Managed Long-Term Services and Supports

Using Capitation To Promote Home and Community-Based Services

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State Medicaid systems are increasingly providing long-term services and supports (LTSS) through a managed care framework, usually as part of an integrated healthcare package. Typically, health plans, known as managed care organizations (MCOs) receive a fixed payment from the state Medicaid agency for each member served. This per-member-per-month payment, known as a capitation rate, generally (but not always) varies according to whether the person receives LTSS, and sometimes whether those services are provided in institutional or community settings. If they choose to do so, states can structure capitation payments to provide financial incentives that encourage MCOs to provide members with sufficient home and community-based services (HCBS) so that institutional placement can be avoided, and to work to transition institutionalized members back into the community. These incentives can help states "rebalance" their LTSS systems, meaning that they increase the proportion of expenditures going to HCBS rather than institutional care.

At least 27 major, capitated managed LTSS programs operate in 22 states. Eleven capitated "duals demonstration" programs, which offer integrated LTSS and healthcare for people covered under both Medicaid and Medicare, operate in 10 states as part of a program established in the Affordable Care Act. Most of the remaining programs are Medicaid managed care programs that integrate LTSS with acute healthcare, and a few others are LTSS-specific programs. These operate as Waiver programs under authority of Section 1115 of the Social Security Act or some combination of Sections 1902(a), 1915(a), (b), (c), and 1932(a).

Examination of the capitation rate structures from these programs reveals several common practices, which can either promote or hinder rebalancing of the LTSS system. The principal issues in

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establishing capitation rate structures are as follows:

- Whether institutional services are part of the capitated rate system, or are "carved out" as a fee-for-service payment separate from the capitation payment.
- Whether MCOs receive a different rate for LTSS-using members according to the setting (institutional versus home/community) or are instead paid a single, "blended" rate based on the expected proportion of members in those settings.
- Whether blended capitation rates are adjusted for a targeted mix of institutional versus community residents.
- Whether capitation rates are calculated by averaging across all types of LTSS recipients or are differentiated by population characteristics or specific programs.
- Whether any of several strategies is used to explicitly penalize MCOs whenever a member is institutionalized and/or reward them whenever an institutionalized member is returned to the community.

Including or excluding institutional services

Two states currently operate some version of an "institutional carve-out," in which the MCO loses responsibility for the member once the member transitions to an institutional setting. When an MCO gets a capitated payment that includes HCBS but not institutional services, plans have a clear financial incentive to try to place their higher-needs HCBS recipients into institutions. Once an MCO is spending more for a member's HCBS than it is receiving in a capitation payment, it seems inevitable that MCO administrators would see the member as a liability, and might encourage staff to either recommend institutionalization or begin to limit HCBS so that institutionalization becomes more likely. Once that happens, the state takes over and that member is no longer the plan's responsibility. There is no need to be concerned, for example, about transitioning the member back to the community if institutional services are no longer needed or if the member wishes to return.

Of the managed LTSS programs studied, only **Kansas**'s KanCare program has a capitation model that fully excludes institutional services, and that exclusion only applies to public institutions (intermediate care facilities) for people with intellectual and developmental disabilities (I/DD). For elderly people and those with physical disabilities, Kansas pays MCOs for both HCBS and institutional services (see below).

Minnesota's Senior Care Options and Senior Care Plus programs relieve MCOs of responsibility for institutionalized members, but only after six months have elapsed since their institutionalization. After that happens, the MCO is discharged of any responsibility for transitioning them back into the community. However, the state imposes rather strong financial incentives that are likely to discourage plans from using institutional placement as a way of getting off the hook for more costly members.

Paying separate versus blended rates for HCBS and institutional services

States typically pay MCOs capitation amounts for each LTSS recipient in one of the following ways:

1. A rate that differs according to the residential setting, with a substantially larger payment for members residing in institutions than for those living in the community.
2. A "blended rate" for LTSS recipients that does not depend on whether the person is living in the community or an institution, calculated using a population-weighted average of the institutional rate and the community (HCBS) rate.
3. A "blended rate" that is averaged across not only LTSS recipients, but also members who do not receive LTSS. This method is used in only a few programs.

