Capitation Rate Setting Strategy Used to Cover Long-Term Services and Supports Provided to Recipients Under the STAR+PLUS Medicaid Managed Care Program Report

As Required by
House Bill 2658, 87th Legislature,
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1. Executive Summary

This report on the Capitation Rate Setting Strategy Used to Cover Long-Term Services and Supports Provided to Recipients Under the STAR+PLUS Medicaid Managed Care Program is submitted pursuant to Section 13, House Bill (H.B.) 2658, 87th Legislature, Regular Session, 2021.

H.B. 2658 requires the Texas Health and Human Services Commission (HHSC) to conduct a study to assess the impact of revising the capitation rate setting strategy used to cover long-term care services and supports provided to members enrolled in the STAR+PLUS Medicaid managed care program, from a strategy based on the setting in which services are provided to a strategy based on a blended rate across settings. HHSC must submit by September 1, 2022, a written report that summarizes the findings of the study to the Governor, Lieutenant Governor, Speaker of the House of Representatives, House Human Service Committee, and Senate Health and Human Services Committee.

The STAR+PLUS Medicaid managed care program provides acute care services, pharmacy services, long-term care nursing facility (NF) services, community-based long-term services and supports (LTSS),[1] and service coordination to adults with physical, intellectual, and developmental disabilities and those age 65 or older. Some members also receive an additional array of community-based LTSS as an alternative to care in a NF through the STAR+PLUS Home and Community Based Services (HCBS) program. The current capitation rate setting strategy calculates two different rates for the NF and HCBS risk groups in the STAR+PLUS program; one for NF and one for HCBS.

This report includes three components.

1. Assessment of the potential impact using a blended capitation rate would have on recipients' choice of setting;
2. Actuarial analysis of the impact using a blended capitation rate would have on program spending; and

[1] LTSS is defined as assistance with activities of daily living such as eating, bathing, and dressing and instrumental activities of daily living such as preparing meals, managing medication, and housekeeping. See Reaves & Musumeci (2015).

3. Summary of the experience of other states that use a blended capitation rate to reimburse managed care organizations (MCOs) for the provision of long-term care and community-based LTSS in Medicaid.

Key Findings include:

1. HHSC is unable to determine whether a blended rate strategy would affect a recipient's choice of setting. An MCO must assess and develop an individualized, person-centered service plan to provide needed supports and services in the least restrictive setting. A member who is eligible for Medicaid HCBS and NF services has the right to choose to reside in either setting.

   With a blended rate approach, MCOs will be more profitable in the short-term if they have a higher proportion of members in HCBS than assumed in the rate development. Therefore, the blended rate may create an incentive for MCOs to try to shift their STAR+PLUS members from NFs to HCBS. This MCO incentive could indirectly influence member choice.

2. The goal for program spending is for the claims component of the blended rate to match actual claims costs. If the blended capitation rate and actual costs align, then there will be minimal profits to the MCOs in the long-term outside of the included risk margin.

3. Separate from MCO incentives, any increase in the proportion of members statewide served in the community instead of in a NF will result in lower costs for HHSC.

4. HHSC surveyed other states about their capitation rate setting strategies for members receiving NF services and HCBS. Of the 18 states that responded, seven reported that they use a blended capitation rate and 11 reported other approaches that do not include blending NF and HCBS rates. The seven states that use a blended capitation rate reported a shift in members from NF to HCBS over a period of a decade or more. However, states did not specify if the shift in members were a direct result of the blended capitation rate. It is also important to note that other state Medicaid managed care programs may vary from Texas Medicaid in ways that could influence the distribution of NF and HCBS members.

2. Introduction

As required by H.B. 2658, HHSC conducted a study to assess the impact of changing the capitation rate setting strategy used to cover long-term care and community-based LTSS provided to recipients under the STAR+PLUS Medicaid managed care program, from a strategy based on setting in which services are provided (separate capitation payments for NF members and HCBS members) to a strategy based on a blended rate across settings (a blended capitation payment for NF members and HCBS members).

