate Development Guide.
  - Promotes policy goals of MLTSS program.
    - Improve health of populations.
    - Support beneficiaries' experience of care.
    - Support community integration of enrollees.
    - Control costs.
  - Can be administered and operationalized.

# MLTSS Rate Setting Federal Requirements

- Federal regulation requires that capitation rates paid to MLTSS plans be **actuarially sound** for a state to receive federal financial participation (FFP) funds (Social Security Act 1903(m)).
- Actuarially sound capitation rates are projected to **provide for all reasonable, appropriate, and attainable costs** that are required under the terms of the contract and for the operation of the MLTSS plan for the time period and the population covered under the terms of the contract (42 CFR 438.4(a)).

# MLTSS Rate Setting Federal Requirements

- To be approved by CMS, MLTSS capitation rates must meet the following requirements:
  - Capitation rates have been developed in accordance with standards specified in **42 CFR 438.5 (rate development standards)** and generally accepted actuarial principles and practices (42 CFR 438.4(b)(1)).

# MLTSS Rate Setting Federal Requirements

- To be approved by CMS, MLTSS capitation rates must meet the following requirements (continued):
  - Capitation rates are appropriate for the covered population and services to be furnished under the contract (42 CFR 438.4(b)(2)).
    - Based only upon services covered under the state plan, including approved waiver services (42 CFR 438.3(c)(1)(ii)).
    - Do not include value added services voluntarily offered by the plan.
    - Include in lieu of services if such services are authorized under the contract (42 CFR 438.3(e)).

# MLTSS Rate Setting Federal Requirements

- To be approved by CMS, MLTSS capitation rates must meet the following requirements (continued):
  - Payments from any **rate cell** must not cross-subsidize or be cross-subsidized by payments for any other rate cell (42 CFR 438.4(b)(5)).
    - Rate cell is a set of mutually exclusive categories of enrollees that is defined by one or more characteristics for the purpose of determining the capitation rate and making a capitation payment.
  - Be certified by an actuary as meeting the applicable requirements of 42 CFR 438.4(b)(6).

# MLTSS Rate Setting Federal Requirements

- 42 CFR 438.5(b) provides that the state must follow the steps below, in an appropriate order, when developing capitation rates.
  - Identify and develop the **base utilization and price data**.
  - Develop and apply **trend factors** to base data developed from actual experience of the Medicaid population or a similar population in accordance with generally accepted actuarial practices and principles.
  - Develop the **non-benefit component** of the rate.
  - Make appropriate and reasonable **adjustments**.
  - Take into account managed care plans' past **MLR experience** (if applicable).
    - Traditionally, Medical Loss Ratio (MLR) is defined as the portion of premium income the managed care plans pay out in the form of health care claims (claims divided by premiums).
  - If **risk adjustment** is applied, select appropriate model and apply it in a budget neutral manner.

# MLTSS Rate Setting Approach

- Capitation rates are developed as a cost per member per month (PMPM) and are set prospectively on an annual basis.
- Separate rate cells or risk adjustment may be used to more accurately project costs for the covered population.
- MLTSS capitation rates can vary by:
  - Age;
  - Gender;
  - Geographic region;
  - Eligibility category;
  - Medicare status;
  - Diagnosis category;
  - Frailty level (nursing facility level of care) and/or setting of care (community or institutionalized).

# MLTSS Rate Setting Approach

- To develop capitation rates, states and their actuaries determine spending amounts and make adjustments for the following components:
  - Base data and adjustments;
  - Projected benefit costs and trends;
  - Projected non-benefit costs.

# Base Data and Adjustments

# Base Data

- States must provide all validated encounter data, FFS data (as appropriate), and audited financial reports that demonstrate experience for the populations under the MLTSS program contract to the actuary **for the 3 most recent and complete years prior to the rating period** (42 CFR 438.5(c)(1)).
- States and their actuaries must use the most appropriate data from the data sets provided (42 CFR 438.5(c)(2)).
  - Base data must be derived from the Medicaid population, or if data on the Medicaid population is not available, be derived from a similar population and adjusted appropriately.

# Base Data Sources

## Fee-For-Service (FFS) Data

- Appropriate for new MLTSS programs and smaller, voluntary MLTSS programs.
- Generally complete, comprehensive, and high quality, but may not reflect the frailty and costs of members enrolled in MLTSS.

