

Managed Long-term Care and the Rebalancing of State Long Term Support Systems

**Topics in Rebalancing State Long-Term Care Systems,
Topic Paper No. 3**

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Preface

In 2003, Congress directed the Centers for Medicare & Medicaid Services (CMS) to commission a study in up to 8 States to explore the various management techniques and programmatic features that States have put in place to rebalance their Medicaid long-term care (LTC) systems and their investments in long-term support services towards community care. In October 2004, CMS accordingly commissioned this study to examine that topic, referred to in shorthand as “rebalancing”. The States of Arkansas, Florida, Minnesota, New Mexico, Pennsylvania, Texas, Vermont, and Washington are participating in the study. For this study, CMS defined rebalancing as reaching “a more equitable balance between the proportion of total Medicaid long-term support expenditures used for institutional services (i.e., Nursing Facilities [NF] and Intermediate Care Facilities for the Mentally Retarded [ICFs-MR]) and those used for community-based supports under its State Plan and waiver options.” CMS further clarified that a balanced LTC system “offers individuals a reasonable array of balanced options, particularly adequate choices of community and institutional options.”

The products for the study include 8 State-specific case studies that look qualitatively and quantitatively at each State’s management approaches to rebalance their long-term care systems; a 2005 Highlight Report summarizing all 8 States, and updates of the State-specific case studies summarizing changes up to July 2006: these have already been released.¹ Final case studies of each of the 8 States are being conducted in late 2007 and should be available in early 2008. The final summary report will generate conclusions and recommendations for CMS and for States undertaking rebalancing activities.

The other products for the study comprise cross-cutting papers, called *Topics in Rebalancing*. Each Topic Paper highlights an issue of importance in State rebalancing efforts or presents quantitative analyses that draws on multiple or 8 States in the Rebalancing Study.² For this particular Topic Paper, we drew on our original State case studies, interviews with State officials, on a specific questionnaire to a liaison in each State, and review of documents and web materials. We considered all 8 states but particularly discuss experiences in Florida, Minnesota, and Texas. We thank everyone who took the time to share their experiences and impressions. We also thank our former CMS project officer, Dina Elani, and our present project officer, Kate King, for their assistance with this work. The findings and conclusions in the paper are those of the authors and do not necessarily reflect those of CMS or its staff or any State officials we interviewed. We hope that this Topic Paper will stimulate discussion, and we welcome any comments or reactions.

Rosalie A. Kane, Project Director

¹ The Rebalancing Project’s reports are available on the CMS website at http://www.cms.hhs.gov/NewFreedomInitiative/035_Rebalancing.asp#TopOfPage, as well as on <http://www.hcbs.org>, and the Study director’s website at <http://www.hpm.umn.edu/lcresourcecenter/>

² Other topic papers on the web are Topic Paper # 1. State Strategies to Build and Sustain Consumer Advocacy, October 2006; and Topic Paper #2. State Long-Term Care Systems: Organizing for Rebalancing, December 2006.

Executive Summary

Purpose and Method

In the last several decades, many States have moved aggressively to design and implement alternatives to institutional care, create more options for self-direction, and promote opportunities for people living in institutions to return to the community. Concurrently, some States are also turning to managed care as a funding and management strategy for long-term care as well as for acute care for various consumer groups that use their Medicaid programs. To varying degrees, States perceive Medicaid managed long-term care (MMLTC) as a way to control the rapid growth of Medicaid long-term care costs, increase access to HCBS, facilitate budget predictability, limit the state's financial risk, allow states to distance themselves from potential fallout on service decisions, and reduce fragmentation between acute care and long-term care or within the long-term care system. This topic paper examines the interplay of these two important developments in the Medicaid program: rebalancing and the growth of MMLTC. Concepts at the heart of managed care -- more cost-effective professional decision-making and restrictions on consumer choice -- may be at odds with the principles of consumer-direction and greater consumer autonomy that are integral to a rebalancing agenda. On the other hand, if a managed care organization is provided with clear policy goals, incentives to perform, and flexibility, possibly MMLTC could operate outside preconceptions about where frail elders and persons with disabilities are best served and develop innovative ways to deliver an array of community services.

