National
MLTSS
Health Plan Association

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John Giles
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Centers for Medicare & Medicaid Services
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Dear Director Giles and Director Spitalnic,

The MLTSS Association represents managed care organizations (MCOs) that have Medicaid managed care contracts with one or more states and take risk for long-term services and supports (LTSS), including home and community-based services (HCBS), provided under Medicaid.[1] Our members assist states in delivering high-quality LTSS at the same or lower cost as the fee-for-service system with a particular focus on ensuring beneficiaries' quality of life and ability to live as independently as possible. Our members currently cover the large majority of all enrollees in MLTSS plans and integrated plans, including national plans and regional and community-based plans.

Actuarially sound rates are a critical component of Medicaid managed care to ensure that MCOs receive adequate funding to serve their members. This is especially crucial for MLTSS plans that manage services for individuals with often long-term and chronic conditions. Those services help members maintain their health, remain in their community, and empower members' independence. In the letter below, we outline key themes and recommendations for MLTSS rate setting.

MLTSS Rate Setting: Key Themes and Recommendations

Actuarially sound rates are a critical component of Medicaid managed care to ensure that Managed Care Organizations (MCOs) receive adequate funding to serve their members. This is especially crucial for Managed Long-Term Services and Supports (MLTSS) plans that manage services for individuals with often long-term and chronic conditions. Those

[1] Members include Aetna, AmeriHealth Caritas, CareSource, Centene, Elevance Health, Florida Community Care, Humana, LA Care, Lakeland Care, Molina Healthcare, Neighborhood Health Plan of Rhode Island, VNS Health, UnitedHealthcare, UPMC Community HealthChoices

services help members maintain their health, remain in their community, and retain their independence.

In managed care, rates are set proactively, and the rate setting process is a collaboration between states and health plans, with CMS ultimately required to sign-off on rates. As the leading association representing MLTSS health plans, the MLTSS Association has a unique lens into both large national MLTSS health plans as well as smaller, regional or single-state MLTSS health plans. This perspective enables the MLTSS Association to identify policy and programmatic issues across states, including those that impact MLTSS Rate Setting. Within MLTSS rate setting, CMS has the ability to release guidance that clearly outlines the potential impacts of state actions and provides recommendations and best-practices for states.

In the document below, we outline specific issues and recommendations for the steps that CMS can take to support states and health plans in setting MLTSS rates that ensure that the programs remain stable.

The Medicaid Managed Care Rate Development Guide is used to outline what is required and, in some circumstances, what is permitted, when states set the rates of Medicaid managed care organizations. These requirements apply across all of Medicaid managed care – including both non-MLTSS and MLTSS plan types. Generally, the rate setting regulatory framework is largely agnostic to the services and populations under consideration. Within the guide CMS' treatment of MLTSS-specific rate setting is limited to a portion that explicitly applies the broader of requirements of the guide to MLTSS and discusses additional documents needed in MLTSS rate certification.

To further the utility of this document, **the National MLTSS Health Plan Association recommends that CMS develop an additional set of best practices that outline in more detail how the rate requirements apply to MLTSS rates.** These recommendations could be added to the end of the Managed Care Rate Setting Guide as an additional appendix (e.g. "Appendix C: CMS Recommendations and Identified Best Practices in the Application of Rate Guide Standards to the Delivery of Managed Long-Term Services and Supports").

The recommendations outlined below are initial concepts that the National MLTSS Health Plan Association believes should be included:

1) Rate Setting for states moving from fee-for-service (FFS) to Managed LTSS (MLTSS)