## Encounter Data from MLTSS Plans

- Best for mature and larger MLTSS programs.
- Data quality and completeness varies by MLTSS plan.

## Audited Financial Reports from MLTSS Plans

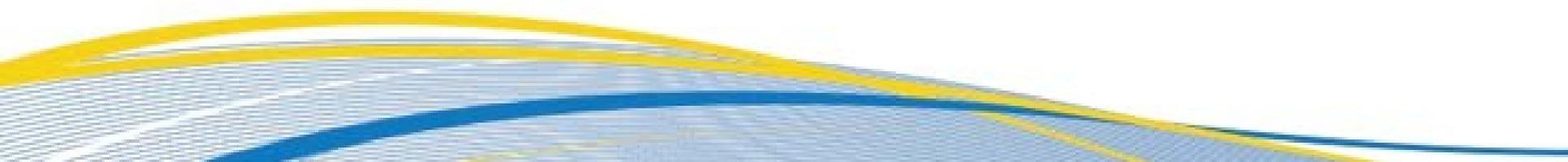
- Supplemental data source to encounter data;
- Summary level information;
- Supports base data adjustments for missing data and other appropriate plan costs not reflected in MLTSS plan encounter data.

# Base Data Adjustments

- Depending on the data source selected, the base data may be adjusted to better reflect the populations and services that will be covered under the MLTSS program.
- Some examples include:
  - Adjustments to address lags in provider claim submission.
  - Adjustments to address missing encounter records.
  - Adjustments to address costs outside of the encounter data system/Medicaid Management Information System (MMIS).
  - Adjustments to account for patient liability.
  - Adjustments to reflect any differences in the health status of the enrolled population.
  - Adjustments to reflect changes in the covered services during the base period.



# **Projected Benefit Costs and Trends**



# Projected Benefit Costs and Trends

- There are three major components of projected benefit costs and trends:
  - Trend
  - Program and policy changes
  - Managed care adjustments

# Trend

- Trend is used to project the historical utilization and costs forward from the base data period to the projected capitation rating period.
- Trend reflects expected changes in the quantity, mix, and price of services on a per capita basis, compounded over time.
- Trend rates are often developed separately for each component (price and utilization) by major service category (e.g., nursing facility, pharmacy, etc.) and population group.
- Trend must be developed primarily from actual experience of the Medicaid population or from a similar population (42 CFR 438.5(d)).

# Program and Policy Changes

➤ Changes may include:

- Changes that occurred after the base data period but prior to the rating period.
- Prospective changes that will be implemented during the rating period.

➤ Reflect one-time changes **outside of normal trend**:

- State fee schedule adjustments;
- Benefit changes;
- Eligibility changes;
- Federal mandates;
- State legislative actions.

# Managed Care Adjustments

- Managed care adjustments reflect expected changes in service delivery due to the effect of utilization or care management activities not otherwise considered in trend.
- For new MLTSS programs, the managed care adjustment may consider the impact of moving from an unmanaged FFS delivery system to a managed delivery system.
- For existing MLTSS programs, the managed care adjustment may consider the additional efficiencies that would be reasonable, appropriate and attainable in the projected rating period compared to the base data period.

# Managed Care Adjustments

- These changes may include:
  - Change in mix of Home and Community-Based Services (HCBS) and Nursing Facility (NF) users.
  - More effective use of personal care/home health services.
  - Reductions in unnecessary hospitalizations and readmissions;
  - Reductions in unnecessary emergency room visits;
  - Increased access to HCBS services;
  - Increases in physician services.

# Projected Non-Benefit Costs

# Projected Non-Benefit Costs

- Rate development must include reasonable, appropriate and attainable expenses related to plan non-benefit costs (42 CFR 483.5(e)).
- Projected non-benefit costs include the following categories of costs:
  - Plan administrative costs;
  - Care coordination and care management (if not considered a benefit);
  - Provision for margin (which may include profit margin, operating margin, risk margin, contingency margin, cost of capital, or underwriting gain).
  - Contribution to reserves;
  - Taxes, fees, and assessments;
  - Other operating costs associated with the provision of services for the populations covered under the contract.