The STAR+PLUS Medicaid managed care program provides a continuum of care with a range of options and flexibilities to meet individual needs. The STAR+PLUS Medicaid managed care program serves adults with physical, intellectual, and developmental disabilities and those age 65 or older. It covers acute care services, pharmacy services, long-term care NF services, community-based LTSS, and service coordination. Some members are eligible to receive additional LTSS in the community as an alternative to care in a NF through the STAR+PLUS HCBS program. A priority goal for STAR+PLUS is to ensure individuals have seamless access to services and supports in the most appropriate, least restrictive settings based on the needs of each person.

Texas Medicaid currently develops separate managed care capitation rates for STAR+PLUS NF and HCBS. STAR+PLUS MCOs are paid a fixed monthly per member capitation payment for the provision of STAR+PLUS covered services to enrolled members regardless of the actual number or nature of services provided. Capitation rates may vary by service area and MCO.

This report explores the potential impact of revising HHSC's capitation rate setting strategy for the STAR+PLUS program from a strategy based on the setting in which services are provided to a strategy based on a blended rate across settings.

3. Background

Senate Bill 10, 74th Legislature, Regular Session, 1995, required HHSC to implement the STAR+PLUS program to create a cost-neutral managed care system to combine acute care with LTSS. STAR+PLUS serves adults with physical, intellectual, and developmental disabilities and those age 65 or older. STAR+PLUS provides a continuum of care of acute care services, pharmacy services, long-term care NF services, community-based LTSS, and service coordination. Through service coordination, STAR+PLUS MCOs are responsible for developing a person-centered service plan that ensures members receive necessary services in the least restrictive setting.

In 2015, HHSC added NF services to the STAR+PLUS service array in compliance with legislative direction from Senate Bill 7, 83rd Legislature, 2013, which amended Texas Government Code Sec. 533.00251.

As an alternative to NF care, STAR+PLUS members may choose to apply for the STAR+PLUS HCBS program where they can remain in the community and receive necessary supports and services such as nursing services and minor home modifications. Members receiving NF services can enroll in STAR+PLUS HCBS if the member requests services while residing in a NF and meets all eligibility criteria.

4. Impacts on Members' Choice of Setting

HHSC is unable to determine whether a blended rate strategy would affect a member's choice of setting because there are many critical factors other than the capitation rate setting methodology that influence a member's choice of setting. For example, members may face the following challenges[2] when selecting a setting, influencing their choice of whether to reside in a NF or in the community:

- access to qualified community providers (e.g., personal care attendants, nurses, adult foster care, assisted-living facilities), especially in rural areas;
- access to affordable and accessible community-based housing with supports;
- access to transportation;
- access to a support system, including unpaid caregivers;
- caregiver burnout;
- 24/7 medical professional availability;
- potential cultural bias or language barriers in the acuity assessment process;
- desire for family members to act as their caregiver.

The challenges listed above are not exhaustive but show some of the major obstacles members face in being able to move to or remain in the community. A blended rate strategy will not resolve these challenges directly.

However, under a blended rate approach, MCO incentives may change. MCOs that are able to transition and maintain a higher percentage of members in the community (as compared to the percentage assumed in the rate setting process) will be more profitable in the short term. If MCOs respond to this new incentive by directly addressing the challenges above, or by supporting members to overcome challenges, MCOs may increase access to community services, and in turn the blended rate could indirectly have an influence on member choice of setting. For example, if the MCOs respond to the new incentive by strengthening provider networks and the availability of 24/7 medical professionals to help more members select HCBS, then member choice could be indirectly influenced by the blended rate. However, HHSC does not have enough information to determine how MCOs

[2] See Burrows et al. (2012); CMS.gov. (n.d.); Garcia (2021); Lipson et al. (2016); Musumeci et al. (2021); RuralHealth Information Hub (2020).

will respond to the new incentive and how that would influence the range of factors that affect a member’s choice of setting.

5. Current Rate Setting Strategy and Proposed Blended Rate Setting Strategy

Current Rate Setting Strategy

In Texas, the capitation rates for Medicaid managed care programs are calculated annually to reimburse MCOs for all expected reasonable and appropriate costs. The actuarial models used for calculating capitation rates rely primarily on historical claims data from MCOs. The process to develop the rates begins with a base period which is a point in time used as a benchmark for the capitation rate. The base period cost includes an estimate for incurred but not reported claims which are claims that have been incurred or provided but not yet paid within the base period. Certain costs, such as Directed Payment Programs, are removed from the historical claims data as they are calculated separately from the capitation rates.

