

Engaging Managed Care Plans in Rate Setting for Medicaid Managed Long-Term Services and Supports Programs

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IN BRIEF

By engaging managed care plans in rate development activities for Medicaid managed care programs, states can gain information to refine their rate-setting models and better support the populations served. As part of a multi-state initiative on managed long-term services and supports (MLTSS) program rate setting supported through the West Health Policy Center, we interviewed managed care plans and states to inform state approaches for working with managed care plans on MLTSS rate-setting methodologies. This brief examines strategies for communicating with managed care plans during rate-setting activities, common concerns raised by plans and how states might address them, and opportunities for plans to support information collection and other rate-setting efforts.

Recommendations for state communication approaches with managed care plans included starting the engagement process well before the effective date of new rates, being transparent in goals and methods and holding face-to-face meetings with plans. Managed care plans can support states' rate-setting activities by providing additional data that provide more detail on plan operations and members' functional assessment status, among other elements. Interviewees also cautioned about the potential impacts that MLTSS rate-setting policy decisions could have on participating managed care plans and other stakeholders.

Engaging managed care plans in rate development activities for Medicaid managed care programs can give states information to refine their rate-setting models and expand their perspectives to better support the populations served. For their part, managed care plans' engagement with states can provide needed assurances that plans can remain financially solvent and continue program participation, pay reasonable rates to providers, and provide beneficiaries with all needed services, including long-term services and supports (LTSS). As more states create or expand Medicaid managed long-term services and supports (MLTSS) programs, managed care plan or other stakeholder involvement in all aspects of program design and operations, including rate development, will also increase. Because rate-setting methodologies have a significant impact on managed care plans' bottom line and may dictate their willingness and ability to participate in these programs, they are likely to be actively involved during state Medicaid MLTSS rate-setting discussions.

As part of the Medicaid MLTSS Rate-Setting Initiative¹ — a state collaborative supported by the West Health Policy Center that tests new rate-setting, risk adjustment, and related data collection approaches for MLTSS programs — we conducted phone interviews with six managed care plans and two states that have experience implementing and operating MLTSS programs to inform other states' approaches to working with managed care plans on MLTSS rate-setting methodologies. Interview questions addressed best practices for communicating with managed care plans during rate-setting activities, common concerns raised by managed care plans and how states might address them, and opportunities for managed care plans to support information collection and other rate-setting efforts.

This brief summarizes our findings in three broad areas: (1) effective approaches to engaging managed care plans and soliciting their feedback on changes to payment and/or rate-setting policies; (2) opportunities for managed care plans to support these activities; and (3) the potential impact that

MLTSS rate-setting policy decisions could have on participating managed care plans and other stakeholders.

Effective State Practices to Engage Managed Care Plans

Under the Centers for Medicare & Medicaid Services' (CMS) new Medicaid managed care regulations, states must engage stakeholders during the design, implementation, and oversight of their MLTSS programs.² Accordingly, all managed care plan interviewees noted that while the states with which they have worked value the input of managed care plans and other stakeholders, states' approaches to engagement activities and their level of transparency varies. Interviewees highlighted several examples of good state practices for engagement and communication, as well as potential resources that managed care plans could provide to inform states' rate-setting models:

1. Begin the engagement process at least three to six months in advance of the rate period effective date

Setting MLTSS program rates is a complicated process, and it is important to provide time for managed care plans to: (1) review rate development assumptions; (2) understand how and why data elements are used in the model; and (3) digest the impact of new rates on their operations. In new MLTSS programs, it is helpful for states to share a work plan prior to program launch that includes expected milestones and outlines the baseline data on which assumptions are built. For states with established programs, following an annual schedule can also make the process more predictable. Lastly, allotting time to review draft rates and expectations about plan savings before rates are final supports managed care plans' planning and decisions about where to invest resources.