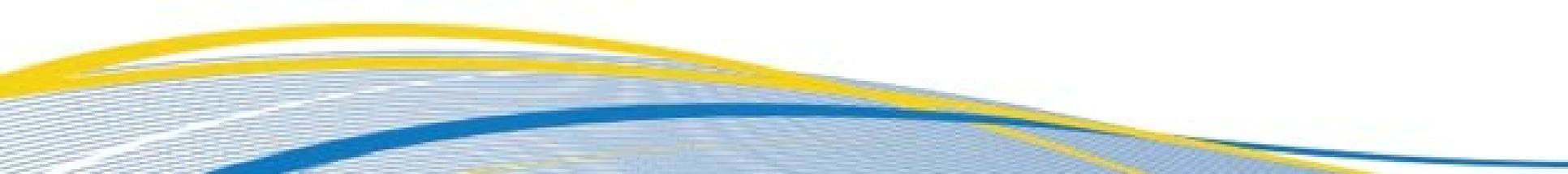
# Projected Non-Benefit Costs

- The projected non-benefit costs can be calculated as either a percentage of the capitation rates or as a fixed per member per month (PMPM) amount.
- Non-benefit component may be developed at the aggregate level and incorporated at the rate cell level.



---

# **MLTSS Rate Setting Numerical Example**



# MLTSS Rate Setting Numerical Example

	(A)	(B)	(C)=(A)x(B)	(D)	(E)	(F)	(G)=(C)x(D)x(E)x(F)
Category of Service	Base Data PMPM	Base Data Adjustments	Final Base Data PMPM	Program Change Adjustments	PMPM Trend Factor	Managed Care Efficiency Adjustment	Projected PMPM
Inpatient Hospital	\$ 150.00	0.95	\$ 142.50	1.00	0.98	0.95	\$ 132.67
Outpatient Hospital	\$ 50.00	1.00	\$ 50.00	1.00	1.02	1.03	\$ 52.53
Nursing Home	\$ 300.00	1.00	\$ 300.00	1.02	1.04	0.98	\$ 311.88
Personal Care/Home Health	\$1,200.00	1.05	\$ 1,260.00	0.95	1.08	1.00	\$ 1,292.76
Dental	\$ 20.00	1.00	\$ 20.00	1.00	1.03	1.00	\$ 20.60
Transportation	\$ 60.00	1.00	\$ 60.00	1.00	1.03	1.00	\$ 61.80
<b>Total Services</b>	<b>\$1,780.00</b>		<b>\$ 1,832.50</b>				<b>\$ 1,872.23</b>
Projected Benefit Costs PMPM							\$ 1,872.23
Non-Benefit Expenses							
Administrative Costs							\$ 100.00
Care Management							\$ 120.00
Risk Margin (2% of total capitation rate)							\$ 42.70
<b>Total Capitation Rate PMPM</b>							<b>\$ 2,134.93</b>

# MLTSS Rate Setting

## Numerical Example (continued)

- There are six categories of service in this example. The following walks through the calculations for Nursing Home category of service line:
  - Base Data PMPM of \$300 is multiplied by Base Data Adjustment of 1.00 to get to Final Base Data PMPM of \$300.
  - Final Base Data PMPM of \$300 is multiplied by the following factors to get to Projected PMPM of \$311.88.
    - Program Change Adjustment of 1.02.
    - PMPM Trend Factor of 1.04.
    - Managed Care Efficiency Adjustment of 0.98.
- The projected PMPM of the five remaining categories of service are calculated in a similar manner.

# MLTSS Rate Setting

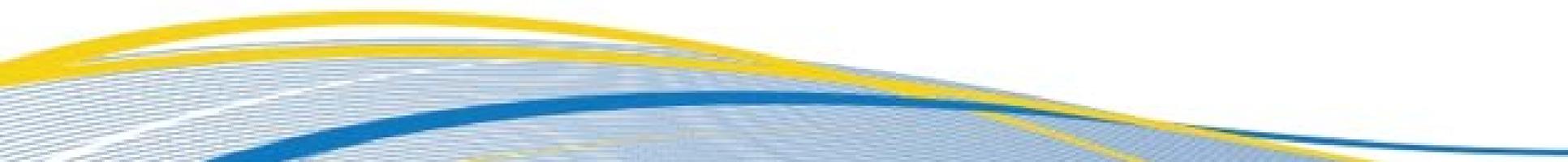
## Numerical Example (Continued)

- The Projected PMPM of the six categories of service are summed to get to the Projected PMPM for all services of \$1,872.23.
- The following three non-benefit expenses are added to the Projected PMPM for all services.
  - Administrative Costs of \$100.
  - Care Management Expenses of \$120.
  - Risk Margin of \$42.70.
    - Which is calculated as 2% of total capitation rate.
- The total capitation rate is \$2,134.93, which is the sum of the Projected PMPM for all services and the three non-benefit expenses.