Base period = (historical claims data – certain costs) + (incurred but not reported claims)

The base period estimates described above are then projected forward to the rating period, the period for which the premiums will be paid, using assumed trend rates. Other MCO expenditures such as subcapitated amounts, service coordination, net reinsurance costs and administrative expenses are added to the claims component in order to project the total average cost within the rating period for each MCO.

Projected total average costs = (base period x assumed trends) + other MCO expenditures

Each risk group has members with unique needs and different levels of care which equates to different costs. The differences require separately projected total average costs calculations for each risk group for each MCO. The differences result in eight distinct risk groups within the STAR+PLUS program. The risk groups are as follows:

- Medicaid Only Other Community Care (OCC)
- Medicaid Only HCBS
- Dual Eligible OCC
- Dual Eligible HCBS

- Medicaid Only NF
- Dual Eligible NF
- Intellectual and Developmental Disability (IDD)
- Medicaid for Breast and Cervical Cancer (MBCC)

The calculations described above are completed separately for each risk group.

For the eight risk groups, each MCO's projected total average costs are then combined for all MCOs in a service area to develop a base community rate for each service area. The base community rate is part of the actuarial process for calculating capitation rates and is unrelated to the HCBS rate. The base community rates are developed using a weighted average of the projected rating period cost for each MCO in the service area. The weights used for the base community rate is the projected number of members enrolled during the rating period per MCO per risk group.

(MCO 1 projected total average costs) x %

(MCO 2 projected total average costs) x %

(MCO 3 projected total average costs) x %

+ (MCO 4 projected total average costs) x %

= Base community rate per service area

This calculation is performed separately for each risk group resulting in a set of base community rates that varies across the eight STAR+PLUS risk groups.

The projected rates are intended to account for all reasonable and appropriate costs to be incurred by the MCOs during the rating period based on the historical claims data and projected populations for each risk group within a service area per MCO. The final adjustment to the base community rates in each service area is an acuity adjustment to reflect the varying health status of the members enrolled within each MCO.

The acuity adjustment acknowledges and represents the differences in levels of need between populations and is intended to better align the calculated rates with the expected costs of each MCO within a service area. The current methodology separately calculates the rates described above for each distinct risk group. The

purpose of these eight distinct risk groups is to create smaller subsets of the overall population with similar cost profiles to adequately compensate MCOs for the risk associated with their members.

From an actuarial perspective, risk groups should be developed for groups with similar cost profiles to limit the opportunity for MCOs to compete based on risk selection, i.e., selecting lower cost members rather than competing based on quality and performance measures.

Proposed Blended Rate Setting Strategy

Under a blended rate strategy, the STAR+PLUS HCBS and NF risk groups - groups based on setting - would be combined and paid a single rate across settings. This would be done by following the current approach for each risk group individually before blending the two individual rates into a single, blended rate. The weighted average would be based on the respective caseload for each risk group.

$$\text{Blended rate} = \frac{\text{HCBS rate x HCBS caseload + NF Rate x NF caseload}}{\text{HCBS caseload + NF caseload}}$$

There is no significant difference in the overall mechanics for the blended rate setting process. Under a blended rate setting process, HHSC would set the rates for each risk group separately and then blend the HCBS and NF rates as outlined above. Any actual savings or cost increase would only be realized if the actual cost and utilization patterns of the NF and HCBS members change. In other words, regardless of a blended or non-blended rate strategy, the actuarially sound rates will be calculated based on the cost profile of the groups being rated. Combining the HCBS and NF risk groups into one risk group will not itself change the cost profile of the populations being served.

Table 1 and Table 2 show examples of the rates in the Bexar service area before and after blending for the fiscal year (FY) 2022 rates. The HCBS and NF blended rates have been calculated as the weighted average of the individual risk group rates. The overall premium paid is expected to be the same under the two approaches. Initially we expect the program spending to be the same using the current (non-blended) and the blended approach.