2. Maintain a level of transparency in the rate-setting process

Being transparent and providing detailed information about how the rate-setting and/or risk-adjustment methodology was developed supports plans' understanding and promotes exchange of ideas about how to improve the model. Helpful information to share with managed care plans might include: (1) a databook that summarizes the base rate data and adjustments used in the rate-setting methodology; (2) summary documentation of assumptions used to develop the base rate; (3) detailed processes for how the data used for rate setting and risk adjustment was or will be collected; (4) preliminary risk scores for each plan, if applicable; and (5) a plan for additional data elements the state would like to collect from the managed care plans. Sharing written information in advance of discussions can increase meeting productivity.

3. Hold face-to-face meetings

Most states hold in-person meetings with all participating managed care plans' actuarial and policy staff to discuss timelines, modeling assumptions, and outstanding data needs. For new programs, managed care plans suggest holding a "pre-meeting" with state and managed care plan actuarial staff to review the state's proposed data sources, collection approach and rate methodology, as well as expected trends and other factors that may impact future years' costs. States may also choose to hold individual, in-person plan meetings to encourage more open dialogue about how rate-setting policies will impact different managed care plans.

4. Include follow-up time in work plans

After sharing preliminary information via written documents and in-person meetings, states should include additional time to resolve plans' outstanding questions. Managed care plans suggested that states have a feedback loop in place for soliciting and responding to comments and questions. Ongoing communication also helps states to better understand how their decisions affect plans' day-to-day operations and budgeting process.

Several interviewees acknowledged that states may face some challenges when conducting these activities. For example, states must balance the time required to finalize this process internally with conducting frequent meetings and furnishing comprehensive information to inform managed care plans. Another challenge involves obtaining the most recent data to calculate rates. The more recent the data used — which can provide the most accurate information about the risk of the population — the less time available to validate, clean, and analyze the data and release initial rate information for plan review. States must also balance transparency with maintaining some degree of confidentiality for managed care plans that might not want their information shared with other plans, as well as to ensure that when relevant, states are able to maintain a negotiating position.

Opportunities for Managed Care Plans to Support Rate-Setting Processes

Managed care plans may have useful data and other information that is not accessible to states. For example, although plans must submit encounter and other claims data to comply with contract obligations, they may collect additional data that can inform modeling and help analyze enrollees' risk profile. In addition, plans may offer new perspectives and operational insights on how rate development model assumptions and decisions may impact future cost trends and providers and beneficiaries at the delivery system level. Examples of data states can request from managed care plans include:

1. Data related to program operations

Managed care plans often collect data to better understand day-to-day program operations such as data on resources needed to transition people out of nursing facilities (e.g., enrollee clinical characteristics, numbers of care management staff/responsibilities around transitions, and additional staff required to maintain individuals in a community setting). State actuarial staff are unlikely to have this level of detail to include in their initial modeling.

2. Ad hoc analyses

Managed care plans often perform periodic functional assessments for care planning but do not report this information to states. Also, managed care plans may use this data to conduct other analyses that can inform states about the full costs of supporting individuals with specific diagnoses and/or functional limitations in the home. For example, when conducting a separate analysis that was outside of the state-required functional assessment, one managed care plan identified a considerable cost difference between individuals who needed help with upper body versus lower body dressing and was able to modify individuals' care plans appropriately.

3. Information about additional supports and services

Managed care plans may provide additional services outside of the standard benefit package, either as “in lieu of” services, whose costs can be factored into the rates, or as “value-added” services, whose costs must come from plan savings.³ Examples include home modifications, various social supports, or other services that address social determinants of health or environmental conditions. Giving states access to data about additional services rendered provides a more accurate picture of what it really costs to care for high-need beneficiaries.

When requesting data beyond required submissions, managed care plans prefer to have a standardized reporting template. This helps plans to more easily code required data elements and set up the appropriate programming to run the reports correctly. They also suggested that states ask for a narrative along with data requests to reduce confusion and ensure correct data interpretation.