Separate rates by residential setting

A few states use a capitation model in which MCOs are paid one rate for members receiving HCBS and another for members receiving institutional LTSS. This model would seem to offer MCOs no incentive one way or the other with respect to rebalancing, as long as both rates reflected the true average expenditure for each setting. On further inspection, however, another possibility emerges. State regulations often limit the allowable profit, or profit plus administrative costs, to a proportion of gross revenue, or they require that profits in excess of a certain proportion of revenue be shared with the state. MCO administrators might therefore want to increase the size of the payments they get from the state, even if the excess is merely passed through to providers, so that they are able to draw higher profits based on higher revenues. Switching members from a lower community rate to a higher institutional rate might therefore be seen as a good business practice, in the absence of other considerations.

Managed LTSS programs in **New Jersey** (Comprehensive Waiver), **New Mexico** (Centennial Care), and **Texas** (STAR+PLUS) use capitation models with separate rate cells for institutional services and HCBS. New Mexico and Texas both require that MCOs share profits that exceed 3 percent of revenues with the state. New Jersey and New Mexico both limit the amount that an MCO can spend on anything other than direct services; the limit is 10–15 percent in New Jersey, depending on setting, and 15 percent in New Mexico. In the absence of strict oversight of institutional placement, it would be theoretically possible for an unscrupulous MCO in these states to maximize profits by needlessly institutionalizing members, or by failing to take appropriate steps to transition members back into their communities.

Blended rates for LTSS recipients

"Blended" capitation rates are often touted as providing a strong incentive for MCOs to avoid institutional placement, but they can have unintended consequences that potentially counteract that incentive. In this model, the MCO receives the same capitation payment for each member regardless of whether they receive LTSS in a community setting or in an institution. The blended rate applies either to all LTSS users, whether receiving HCBS or institutional services, or for those LTSS users meeting the "institutional level-of-care" (or "nursing facility level-of-care") threshold, again regardless of setting. The blended rate is generally obtained by first computing separate HCBS and institutional rates, and then taking a weighted average based on

the expected proportion of members receiving services in each setting.

In principle, a blended rate for high-need LTSS users would seem like a strong incentive for MCOs to both keep members out of institutions and work toward transitioning members back to the community. For each member who remains on or returns to HCBS (which typically costs an average of between $1,000 and $2,000 per member per month), the plan effectively saves thousands of dollars compared to institutional services (around $5,000 per member per month), and that is just in a single month. MCOs should therefore try to be as generous as possible in providing HCBS, so as not to risk the penalty of having to pay for institutional services.

But there is another consideration. Suppose an MCO worked hard to both divert members from institutional placement and transition members out of institutions, thereby contributing to a rapid rebalancing of the state's LTSS system. Aside from short-term profits, how is the MCO rewarded? When the blended capitation rate is re-calculated the following year, there is now a much higher proportion of LTSS users living in the community. Wonderful, except that the blended rate reflects the mix of community and institutional residents, calculated according to the proportion of each in the prior year, and now the rate is more heavily weighted toward the lower, HCBS component of the blended rate. The capitation amount is therefore substantially lower than it was the previous year, meaning that total revenue received from the state for LTSS users is a lot less. If MCO administrators are focused on long-term profitability, they are likely to be very concerned that their future revenues, which often dictate the amount of allowable profits, decline whenever they contribute to the rebalancing of the LTSS system.

There are two versions of this model: In one, a blended rate applies to people meeting the institutional level-of-care threshold, and separate capitation rates applies to members without LTSS needs or to members with LTSS needs that do not reach the institutional level-of-care threshold. The non-LTSS rates are not blended and apply only to community residents. Programs with a blended rate for LTSS users and one or more separate, non-blended rates for non-LTSS users operate in **Delaware** (Diamond State Health Plan Plus), **Iowa** (IA Health Link), **Kansas** (for elderly people and others with physical disabilities participating in KanCare), and **Virginia** (Commonwealth Coordinated Care). **New York's** FIDA duals demonstration is limited to elderly people and people with physical disabilities needing LTSS; the blended capitation rate applies only to those meeting the institutional level-of-need criteria, with a separate rate for those not meeting this threshold.