Table 1: Bexar Service Area FY2022 Rates Current Method, FY2022 Total Premium Rates Per member per month (PMPM)*

Health Plan	Medicaid Only – OCC	Medicaid Only – HCBS	Dual Eligible - OCC	Dual Eligible - HCBS	Medicaid Only - NF	Dual Eligible - NF	IDD	MBCC	Total
Amerigroup - Bexar	1,450.73	4,838.86	475.91	2,301.40	9,388.07	6,752.47	1,037.58	4,519.71	1,625.15
Molina - Bexar	1,503.80	4,684.36	480.05	2,158.04	9,155.95	6,752.47	1,064.45	4,266.42	1,955.16
Superior Bexar	1,593.36	5,231.00	506.38	2,405.45	9,374.32	6,752.47	1,231.27	3,818.85	1,819.89

Table 1: Bexar Service Area FY2022 Rates Blended HCBS and NF, FY2022 Total Premium Rates PMPM*

Health Plan	Medicaid Only – OCC	Medicaid Only – HCBS and NF	Dual Eligible – OCC	Dual Eligible – HCBS and NF	IDD	MBCC	Total
Amerigroup - Bexar	1,450.73	5,832.79	475.91	4,633.58	1,037.58	4,519.71	1,625.15
Molina - Bexar	1,503.80	5,852.74	480.05	4,968.17	1,064.45	4,266.42	1,955.16
Superior Bexar	1,593.36	5,863.00	506.38	4,483.77	1,231.27	3,818.85	1,819.89

*The above tables provide premium rates in the Bexar service area as an example. The United STAR+PLUS MCO is not included in these tables because it does not serve the Bexar service area.

6. Impact on Program Spending

Members who are eligible for Medicaid HCBS and NF services have the right to choose to reside in either setting. STAR+PLUS MCOs must develop an individualized person-centered service plan based on an assessment of the member's needs. Members, family members or authorized representatives take part in the service planning process to identify the member's preferences, strengths and the supports and services needed to achieve personal outcomes in the least restrictive setting. When a NF resident indicates they would like to move to the community through the use of STAR+PLUS HCBS, the MCO must meet with the member to describe the transition and must also assess if the individual can be safely served in the community.

A blended rate approach provides a financial incentive for MCOs to try to keep members in the community longer and avoid members entering a NF; however, it is difficult to forecast the magnitude of this effect on total program spending. Based on recent historical rates, the average NF member will cost one and a half to two and a half times more than the average HCBS member. Under a blended rate approach, the MCO will be "overpaid" for each HCBS member and "underpaid" for each NF member because the blended rate will be the weighted average of these two groups. As shown in Table 1, Amerigroup Bexar's non-blended rates for a Dual HCBS member is $2,301.40 and $6,752.47 for a Dual NF member. Per Table 2, the blended rate would be $4,633.58 which is higher than the HCBS rate but lower than the NF rate. Thus, such an approach creates an incentive for the MCO to try to shift their membership from NFs to HCBS.

Under a blended rate approach, an MCO that can achieve and maintain a higher percentage of members in the community will be more profitable in the short-term. It is also important to note that, separate from MCO incentives, any increase in the proportion of members statewide served in the community as opposed to in a NF will result in lower costs for HHSC. The impact on program spending will ultimately depend on whether there are shifts between NF and HCBS. It is difficult to predict how the blended rate might influence a shift in the proportion of members in the community and NF. The two scenarios below are examples of what could happen.

Scenario 1: Larger proportion of STAR+PLUS HCBS members than historical data

- Under this scenario, the MCOs will experience short-term profits.[3] The blended rate will be initially based on historical NF and STAR+PLUS HCBS member distribution. If MCOs increase the proportion of STAR+PLUS HCBS members, then the actual average costs across HCBS and NF members will be lower than the blended rates. However, because HHSC will recalculate future blended rates based on this new distribution, MCOs can only continue to make a profit in future years by continuing to increase the proportion of STAR+PLUS HCBS members.
- A larger proportion of STAR+PLUS HCBS members would likely lower the cost of services overall, and thus result in future savings to HHSC from lower MCO capitation payments.