Texas' Approach to Engagement in Rate Setting Activities

Texas, which participates in the Medicaid MLTSS Rate-Setting Initiative², provided tips for involving its five participating managed care plans in its annual rate update discussions for its MLTSS program, STAR+PLUS. (Note: Texas follows the same process for all 19 contracted managed care plans that participate across all Medicaid programs). The Health and Human Services Commission (HHSC), Texas' Medicaid agency, updates capitation rates for all managed care programs annually to reflect changes in benefits, utilization, beneficiary characteristics and needs, and other factors driving costs. The five plans in STAR+PLUS engage in an annual series of rate development work group meetings to help the state gather plan input on major decisions, maintain a high level of transparency, and provide a venue for plans to voice their concerns:



- **In January**, four months before the start of the next rate period, Texas releases initial rates for comment from managed care plans. Comments generally focus on reactions to the proposed rate assumptions, as well as other programmatic changes, such as changing enrollment that might impact participating plans. Recent comments about STAR+PLUS rates included concerns about adequately predicting the risk level of enrollees who are at-risk for needing LTSS. Although individuals must meet a nursing facility level of care to be included in the nursing facility or home-and community-based services risk groups, STAR+PLUS has an “Other Community Care” risk group. This group has a large number of enrollees who receive some LTSS and, due to the sheer size of this group, has a large fiscal impact on the program.
- **Approximately one week after initial rates are released**, Texas officials conduct an in-person meeting with managed care plans' actuarial and policy staff to review the rate development model assumptions and address questions. Following this meeting, Texas officials may meet with individual managed care plans to discuss specific concerns and data points.
- **Semi-annually**, Texas convenes capitation work group meetings with managed care plans to discuss refinement of the model assumptions and address subsequent comments and questions. Texas staff often take feedback to state leadership to discuss potential adjustments.
- **In June**, rates are usually finalized.

Texas shared the following best practices for other states that are updating MLTSS rates:

- Choose rate development models that are transparent and defensible based on the data available and sound actuarial principles.
- Strive for transparency and opportunities to collect feedback from participating managed care plans, although states themselves should ultimately make rate-setting decisions.
- Ask for plans to submit all comments to the state in writing and present to leadership with rating decisions. Comments should also be based on managed care plans' most recent experience (e.g., the current or past year if possible).
- Predict how much time engagement activities will take, and include time for managed care plans to review rates and offer comments. Anticipate these activities to take longer than expected.

Lastly, Texas currently does not use functional assessment data to risk adjust MLTSS rates in its STAR+PLUS program, but it is considering this option. It suggests that other states considering using functional assessment data to assess the data very carefully and develop a solid understanding of its limitations. In recent discussions with managed care plans, Texas realized for much of the population receiving MLTSS, functional status data is currently collected on paper, which would be very difficult to use in a risk-adjustment model that links encounter data to functional assessment data.

Massachusetts' Approach to Broad Stakeholder Engagement in Rate Setting Activities



Massachusetts, which also participates in the Medicaid MLTSS Rate-Setting Initiative, recently conducted a series of stakeholder workgroups to assist in planning activities for a major initiative that will restructure how MassHealth, Massachusetts' Medicaid agency, pays for and delivers services. To support this comprehensive initiative, it convened several public meetings across the state and stakeholder work groups on eight topics, which met regularly over several months to provide input on key design issues: strategic design, payment design, attribution, certification criteria, behavioral health payment model, long-term supports and services payment model, quality improvement, and health homes. The Long Term Services and Supports Payment Reform Work Group focused on payment models that would support integrated, person-centered care for enrollees with disabilities and/or significant LTSS use.⁴ Based on the state's experience convening these groups, MassHealth officials offered several lessons for states undergoing similar efforts:

- **Involve a broad membership:** MassHealth selected a diverse group of participants for its workgroups. Interested individuals submitted applications, and then the state selected a mix of beneficiaries, advocates, hospitals, providers, managed care plans, and other stakeholders to participate. Participants were chosen based on: (1) the quality of their applications; (2) the extent to which they or the group they represented would be impacted by these policy changes; (3) technical or subject matter expertise; (4) geographic diversity; and (5) expressed interest in the topic. The resulting participants were very committed, active members who represented a range of community groups and interests.
- **Clearly define topics for workgroup sessions:** If states have resources to facilitate several different work groups concurrently, they should consider focusing workgroups on specific topics for more targeted stakeholder discussions regarding complex program changes. In addition, state staff should meet internally at regular intervals (e.g., weekly) to synthesize findings and common themes from different workgroups, ensure the different groups move forward in unison (i.e., using identical definitions and framing), and troubleshoot solutions to issues that arise.
- **Create a targeted discussion structure:** Within the workgroups, MassHealth officials used small groups to address structured discussion questions, and then re-convened larger groups to discuss agenda topics broadly, allowing groups to quickly hone in on the core issues. This format generated more input than a one-directional presentation. It also encouraged greater interaction and understanding of different perspectives and approaches to resolving complex policy questions. MassHealth officials found that limiting time for discussion exercises increased workgroup productivity. Lastly, meeting facilitation should be robust, active, and targeted to the issue at hand. Meeting facilitators ensured that all members participated by managing specific interests or individuals who tried to dominate the conversation. This was particularly important given the range of sophistication and technical knowledge among workgroup participants.
- **Provide frequent and transparent updates:** MassHealth created a dedicated website and email address to manage the stakeholder engagement process. Public meetings were continued at intervals throughout the workgroup process so that the public, as well as all workgroup members, were able to see the overall progress and direction of the discussion. The email address allowed for dissemination of information, as well as a mechanism to receive information from stakeholders.

Considerations for States from Managed Care Plans

Managed care plans have clear interest in states' rate-setting decisions because the outcome will impact their financial viability. The plans interviewed suggested that states consider the potential impact that MLTSS rate-setting policy decisions could have on their participating managed care plans and other stakeholders and made the following suggestions for states designing MLTSS rate-setting methods:

1. Understand the base rate

One of the primary goals of MLTSS programs is to encourage home- and community-based care over institutional settings. States may use several different methods to establish these incentives (see [Medicaid Rate-Setting for Managed Long-Term Services and Supports: Basic Practices for Integrated Medicare-Medicaid Programs](#)).⁵ For example, states might use a blended rate, in which managed care plans are paid a single rate representing a blend of home- and community-based services (HCBS) and institutional care costs for individuals who reside in the different settings. The structure of a blended rate creates incentives to keep people in lower cost, community care.

Managed care plans generally support the use of blended rates, but cautioned that states should account for acuity and other factors affecting the cost of care for specific populations. To better reflect changes in acuity in HCBS and institutional settings, interviewees suggested that states develop and update rate cells for major rate categories separately, and then blend rates or apply other incentive structures to encourage community placement. For example, after participating in a state's MLTSS program for a few years, one managed care plan noted that as more individuals transitioned to the community or remained in the community longer than they did before the program, the acuity of individuals receiving HCBS increased, resulting in higher per capita HCBS costs. Because the state did not conduct a separate analysis of the HCBS rate cell when making updates to the rate, it was unable to capture this new trend, which complicated rates for the subsequent year.

Another important consideration is the extent to which unmet need may impact costs among individuals who are: (1) at-risk for becoming LTSS users; (2) high users of state plan benefits; (3) on HCBS waiver waiting lists that are removed under MLTSS programs. Because these individuals typically have not yet undergone an assessment to identify LTSS needs, there is likely to be less data available about their risk. In states that enroll dually eligible beneficiaries in these programs and do not have good access to Medicare data, lack of information about use of primary and acute care services may also be an issue. Understanding this at-risk population and reflecting that risk in the "community well" rate cell (i.e., inclusive of individuals in the community who do not currently use HCBS) could have significant implications for rates. States might partner with managed care plans to gather more information to better understand the clinical and risk profile of individuals who are likely to become LTSS users, absent information from comprehensive functional assessments.

2. Set realistic rebalancing targets

States often set rebalancing targets for the proportion of individuals that plans must serve in the community rather than an institution. These targets are often included in the assumptions that states used to build blended rates, and they may be enforced through financial bonuses and/or penalties. When establishing these targets, managed care plans urge states to think about appropriate targets, as well as external factors that could influence them. For example, states often increase transition targets each year, assuming that more experienced managed care plans will have the infrastructure and experience to move or retain individuals in the community more effectively. However, plans noted that transition rates often slow after the first year or two because individuals that are most easily moved are often transitioned first, leaving more complex and frail beneficiaries in institutional settings. Plans also urged states to consider: (1) the availability of affordable housing opportunities; (2) the number of waiver slots available for individuals requiring HCBS; and (3) personal care services or other supports available to help individuals function independently on a long-term basis.