In the second version of this model, the program is limited to LTSS users with institutional level-of-care needs, and all capitation payments are made in the form of blended rates combining institutional and community residents. **New York**'s FIDA-IDD, a second duals demonstration program for people with I/DD, operates in this way. **Arizona** (Arizona Long-Term Care System) and **Florida** (Statewide Medicaid Managed Care Long-Term Care Program) operate managed LTSS programs that provide LTSS only and are targeted to people meeting the institutional level-of-care threshold. Both

states have separate, capitated managed care programs for other healthcare services.

Blended rates that include LTSS recipients and non-recipients

Two states include non-LTSS users in their blended capitation rates; that is, the same capitation payment is made for members who do not use LTSS, member receiving HCBS, and members residing in institutions. As for other blended rates, the capitation payment is calculated by separately computing rate cells for people in each category, and then taking a weighted average based on the number of members expected in each category. It is not immediately clear what kind of incentive this model provides.

An MCO might see itself as making money on a member who is not receiving LTSS (and whose expenditures are therefore lower than the blended rate), losing a substantial amount of money on a member receiving HCBS, and losing a great deal of money on an institutionalized member. As an example, in **California** in 2014, MCOs participating in the Cal MediConnect duals demonstration in one county received a blended rate of about $700 per member per month, which is a weighted average of about $100 per month for a member not receiving LTSS, about $750 for a member receiving HCBS at a low level and $1,750 for a member at a high level, and about $5,700 for an institutionalized member. Thus, an MCO might see itself as losing about $5,000 on every institutionalized member and $1,000 for every high-level HCBS member; in contrast, an administrator might consider members not receiving LTSS as highly profitable to the tune of $600 each per month.

In California and in **Hawaii** (QUEST Integration), the only other state to use such a capitation scheme, the rate structure would seem to offer a disincentive for MCOs to promote HCBS and encourage members to obtain eligibility for services. On the other hand, administrators might well be aware that, in some cases, unmet need for HCBS can lead to institutionalization, which would be even more costly to the plan. Perhaps these considerations would lead them to try to restrict HCBS only to those with a high risk of becoming institutionalized.

Adjusting capitation rates to meet rebalancing targets

Several states adjust capitation rates to reflect the goal of saving the state money compared to the former fee-for-service system. These adjustments are generally modest. However, two states, **Florida** and **Iowa**, go one step further. Their blended capitation rates for LTSS users are reduced to meet a "rebalancing target" or "transition percentage"; in other words, the actual proportion of members who are institutionalized is artificially adjusted downward (and the proportion in the community adjusted upward) and the rates recalculated with those revised proportions. If the MCO meets or exceeds the target, then the blended rate they receive is (ostensibly) enough to meet their expenses and perhaps provide a profit.

But what if the transition target, of a 2–3 percentage-point shift away from institutional settings per year, is not realistic or achievable, especially given the reduced payment rates? The MCO either needs to take a substantial loss or save money by limiting services. If what

is ostensibly intended as a rebalancing incentive instead serves as a deterrent to LTSS provision altogether, then this practice may do more harm than good. Furthermore, MCOs might be motivated to game the system, for example by recruiting new members with low LTSS needs, the addition of whom would technically achieve the goal of increasing the proportion of members receiving services in the community, without their having done anything to prevent unnecessary institutionalization or transition institutionalized members back to the community.

Varying rates by LTSS population

Whether LTSS capitation payments vary according to setting or are blended across settings, there remains a distinct issue: In terms of need for services, how broad is the population whose utilization is averaged to obtain the aggregate rate? Some states simply average across all types of HCBS users (perhaps in rate cells defined by geographical location, Medicare eligibility, and/or age group), and then use that rate (or set of rate cells) either for the capitation payment (as in **Illinois, New Jersey, Ohio**, and **South Carolina**) or as the HCBS component of the blended capitation rate (as in **Delaware**, **Florida**, **Rhode Island**, and **Virginia**). In some programs, such as those in **Michigan**, **New York** (FIDA), **Tennessee**, **Texas**, and **Wisconsin** (Family Care), there are two classes of LTSS users, some of whom meet the state's criteria for institutional placement (i.e., "nursing home level of care") and receive substantial amounts of either HCBS or institutional services, and others who do not meet those criteria but are eligible for limited amounts of HCBS. Those programs use separate capitation rates for the two groups.