Scenario 2: Smaller proportion of STAR+PLUS HCBS members than historical data

- Under this scenario, the MCOs will experience short-term losses. The blended rate will be initially based on historical NF and STAR+PLUS member distribution. If the proportion of STAR+PLUS HCBS decreases, then the actual average costs across HCBS and NF members will be higher than the blended rates. However, future blended rates will be based on this new distribution and calculated to align the capitation rate with actual costs, lowering the probability of additional losses to the MCO.
- A smaller proportion of STAR+PLUS HCBS members would raise the cost of services overall, and thus result in future costs to HHSC from higher MCO capitation payments.

Under both scenarios, the annual calculation of future rates will be based on updated enrollment and cost distribution. The actual costs of the groups being rated will drive the overall premiums paid regardless of whether a blended or non-blended approach is used. The rating approach does not create savings; savings are a byproduct of the actual cost and utilization of services.

Ongoing cost reductions will only occur if NF members continue to move from a higher cost setting into a lower cost setting. There is a point at which all members

[3] HHSC has a process to share in any MCO profits through experience rebates. More information about experience rebates can be found in the Texas Medicaid and CHIP Reference Guide, Thirteenth Edition (Pink Book).

who practically can transition from NF will have done so. At this point, no further savings would occur and the blended approach would exactly break even. The percentage of members with a NF level of care who live in the community has been steadily growing over time and STAR+PLUS HCBS members now comprise nearly 60 percent of total HCBS and NF enrollment. Given that most of the STAR+PLUS population needing NF level of care are already being served in the community, it is difficult to predict at what point Texas will reach the breakeven point. There will always be a certain portion of STAR+PLUS members with high acuity who cannot safely live in the community and must be served in NF.

7. Experience of Other States

Survey Data

HHSC solicited feedback from other states via surveys distributed through the National Association of Medicaid Directors and separately through an HHSC contractor. The surveys were designed for states with managed care LTSS, and asked states that use a blended rate if they observed shifts in utilization of NF and HCBS, member and provider impacts, and lessons learned. HHSC received responses from 18 states in total. Of the 18 states who responded, seven states blended their capitation rates, nine states do not blend their rates, one state does not operate under a managed care model, and one state statutorily prohibits capitating LTSS.

Of the seven states that use a blended capitation rate, two states reported a "significant" shift from their NF population to their HCBS population. All seven states reported a continued decline in institutional care since implementing a blended capitation rate setting strategy. These seven states reported prospectively adjusting the rates on an annual basis. One state, which has used a blended rate since the inception of their managed care program 33 years ago,[4] reported their HCBS percentage shifted from nearly zero percent to a little over 75 percent. Another state reported a shift from 40 percent to 78 percent in their HCBS population since they implemented their blended rate 25 years ago. An additional state reported a 10 percent increase in their HCBS population within the first two years of implementation of a blended rate and a four percent increase in aggregate from 2012-2019 in their HCBS population. This state also reported savings to the state due to their blended capitation rate.

States were also surveyed for possible adverse impacts resulting from blending their rates, but none were reported. Although the states surveyed reported a decline in institutional care, state Medicaid programs operate differently from state-to-state. It is important to note that utilization and populations vary between states therefore the shifts in Texas' populations from institutional care to HCBS may not mirror the patterns of other states.

[4] See McCall & Korb (1997), p. 119–134.

Example State Feedback: Cost Effectiveness in Florida

Florida uses a blended rate setting approach. In 2016, the Florida Agency for Health Care Administration sponsored an independent cost-effectiveness assessment of their Florida Statewide Managed Care Long-term Care (LTC) Program for three state fiscal years[5] after the implementation of the blended rate approach. The cost-effectiveness analysis examined the relationship between health outcomes and the expenditures that affected them. The independent cost-effectiveness assessment reported an increase in their HCBS population from 49 percent to 54.7 percent[6]. It is unclear from the report whether other strategies contributed to this increase. The assessment concluded the direct LTC program costs remain close to cost-neutral on a PMPM basis.[7] The assessment also reported an increase in HCBS PMPM capitation payment and a decrease in NF PMPM capitation payment with a resulting savings of $0.40 NF PMPM in the last state fiscal year assessed.[8] The study attributed the cost effectiveness of their LTC Program to their blended rate setting strategy.