3. Approach the use of functional assessment data for risk adjustment slowly and thoughtfully

Many states adjust MLTSS plans' capitation rates to some degree to account for the effect that health status or residence may have on risk and costs of providing services, but only a few states risk-adjust rates using functional assessment data, which is an important predictor of beneficiary costs in MLTSS programs. Risk adjustment is a statistical method that accounts for differences in the characteristics of each managed care plan's enrollees that affect the use and cost of services (see [Look Before You Leap: Risk Adjustment for Managed Care Plans Covering Long-Term Services and Supports](#)).⁶ Although managed care plans generally support risk-adjustment because it can protect plans that enroll more high-need beneficiaries than others, it is important to note that risk adjustment does not increase the funding available overall. Instead, risk adjustment reduces the possibility of “winners and losers” among participating plans depending on the case mix of their enrollees.

Many states are interested in learning how to incorporate functional data into their rate-setting methodology. States face many challenges with collecting and using this data for risk adjustment purposes (see [Developing Capitation Rates for Medicaid Managed Long-Term Services and Supports Programs: State Considerations](#) and [Building Managed Long-Term Services and Supports Risk-Adjustment Models: State Experiences Using Functional Data](#)).⁷ Interviewees provided several recommendations for states considering this option:

- **Move slowly.** It often takes longer than expected to develop a new rate-setting methodology, particularly in a new MLTSS program for which states are managing several other implementation issues and collecting complex data. Adopting a slower-than-expected timeframe upfront provides more leeway to “get it right,” and to collect input about how variation in beneficiary acuity could impact plans. States that take additional time to work with complicated data will help ensure that the model will not have a disproportionate impact — either over- or under-payments — on specific managed care plans.
- **Consider a transition period or phased-in implementation of a risk-adjustment model.** When New York launched its risk adjustment model in 2009, it phased it in over a three-year period.⁸ A similar transition period can help mitigate uncertain impacts that new policies may have on managed care plan operations and budgets.
- **Address questions related to data needs upfront to ensure data are complete, objective, reliable, accurate, and timely.** Questions that may mitigate data-related challenges include:
 - » *Do you have complete and accurate data?* For new programs, states should identify any missing data elements that could hinder model accuracy. States may also consider analyzing what payment rates would be both with and without risk-adjustment to better understand the impact of these new policies across plans.
 - » *Where is the data located?* For example, does the Medicaid agency collect or have ready access to data, or is it located in different agencies (e.g., Aging, Disabilities, Mental Health, Public Health, others)? If data lies outside of the Medicaid agency, states should develop a process for getting data from other agencies, ensuring it is collected in a usable format, and assess how difficulties in accessing this data could impact participating plans.
 - » *How might delays in getting data affect the rates?* Some MLTSS program enrollees' conditions can change rapidly. Some interviewees suggested that states use data no older than 18 months.
 - » *Are states equipped to analyze the data?* Once states receive the data, they may consider obtaining expert assistance in analyzing it, if Medicaid staff do not have all the needed knowledge or skills. Linking functional assessment data to encounter claims is a very complex process and state staff need to be prepared and knowledgeable to avoid miscalculations.

- » *How often does the state plan to risk-adjust?* Larger plans, particularly those covering a range of physical health benefits, may have more protection against volatility in service utilization and spending for higher-cost enrollees compared to smaller plans. Therefore, larger plans may prefer annual rate adjustments; less frequent adjustments minimize administrative burden, provide better budget predictability and allow for more time to meet rebalancing or other performance targets. In contrast, smaller plans may have a few very high-cost enrollees who can have a major impact on a plan’s financial stability. These plans may benefit from adjusting rates more frequently to address changes in service use and costs, as well as to account for enrollment ramp-up in new programs until the enrollment stabilizes. For example, one health plan interviewee noted that a state that expanded its MLTSS program made quarterly adjustments for newer, smaller plans during the first year of operation. Larger, more established plans continued to receive annual risk score updates.