- **Background**: When moving from FFS to MLTSS, states must rely on FFS historical data to set a baseline. This baseline can often lead to problematic implementation, as the costs of moving to MLTSS must be accounted for in rates. CMS notes that states should account for managed care adjustments when transitioning from FFS to MLTSS, and that these adjustments may results in reductions (ex: reductions in unnecessary hospitalizations and emergency room utilization, rebalancing towards home and community-based services (HCBS), and more effective use of home health services) or increases (ex: increased access to HCBS services and increases in physician services) in program costs.[2] Upfront costs of moving to MLSS can also include new care coordination requirements for MLTSS plans, and other new services provided by MLTSS plans that were not included in the state's FFS program. MLTSS plans also often have lower case load ratios than FFS, leading to increased administrative costs for plans. While transitioning to MLTSS may ultimately be cost-effective for states, studies have shown that it can take 2 - 6 years for MLTSS costs to become less than or equal to FFS, with cost savings realized in years 4 – 12 of the transition.[3]

- **Recommendation:** In order to better assist states with the transition to MLTSS, CMS should outline key considerations and options that stress the need for accurate rate setting and outlines successful methods and practices used in relation to rate setting on program implementation.

  Topics to consider include:

  - The appropriate use of blended rates of institutional and waiver members in the setting of rates. States may make assumptions about how quickly rebalancing from institutional to HCBS settings may occur during the transition to MLTSS that are not realistic. States should carefully consider their current FFS controls for utilization (e.g. service cost maximums, etc.), the amount of flexibility plans will have to manage utilization (and if there will be strict restrictions / program requirements), and the fact that

[2] https://www.medicaid.gov/medicaid/home-community-based-services/downloads/rate-setting-mltss-prgrms.pdf
[3] https://us.milliman.com/en/insight/medicaid-long-term-services-and-supports

plans may not be allowed to authorize utilization more efficiently for existing members due to existing care plans.
- The use of historical data to provide this context.
- The advantages/disadvantages of using stronger risk mitigation strategies early in the transition to MLTSS, such as risk corridors.
- The advantages/disadvantages of tying rates to fee schedules.
- How the availability of institutional and HCBS service providers impacts rates and rate setting.
- Accounting for the prevalence of self-directed care. Instead of managing service delivery directly, MLTSS plans often facilitate access to providers. As a consequence, cost savings expectations may be more attenuated.

2) Bottom-up Rate Development

- **Background:** MLTSS contracts often include care management requirements for both nursing home and waiver populations. These care management requirements dictate the number of FTEs (and related salary and benefit expenses) the health plan will be responsible for. Care management requirements, set by both federal and state mandates, for waiver populations often require lower ratios of care managers to members, in turn increasing admin cost. Moreover, the support provided by those care managers may be more intense compared to a less acute physical health risk pool.

- **Recommendation:** CMS could recommend a review of care management cost projections (and other administrative/contractual requirements) using a bottom-up approach for contract requirements, such as care management ratios and other relevant admin costs. This would encourage states to more accurately identify non-service-related costs. In such a bottom-up approach, it is important that the state actuary ensure that the aggregate administrative cost in rate-setting is reasonable relative to health plan reporting and other benchmarks.

- **Examples:** Pennsylvania utilizes a bottom-up build for their rates. In the rate buildup, the state discloses the care management FTE counts, expected supervisor ratios, and care manager ratios relative to HCBS and nursing facilities. The state also discloses where their assumptions come from for

salary/benefits and the inflation trend adjustments for these salaries and benefits

3) Mid-year capitation rate adjustments

- **Background:** MLTSS rates are intended to account for factors such as changes in utilization patterns, state program design changes, and inflation, and when correctly calibrated, reflect the true costs of delivering MLTSS. States that employ real-time monitoring of utilization and review cost reporting data from plans may be better equipped to address fluctuations in rates before instability, and the need for mid-year adjustments, occurs. When possible, states should align any policy change effective dates and changes to mandated payment levels to the rate year period, so that they can be accounted for during the rate-setting process.

  Certain changes, whether instigated by the state or due to unforeseen circumstances, may necessitate mid-year capitation rate changes. CMS emphasizes that changes that may necessitate mid-year capitation rate changes must be **outside of normal trend**, and may include state fee schedule adjustments, benefit changes, eligibility changes, new federal mandates, and state legislative actions.[4] These changes should be minimized to the extent possible but are sometimes unavoidable.