Variation Between States

State Medicaid programs vary in key areas, including covered populations, services, geographical areas, as well as policy and operational considerations. Given the focus of the report, HHSC looked at other states that have a blended capitation rate.

Iowa and Florida's managed care programs calculate capitation rates with a rebalancing target; meaning, the proportion of HCBS and NF are artificially adjusted upward for HCBS and downward for NF as a rebalancing initiative.[9] Kansas, Iowa, and Massachusetts' rate setting methodologies risk adjustments involve dividing their HCBS populations according to their variations in health status and care needs.[10] For example, Kansas separately calculates capitation rates for their Frail Elderly and Physical Disability Waiver; their Autism, Technology Assisted, Traumatic Brain Injury, or Serious Emotional Disturbance Waivers; and people in the

[5] See Beitsch. et al. (2019).
[6] Ibid.
[7] Ibid.
[8] Ibid.
[9] See Kaye (2017).
[10] Ibid.

Developmental Disability Waiver.[11] This approach considers variation in health status between members and mitigates the potential of overpayment to MCOs. It also addresses possible incentives to underserve or avoid enrolling members with costly and riskier profiles.[12]

Ohio, Virginia, and Arizona's rate setting methodologies calculate the risk of the HCBS members to make risk more predictable and reduce opportunities and incentives to enroll people whose care costs are potentially lower than the capitation payment rate. This is done by routinely adjusting the rates with a variety of incentives. Virginia proactively adjusts rates based on their NF and HCBS population the month before enrollment and periodically updates the rates as new members join.[13] Ohio adjusts rates semi-annually, which helps provide more revenue to health plans that have a greater proportion of high risk or high-cost members who reside in a NF while still incentivizing HCBS.[14] Arizona performs a similar adjustment retroactively through a year-end reconciliation that aligns the actual NF and HCBS population mix to the expected population mix.

[11] Ibid.
[12] See Dominiak & Libersky (2016).
[13] Ibid.
[14] Ibid.

8. Conclusion

Pursuant to H.B. 2658, this report evaluated the potential impacts, including effects on member choice of setting and program cost, of revising the current STAR+PLUS capitation rate setting strategy to a blended rate.

HHSC is unable to determine whether a blended rate strategy would affect a recipient's choice of setting. However, with a blended rate approach, MCOs will be more profitable in the short-term if they have a higher proportion of members in HCBS than what was assumed in the rate setting. Consequently, the blended rate may create a financial incentive for MCOs to shift their STAR+PLUS members from NFs to HCBS, which could indirectly influence member choice. In all managed care programs, HHSC aims for the MCO capitation rates to equal the actual cost of services. Therefore, the goal for program spending with a blended rate would be for the claims component of the blended rate to match actual claims costs, which would likely lead to minimal profits for the MCOs in the long-term outside of the included risk margin.

Of the 18 states that HHSC surveyed, seven states utilizing a blended capitation rate reported a shift in members from their NF to their HCBS population over a period of a decade or more. HHSC cannot assume a similar shift would occur from implementing a blended rate in STAR+PLUS. However, if HHSC decided to implement a blended rate, any increase in the proportion of members statewide served in the community as opposed to in a NF will result in lower costs for HHSC.

An environmental scan of provider capacity, demand for community services and need of current NF residents could assist HHSC in determining programmatic changes that might complement the intent of the blended rate, such as efforts to strengthen MCO HCBS provider networks. The collaboration between HHSC and MCOs will be crucial to successfully transition members to the community, regardless of the rate setting methodology. HHSC will continue to promote and deliver sustainable and quality-based care for Texans, regardless of setting.

List of Acronyms

Acronym	Full Name
DPP	Directed payment programs
FY	Fiscal year
HCBS	Home and Community Based Services
HHSC	Texas Health and Human Services Commission
IDD	Intellectual and Developmental Disability
LTC	Long Term Care
LTSS	Long-term services and supports
MBCC	Medicaid for Breast and Cervical Cancer
MCO	Managed care organization
NF	Nursing facility
OCC	Other Community Care
PMPM	Per member per month
STAR+PLUS	State of Texas Access Reform Plus

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