Either of these approaches is potentially flawed. There can be a great deal of variation in service need among HCBS users, even among those eligible for institutional placement. A state might be paying MCOs the same amount for one member, who needs a small amount of paid help in a few activities when the primary, unpaid helper is not available, as for another member, who needs help with a great many daily activities, plus supervision due to a cognitive impairment, and has no source of unpaid help. The plan, which sees itself as losing money whenever a high-need HCBS user exceeds the capitation amount, might have an incentive not to serve such people at all. They might discourage people with costly needs from joining the plan, provide poor service in the hope that they will "opt out" of managed care or switch to another plan, or might (depending on other cost considerations) deny services so that the person is forced into an institution. Or they might try to cherry-pick LTSS users with lower needs to recruit as members. Any of these responses would hinder rebalancing, which depends on the high-needs LTSS users, who are most vulnerable to institutionalization, getting the services they need in the community.

A more fine-grained approach, which might circumvent this potential problem, is taken in several other states, which divide the HCBS population according to either the program they participate in or their type and level of service need. **Kansas** separately calculates capitation rates for (1) people in the Frail Elderly or Physical Disability Waivers; (2) participants in the Autism, Technology

Assisted, Traumatic Brain Injury, or Serious Emotional Disturbance Waivers; and (3) people in the Developmental Disability Waiver. **Iowa** has separate, blended rates for four populations groups, which apply regardless of setting: elderly people, non-elderly or others without Medicare coverage who have various physical disabilities, people with intellectual disabilities, and children with mental health disabilities. **Massachusetts** (OneCare) has capitation rates for community residents depending on whether the person has an institutional level of need (and, among those who do, whether the person has a specific diagnosis predicting high utilization) and whether the person has a behavioral health need (and, among those who do, whether the person has both a specific mental health diagnosis and a concurrent substance abuse disorder).

Incentivizing diversion and transition through lagged rate changes

In some states, rate structures attempt to incentivize either institutional diversion (foregoing or delaying institutional placement through provision of needed HCBS) or transition (facilitating return of institutional residents to the community by offering needed HCBS and additional services related to the transition) by adjusting the timing of the shift from a lower community rate to a higher institutional rate, or vice versa. Typically, the state continues to pay the lower rate for a few months following institutionalization and/or continues to pay the higher rate for a few months following transition back to the community. These lagged rate shifts are intended as a penalty for failing to divert the member from institutionalization or, to a certain extent, a bonus for a successful transition.

Lagged rate changes in a separate rate structure

The model of separate capitation rates for HCBS recipients and institutional residents has already been described as offering a potential disincentive to rebalancing, due to possible concerns over future revenues, which decline if fewer people are institutionalized. Several state programs use lagged rate shifts to create a stronger rebalancing incentive. The duals demonstrations in **Illinois** (Medicare-Medicaid Alignment Initiative) and **South Carolina** (Healthy Connections Prime) use a 90-day lag following institutionalization before the nursing facility rate takes effect, and offer a bonus capitation payment, higher than the ordinary HCBS or non-LTSS rate, for three months after transition back to the community. In **Massachusetts**, both the OneCare duals demo and the Senior Care Options program use 90-day lags when shifting to the institutional rate; Senior Care Options, but not OneCare, continues to pay an institutional rate for three months following transition back to the community. **Michigan**'s duals demo (MI Health Link) also delays the shift to the institutional rate until three months following institutionalization; when a member is transitioned out of the institution, the MCO gets a single, bonus capitation payment only after the member has remained in the community for three months.

In terms of institutional placement, here is a typical scenario: When a member moves into an institution, the MCO continues to receive the prior, community-based rate for the three

months following institutional placement. If the member was not receiving HCBS, then the plan is liable for the difference between the non-LTSS rate (say about $100 per member per month) and the cost of institutional services (say, $5,000 per month). Over a three-month period, the plan must shell out roughly $15,000 for every member who is institutionalized without receiving HCBS first. For members receiving HCBS before the transition, the amount is somewhat less, probably closer to $10,000 for the three months. These large penalties would seem to substantially eat into MCO profits, which are probably only a few dollars per member per month, on average.