---

# **Payment Strategies To Support Policy Goals**



# Payment Strategies To Support Policy Goals

- A primary goal for most MLTSS programs is to increase the proportion of beneficiaries who receive LTSS in the community and not in an institution.
- The following are common payment strategies that states can use to encourage using home and community based services (HCBS) instead of nursing facility (NF) services:
  - Rate structure
    - Blended NF/HCBS rate;
    - Transitional NF/HCBS rate;
    - Needs-based risk-adjusted rate.
  - Bonus payment;
  - Performance incentive/withhold;
  - Value based purchasing arrangements.

# Payment Strategies To Support Policy Goals: Rate Structure

- Blended NF/HCBS rate:
  - State pays a single blended rate each year that combines all covered MLTSS costs, including NF and HCBS, for those members who meet the state's criteria for nursing facility level of care regardless of setting.
- Transitional NF/HCBS rate:
  - State uses separate rate cells to reflect cost variations by setting, but delays the change in individuals' assignment to the new rate cell to encourage the use of HCBS over NF.

# Payment Strategies To Support Policy Goals: Rate Structure

- Needs-based risk adjusted rate:
  - State pays using a sophisticated classification algorithm based on a member's medical condition and functional, cognitive, and behavioral needs, regardless of setting.
  - Risk adjustment must be budget neutral, meaning that application of the methodology does not create a net aggregate gain or loss across all payments to plans under the MLTSS program (42 CFR 438.5(g)).

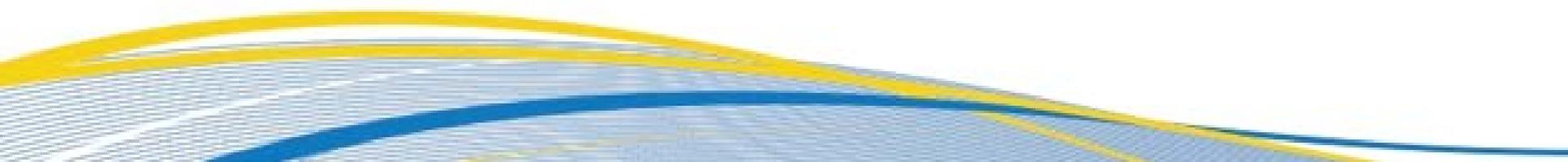
# Other Payment Strategies To Support Policy Goals

- **Bonus payments** provide additional funding to MLTSS plans above and beyond the capitation rate for members who are successfully transitioned from a NF to their home or community.
  - Money Follows the Person (MFP) provides grants and enhanced federal match to support community transitions.
- **Performance incentives/withholds** provide additional payments (or withhold a portion of the capitation rates that can be earned back) to encourage MLTSS plans to meet policy goals and achieve performance targets.

# Other Payment Strategies To Support Policy Goals

- **Performance incentives/withholds (Continued)**
- Examples of performance measures include:
  - The rate of nursing facility admissions for enrolled members.
  - The percent of members who return to the community following a nursing facility admission.
  - The percent of members using personal assistance or respite service who self-directed these services.
- **Value based purchasing arrangements**, such as shared savings, can be included in MLTSS contracts with LTSS providers to incent quality and outcome goals.

# **Risk Mitigation Strategies**

The slide features a solid blue header at the top, a thin yellow horizontal line below it, and a white background for the main content. At the bottom, there are decorative wavy lines in yellow and blue, with a light blue textured pattern underneath.

# Risk Mitigation Strategies

- Risk mitigation strategies are often used to protect plans from excessive losses, and protect the state from excessive overpayments.
- Risk mitigation approaches are either budget neutral to the state, require additional state funds and/or allow for plan rebates of excess funds back to the state.
- Examples of risk mitigation strategies used in MLTSS programs include:
  - Risk sharing,
  - Minimum medical loss ratio requirement,
  - Risk pools,
  - Reinsurance,
  - Risk adjustment.