- **Recommendation:** CMS should include the benefits of tying MLTSS rates more directly to fee schedules and effectively utilizing mid-year cap updates within the Medicaid Managed Care Rate Development Guide. These recommendations should exist in recognition of broader federal requirements that any changes leading +/- 1.5% of existing rates requires new contract amendments.

- **Examples: Michigan** amended their capitation rates based on the nursing facility fee schedule on October 1st to reflect fee schedule changes. Illinois makes mid-year changes to its Nursing Facility per diem rates and HCBS fee schedules that are then reflected in updates to MLTSS rates.

[4] https://www.medicaid.gov/medicaid/home-community-based-services/downloads/rate-setting-mltss-prgrms.pdf

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4) Rate Cell Use in MLTSS Rate Setting

- **Background**. Rate cells are one of the most common tools used in Medicaid managed care rate setting to help achieve granularity in acuity measurement and subsequent anticipated costs of populations. Homogeneity within rate cells will help to ensure that all rate cells are appropriately funded. Federal regulations outline requirements states must follow when developing rate cells that apply equally across non-LTSS and MLTSS rate setting. Plans believe it would be useful to states for CMS to outline additional considerations with respect to acuity groupings and rate cells specific to MLTSS rate setting.

- **Recommendation:** CMS could outline actuarial approaches related to rate cell population division in MLTSS rate setting:
    - States should be encouraged to shift away from a current common rate cell practice of establishing macro level rate cells such as "LTSS" vs "non-LTSS" or "HCBS" vs "non-HCBS." This type of rate setting approach does not provide for sufficient granularity, homogeneity, and ultimately reliable cost predictions within rate cells.
    - States could consider creating new rate cells within the HCBS population using specific clinical indicators (e.g. ventilator or feeding tube dependent). When rate cells are mapped to specific conditions, it is possible to conduct more accurate analyses on the correct funding level for each rate cell.
    - States could also consider rate cells within the HCBS population by age, region, waiver type, living arrangement, functional assessment scores (grouping the highest and lowest scores together to form different rate cells), or specific clinical indicators.
    - States should consider the impacts of individuals who receive LTSS (either via HCBS or in an institutional setting), but who are included in non-LTSS rate cells, on rate setting. These members have much higher costs compared to the typical members of their rate cell. States could consider moving those individuals to separate rate cells or include a risk-adjustment indicator for their consideration.

- **Examples**:

- **Wisconsin splits their LTSS population into three target groups for the purpose of rate setting –** Developmentally Disabled (DD), Physically Disabled (PD) and Frail Elderly (FE). Each enrollee is assigned to one of these target groups, and this target group assignment is used in the actuarial rate development process, including as risk weights in the capitation rate model.
- **New Jersey allows for capitation rates to be adjusted for risk factors associated with specific enrollee populations (Administrative Code § 10:74-12.2) –** this serves as the regulatory basis for any special high-needs rate cells (ex: ventilator/technology dependent populations).

5) Use of Functional Assessments in MLTSS Rate Setting

- **Background:** Functional status assessments are a foundational tool in MLTSS rate setting. States often rely on functional assessments to translate individual-level needs and acuity into actuarially sound rates. States differ in their approaches to administering and evaluating functional assessments, and the MLTSS Association supports states' flexibility to choose the approach that works best for their specific MLTSS program. We understand that CMS should not be prescriptive in guidance or promote one approach over another, but we believe it is important that CMS provide sufficient guidance to ensure that no matter which pathway a state chooses, they have the necessary to support to produce actuarily-sound rates that reflect member acuity.
- Given the importance of functional assessments in MLTSS rate setting, the MLTSS Association believes that CMS should provide additional guidance to states on the best way to operationalize them. Specifically, the MLTSS Association believes that any administration of functional assessments needs to have appropriate training, oversight, and auditing as primary components of its structure. This will ensure that there is consistency in the administration, application, and use of functional assessments between plans and populations.