The flip side of this process occurs in some programs when an MCO transitions a member from an institutional setting back to the community. Suppose someone moves out of a nursing home and then receives HCBS at home. In South Carolina, the MCO would get an enhanced capitation payment of about $3,000 per month rather than the normal HCBS payment of about $1,000 per month, for a gain of about $6,000 over three months. The bonus is about $3,000 in Illinois and $1,500 in Michigan. Although some of these funds might go toward one-time expenses associated with the transition, much of it would presumably go directly into the MCO's coffers.

Lagged rate changes in a blended rate structure

Ohio (MyCare Ohio) and **Rhode Island** (Integrated Care Initiative) use a blended capitation rate structure, adding an additional incentive that might tilt the scale more strongly in favor of rebalancing. In these programs, when a member who is not already receiving HCBS transitions to a institution, there is a delay of approximately three months before the MCO starts receiving the higher, blended LTSS rate for that member. Instead, they continue to receive the much lower rate for non-LTSS users. Thus, plans are penalized if they have not provided HCBS to the member before that member is placed in a nursing home or other institution.

For a member who remains in the institution for the full three months, the MCO would be penalized by somewhere between $3,000 and $6,000 over the full period (three months worth of the difference between the blended LTSS rate and the non-LTSS rate). Note that this scenario involves a lag in shifting from a non-LTSS rate to a blended rate for LTSS, rather than from an HCBS rate to an institutional capitation rate, as described above.

Incentivizing diversion and transition through other means

Offering bounties for successful transitions

In two states, rebalancing incentives provided by a blended capitation structure are enhanced by offering a supplemental payment to reward plans for successfully transitioning members who have had lengthy institutional stays back to the community.

Tennessee's TennCare program pays MCOs a blended payment for each member with a nursing home level-of-care need. The MCO also receives a bonus whenever a member has been transitioned out of an institution via the state Money Follows the Person program, which requires a minimum institutional stay of 90 days. The bonus is $1,000 or

$2,000 for a successful transition, followed by an additional payment of $5,000 for each member who has not been reinstitutionalized (except possibly for a short stay) during the year following transition. MCOs are also eligible for substantial bonuses if they meet certain targets established for Money Follows the Person, such as increasing HCBS expenditures, increasing the proportion of LTSS recipients receiving HCBS, and increasing participation in consumer-directed services.

Similarly, but on a more modest scale, **Wisconsin** pays MCOs a $1,000 bonus for members successfully transitioned from institutions back to the community under Money Follows the Person. This bonus payment is on top of a blended capitated payment for all LTSS recipients meeting the institutional level of need criteria, regardless of residential setting.

Paying MCOs to assume the risk of institutionalization

It comes as no surprise that **Minnesota** has its own unique and innovative capitation model. In both the Minnesota Senior Heath Options and Minnesota Senior Care Plus programs, MCOs get paid only a token amount for any member living in an institution. That payment, roughly $300, covers only medical care and not LTSS. In contrast, the capitation payment for HCBS Waiver participants, which varies by age and extent of need, is roughly $2,000 to $3,000 per member per month. MCOs can't be expected to cover the cost of institutional LTSS out of their own pockets, however, so the state pays them for it in an unusual way: by adding a supplement to the base payment for every member living in the community. In other words, plans get a extra payment for all community-resident members to cover the risk that any one of them will need institutional LTSS. That payment averages about $100 per member per month.

The state assumes responsibility for institutional residents who remain institutionalized for longer than six months, so the plan is on the hook for only 180 days of institutional LTSS. Meanwhile, if the MCO is forced to place a member in an institution and fails to return him or her to the community, the MCO is responsible for paying the facility nearly $6,000 per month or about $35,000 total over a six-month period. That is a rather large expense that the MCO could have avoided had it managed to divert the member from institutional placement. In contrast, MCOs that successfully serve large numbers of LTSS users at home and in their communities get to reap the rewards from the supplemental payments they receive to cover the risk of institutionalization. This arrangement would seem like a rather strong incentive to ensure that LTSS users are supplied with adequate HCBS to keep them living and thriving in their communities.