Conclusion

MLTSS programs offer states an opportunity to improve care and reduce costs for high-need beneficiaries, but rates must be carefully structured to achieve these goals and ensure managed care plans will be able to effectively participate in these programs. Actively engaging plans and, as appropriate, other stakeholders in the MLTSS rate setting process by communicating about information gathering and seeking feedback, is a valuable endeavor. In addition to generating goodwill with participating managed care plans by establishing a level of transparency, active discussions can offer states insight into perspectives and information to improve rate-setting methodologies that they might not access to otherwise.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

MEDICAID MANAGED LONG-TERM SERVICES AND SUPPORTS RATE SETTING RESOURCES

This brief is a product of CHCS’ [Medicaid Managed Long-Term Services and Supports Rate-Setting Initiative](#), which is made possible by the West Health Policy Center to help states and other stakeholders advance rate-setting methods for MLTSS programs. Other resources on www.chcs.org, include:

- *Building Managed Long-Term Services and Supports Risk-Adjustment Models: State Experiences Using Functional Data*
- *Developing Capitation Rates for Medicaid Managed Long-Term Services and Supports Programs: State Considerations*
- *Look Before You Leap: Risk Adjustment for Managed Care Plans Covering Long-Term Services and Supports*
- *Population Diversity in Medicaid Managed Long-Term Services and Supports Programs: Implications for Rate Setting and Risk Adjustment*
- *Strategies to Mitigate Risk in Medicaid Managed Long-Term Services and Supports Programs*
- *“Trust but Verify”: Tennessee’s Approach to Ensuring Accurate Functional Status Data in its Medicaid Managed Long-Term Services and Supports Program*

ENDNOTES

¹ For more information, see: <http://www.chcs.org/project/medicaid-managed-long-term-services-supports-rate-setting-initiative/>.

² U.S. Code of Federal Regulations. 42 CFR §438.70. S81 Fed. Reg. 27498-27901 (May 6, 2016). Available at: <https://www.federalregister.gov/articles/2016/05/06/2016-09581/medicaidand-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>.

³ 42 CFR §438.3(e). S81 op. cit.

⁴ Ibid.

⁵ M. Dominiak and J. Libersky. “Medicaid Rate-Setting for Managed Long-Term Services and Supports: Basic Practices for Integrated Medicare-Medicaid Programs.” Mathematica Policy Research, July 2016. Available at: <https://www.mathematica-mpr.com/our-publications-and-findings/publications/medicaid-ratesetting-for-managed-longterm-services-and-supports-basic-practices-for-integrated>.

⁶ For a more detailed discussion about risk adjustment, see: D. Lipson. “Look Before You Leap: Risk Adjustment for Managed Care Plans Covering Long-Term Services and Supports.” Center for Health Care Strategies, August 2016. Available at: <http://www.chcs.org/resource/look-leap-risk-adjustment-managed-care-plans-covering-long-term-services-supports/>.

⁷ For a more detailed discussion about challenges related to collecting and using functional status data for risk adjustment, see: D. Lipson., M. Dominiak, M. Soper and B. Ensslin. “Developing Capitation Rates for Medicaid Managed Long-Term Services and Supports Programs: State Considerations.” Center for Health Care Strategies, January 2016. Available at: <http://www.chcs.org/resource/developing-capitation-rates-medicaid-managed-long-term-services-supports-programs-state-considerations/> and M. Dominiak and A. Bohl. “Building Managed Long-Term Services and Supports Risk-Adjustment Models: State Experiences Using Functional Data.” Center for Health Care Strategies, August 2016. Available at: <http://www.chcs.org/resource/building-managed-long-term-services-supports-risk-adjustment-models-state-experiences-using-functional-data/>.

⁸ M. Dominiak and A. Bohl. “Building Managed Long-Term Services and Supports Risk-Adjustment Models: State Experiences Using Functional Data.” Center for Health Care Strategies, August 2016. Available at: <http://www.chcs.org/resource/building-managed-long-term-services-supports-risk-adjustment-models-state-experiences-using-functional-data/>.