# Risk Mitigation Strategies

## Risk Sharing

- The state retains full or partial responsibility for plan costs above a predetermined threshold or risk corridor.
- If actual plan costs are below the threshold, excess amounts are either fully or partially returned to the state by the plan.
- Provides both upside and downside protections; it protects plans from excess losses and protects the state from excessive overpayments.
- Example of risk sharing:
  - Plan is fully responsible for costs within 3 percent of the targeted benefit costs (both gains and losses).
  - Plan and State share equally in the gains and losses that are between 3 percent and 8 percent of the targeted benefit costs.
  - State is fully responsible for costs beyond 8 percent of the targeted benefit costs (both gains and losses).

# Risk Mitigation Strategies

## Minimum Medical Loss Ratio (MLR) requirement

- Plans are required to calculate and report MLR experience for each contract year, but states have flexibility to impose a remittance requirement (42 CFR 438.8).
- If actual expenditures are less than the minimum MLR, the state can require the plan to refund the excess payments.
- Considered a one-sided risk sharing arrangement since the MLR only protects the state from excessive overpayments.
- Example of a minimum MLR requirement:
  - State requires the MLTSS plans to meet a minimum MLR of 85%. Plans that spend more than the minimum 15% of the total capitation payments on non-benefit expenses must return the excess funds to the state/federal government in proportion to their contributions.

# Risk Mitigation Strategies

## Risk Pools

- Plans contribute to a risk pool administered by the state in exchange for coverage against additional risk uncertainty.
- Often used to cover unanticipated costs for high cost individuals or services.
- Funded by a withhold to the capitation rate and is budget neutral to the state.

# Risk Mitigation Strategies

## Risk Pools (continued)

### ➤ Example of a risk pool:

- A state uses risk pools for high need users of community-based and facility based-care whose costs exceed a certain level of spending on selected Medicaid LTSS and behavioral health services.
- A portion of the capitation payment (<2 percent) that Medicaid makes to plans on behalf of these two groups is allocated to a risk pool.
- At the end of each calendar year, the state distributes the risk pool to plans in proportion to the amount of spending on applicable LTSS and behavioral health services incurred above an established threshold amount for these high-need users.

# Risk Mitigation Strategies

## Reinsurance

- Protects plans from high cost, low frequency claims incurred by an individual beneficiary.
- Plans may purchase private reinsurance (expensive), or the state can act as reinsurer.
- Plans pay a portion of the capitation rate in exchange for the reinsurance protection.
- Generally targeted to certain high cost conditions or services.
- Example of a reinsurance program:
  - If an individual's costs exceed \$250,000 in a given year, the plan will pay 20 percent of costs above the \$250,000 threshold and the state will pay the remaining 80 percent of costs above \$250,000.

# Risk Mitigation Strategies

## Risk Adjustment

- Methodology to account for differences in health status of members enrolled in each MLTSS plan via relative risk factors when projecting or explaining plan costs.
- Risk adjustment is budget neutral to the state.
- Risk adjustment may be applied either prospectively or retrospectively.

# Risk Mitigation Strategies

## Risk Adjustment (continued)

### ➤ Example of risk adjustment:

- State calculates a baseline capitation rate that includes the projected mix of HCBS and NF users during the contract year across all plans.
- State applies a plan specific risk adjustment factor to the baseline rate for each MLTSS plan. The plan-specific risk adjustment factor is based on the projected member months and mix of HCBS and NF users for each plan, normalized so that it is budget neutral to the state.
- As a result, some plans receive a higher capitation payment and other plans receive a lower capitation payment for the rating period, based on the relative projected mix of HCBS and NF users.

# Summary

- The goal of MLTSS rate setting is to develop a capitation rate that meets all four rate setting objectives.
- To develop capitation rates, states and their actuaries determine spending amounts and make adjustments for the three major components, which are base data and adjustments, projected benefit costs and trends and projected non-benefit costs.
- The common payment strategies that states can use to encourage the use of home and community based services (HCBS) instead of nursing facility (NF) services are rate structure, bonus payment, performance incentive/withhold and value based purchasing arrangements.
- The risk mitigation strategies to protect the state from excessive overpayments and/or the plan from excessive losses are risk sharing, minimum medical loss ratio requirement, risk pools, reinsurance and risk adjustment.

# Additional Resources

- Additional rate setting resources are available in the below website.
- <https://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/hcbs-training.html>

# Questions

**For questions contact:**  
**[HCBS@cms.hhs.gov](mailto:HCBS@cms.hhs.gov)**