Early in an institutional stay, the plan would also have a strong incentive to work to return the member back to the community. As time goes on, however, that incentive diminishes, due to the six-month limit on the MCO's responsibility for the institutionalize member. The experience of Money Follows the Person and similar programs, however, indicates that it becomes increasingly difficult to transition institutional residents back to the community the longer they have been institutionalized, and the more opportunity there is for their former

support network to diminish and them to lose their former home. When presented with a large incentive to transition people with short-term stays but a diminishing incentive to attempt to help people with longer-term stays, MCOs likely focus on the easier-to-transition and more highly incentivized institutional newcomers. Longer-term residents, who soon become the state's responsibility, are probably less of a concern, after which it becomes the state's concern as to whether to devote substantial resources toward that population.

Recommendations

- **Identify clear, specific policy objectives.** "Rebalancing" is usually defined to mean increasing the proportion either of total LTSS expenditures going to HCBS or of LTSS recipients receiving HCBS. Either goal can be achieved in multiple ways. MCOs could reduce the number of people who live in institutions, whether by making sure their members have sufficient HCBS so their risk of institutionalization is reduced, by working to shorten institutional stays, by restricting access to institutions, or by reducing the number of high-needs members who are at greater risk of institutionalization. Or they could do nothing to reduce the institutional population, but instead increase the HCBS population, for example, by offering HCBS to members with low needs who, perhaps, were getting along fine without paid services. Or they could continue providing the same services to the same people, but adjust payment rates on either side, thus achieving a shift in expenditures if not participants.

  Clarity as to what the true policy goals are can help shape the incentives that are offered. Rather than simply rebalancing, is the goal to avoid unnecessary institutionalization? Move people who are already institutionalized back to the community? Ensure that people are getting the HCBS they need? All of the above?

- **Align incentives with specific policy objectives.** Blended capitation rates are a blunt instrument, which may (or may not) be effective in encouraging MCOs to "rebalance" their proportion of LTSS-using members who reside in the community. The same can be said for "rebalancing targets" and payments that reward plans for increasing the HCBS population relative to the total. Whether these incentives truly encourage rebalancing is an empirical question, which would make for an interesting study. But all such incentives, which depend on aggregate measures, do not explicitly address the trajectories of individual LTSS users. For example, if increasing transition out of institutions is the policy goal, then a reward for transitioning a particular member out of an institution (as in Tennessee and Wisconsin) seems likely to be far more effective than a more general incentive. If obviating the need for institutional placement is a policy objective, then a large penalty that applies whenever someone enters an institution would seem likely to serve as a strong incentive. Lagged rate shifts might serve that purpose, or perhaps an innovative approach like that used in Minnesota, which penalizes MCOs for institutional

placement more than any other model does.

- **Ensure that high-needs LTSS users are appropriately served.** There is a vast range of expenditures needed to meet the needs of LTSS users with different types of disabilities and different levels of need. Because high-needs LTSS users are typically at greatest risk of institutional placement, states expecting plans to offer HCBS that are robust enough to reduce institutionalization must make meeting the needs of such members paramount.

  However, paying MCOs the same rate for all members receiving LTSS, or for all "nursing-home certifiable" members, seems likely to encourage MCOs to either deny access to needed HCBS to the highest-cost members or to find ways of excluding such individuals from participation in the plan. If a single rate is used, then it should at least be calculated based on the "case mix," using factors (aside from setting) related to the extent and type of needed services that can predict expenditures for each member.

Conclusions

When state Medicaid agencies contract with managed care organizations to provide long-term services and supports, they have several ways of ensuring that the MCOs offer adequate and appropriate home and community-based services, enabling their members to remain in their homes and participate actively in their communities. Thorough quality measurement and reporting, careful oversight, and well crafted contract provisions are all critical to the success of a managed LTSS system. Financial incentives offered through the structuring of capitation payments, possibly also including bonuses for desired performance, are an important means to encourage MCOs to think of HCBS as a first response to identified need for LTSS. If contract enforcement is the stick, then appropriately structured capitation can be seen as a carrot in persuading MCOs to move in the desired direction.

Some capitation models, however well they are intended, might have unintended consequences that could counteract their intended role of promoting rebalancing, or the incentives they offer might be mixed and their effects will likely vary according to the priorities of MCO administrators. Other models, especially those offering an institutionalization penalty and a transition bonus, seem more likely to be effective in incentivizing MCOs to give members the home and community-based services they need to avoid institutionalization.