  Current state approaches to administering functional assessments generally include:

  - **Having health plans be responsible for administering and interpreting plan-specific functional assessments for their members:** This approach provides health plans with the greatest control of the

administration of functional assessments for their members. However, there are concerns with inter-rater reliability as individuals move between plans and are reassessed.

1. There are also states in which health plans administer a common assessment (ex: InterRAI). These standardized assessments may decrease the potential for inter-rater reliability issues, but can be administratively burdensome and stifle plans' ability to design assessments for their specific populations.
2. There is an important relationship between state implementation of functional assessments and how they are ultimately used for MLTSS rate setting. To the extent that states use increasingly nuanced rate cells that rely on information gleaned from functional assessments (e.g. separate rate cells for ventilator-dependent individuals or individuals who have some threshold level of functional limitation), then there is a correspondingly increased need to ensure greater emphasis on the integrity of implementing the assessments themselves. Thus, if states do choose to adopt more nuanced rate cell approaches (as we discuss above), they should similarly adopt greater oversight and standardization measures of functional assessments. Overall, if a state builds their MLTSS rates using specific rate cells based on acuity/complexity/etc, we recommend utilizing standardized assessments.

- **Having the state administer, or contract with an independent entity to administer, functional assessments for MLTSS members:** This approach provides states with the most oversight and control over the administration of functional assessments for MLTSS members and could provide more consistency and standardization across assessments. However, delegation of this responsibility puts plans and states downstream of some of the core data sources that inform care plan development. Having the state, or their contractor, conduct the assessment also removes an opportunity for a touchpoint between the health plan and the member and impacts relationship-building.

- **Having the state, or an independent entity contracted with the state, administer an individual's initial functional assessment, and then having health plans administer subsequent functional assessments for that individual:** This approach provides one consistent touchpoint for states as individuals complete their initial assessment and then allows for health plan management of the process in subsequent years.

All of these approaches are valid and should be considered as options for state MLTSS programs. Ultimately, the integrity of the assessments is what is most important.

- **Recommendation:** Without promoting one approach over another, CMS can provide guidance support to states on the different approaches states can take to the application of functional assessments. This guidance could include:
  - Outlining the advantages and disadvantages of using independent vs plan-run functional assessment tools. Highlighting that regardless of choice, the state must ensure that there is appropriate quality control measures built into the programs to ensure consistency and accuracy.
  - Ensuring that standardized assessments, administered by either states or health plans, are comprehensive, updated timely due to change in conditions, and provide the data needed accurately capture members' functional status.

6) **Data Use in MLTSS Rate Setting**
   - **Background:** Generally, federal regulations require that capitation rates must use all validated encounter data, FFS data, and financial reports relevant to a population. Furthermore, the data must be no older than 3 complete years prior to the rating period. These standards apply across all of Medicaid managed care rate setting. However, health plans note that the lag in reference data used in rate setting is inherently unable to highlight more emerging trends. This issue was pronounced during the COVID-19 pandemic but holds to true to significant shifts in utilization overall. Such shifts can occur from sudden legislative/regulatory changes, changes in provider capacity or access, or any number of other factors. In LTSS, such changes are more pronounced because

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of the increased use of utilization limits on non-mandatory services as well as from the higher underlying acuity of the population.

- **Recommendations:** In guidance documents CMS should highlight the value of maximizing use of emerging data and how states can achieve such ends through investments in data sharing capabilities, TMSIS reforms, the use of HIEs, and other means. States could also be encouraged to review the amount of patient liability that is actually being collected by health plans for patient nursing facility use and trends in Patient Liability relative to changes in the Social Security COLA.

- **Examples:** In setting rates, **Illinois** looks at functional assessments and waiver type data between the base period and a point in time directly prior to rate-setting to see if the acuity of the HCBS population has shifted.

The MLTSS Association appreciates this opportunity to provide feedback on MLTSS rate setting and looks forward to continued partnership with the Managed Care Group. If you have any questions about our feedback, please feel free to contact Mary Kaschak at mkaschak@mltss.org.

Sincerely,

Mary Kaschak
Chief Executive Officer
MLTSS Association