Experience in the 8 States

As November 2007, the 8 states participating in the Rebalancing Research divide as follows in their MMLTC portfolios:

- Florida, Minnesota and Texas are in the vanguard of state MMLTC initiatives; each has multiple and large-scale programs.
- New Mexico and Vermont have developed proposals to implement statewide MMLTC programs in 2008.
- Pennsylvania has actively encouraged the development of Program for All-Inclusive Care for the Elderly (PACE) programs, known there as Living Independently for Elders (LIFE).
- Washington has developed several small pilots for MMLTC, one for dually eligible consumers over 65 and one for consumers under age 65 on SSI as well as several projects to better coordinate acute and long-term care that do not rely on capitation, and is in early planning for a new model to integrate acute and long-term care while preserving the strengths of its existing long-term support services.
- Arkansas is not currently planning any MMLTC initiative beyond its rural PACE initiative, but is working to develop a State Plan enhanced primary care case management program to link primary health care with home and community based services.

MMLTC programs in these States differ on fundamental characteristics such as who is eligible, whether participation is mandatory or voluntary, the geographic area covered, the degree of integration of Medicaid and Medicare, the degree of integration of acute and long-term care for non-dual populations and the type of organizations the state contracts with to provide services.

Conclusions and Implications

- Several States have maintained an active involvement as a partner in MMLTC efforts not only to establish and monitor contracts with Managed Care Organizations (MCOs) and set rates, but also to ensure that the long-term support services are consistent with the State's community care values and emphasis on choice, consumer direction, and community integration.
- Most of the cost savings to date come from more aggressive approaches to primary care and care coordination leading to reductions in hospital costs. In some instances different forms of LTC have been substituted for nursing homes; for example, the Florida Diversion Program often utilizes assisted living instead of nursing homes. The actual savings from MMLTC will depend on services for which the MCO is at risk and the capitation rates that have been negotiated.
- State expectations for MMLTC to better coordinate care and services, reduce fragmentation, and improve health and social outcomes have been high. Evidence of MMLTC's impact on consumer outcomes, however, has been inconclusive and at times contradictory
 - States seem pleased with their experiences with MMLTC, even though little detailed evaluation has actually been done.
 - Texas cites the advantage of having no waiting lists compared to the waivers as a way that Star+Plus might forward a rebalancing goal
 - Florida officials perceive MMLTC as a means towards rebalancing LTC systems
 - Minnesota sees various advantages in improved care that might indirectly affect the ability to be in the community
 - New Mexico is working closely with managed care organizations (MCOs) during its MMLTC program planning stage over details of the State's expectations for consumer directed care
- The interface between consumer direction and choice, on the one hand, and managed care, on the other hand, remains to be fully determined
 - Some managed care plans claim they can allow consumer direction by allowing consumers to choose from a list of approved providers; others may provide some allowance to purchase services informally. Minnesota and Texas require MMLTC organizations to offer consumer-directed services, but details about how those choices are presented to consumers and by whom are still under development
 - On the surface, reconciling the current emphasis on consumer choice with mandatory MMLTC seems challenging. Presumably, however, case managers can help consumers negotiate choices. To the extent that preferred provider arrangements help dictate where consumers live, consumer choice is diminished.
- So far, managed care has been used more extensively with older persons than younger persons with disabilities. None of the 8 States have so far developed MMLTC for persons with developmental disabilities.
- Managed care plans have varied widely in the extent to which they contract with aging network services or other publicly funded service networks. In Minnesota, Florida, and Texas, entry into MMLTC is mediated through the extant care coordination systems, but

there are no requirements to contract with aging or disability networks for ongoing services such as exist, for example, in Massachusetts. Community organizations have some concern that the growth of MMLTC could erode local infrastructures and the MCOs may try to take advantage of aging network services without paying for them.

- The extent to which MMLTC is likely to emphasize community over institutional care will depend on the costs of services in each arena, the amount of financial risk the plans bear for nursing homes or other institutions, the rules and financial arrangements surrounding disenrollment, and program administration.
 - In Florida, Texas, and Minnesota, in varying ways, the plans bear risk for nursing home care but those risks are limited.
 - Some concerns have been expressed—particularly in Florida-- that MCOs may prefer to deal with assisted living or residential care providers rather than a myriad of in-home services.
 - In Texas, some consumer stakeholders are concerned that administration of STAR+PLUS in the central office of the Commission for Health and Human Services weakens the consolidation of all long-term care and supports in the Division of Aging and Disability (DADS).

Managed Long-term Care and the Rebalancing of State Long-Term Support Systems

Background

Relevance to Rebalancing

The Medicaid waiver programs, the 1999 Supreme Court decision in *Olmstead v. L.C.* (and the New Freedom Initiative it spawned), the Real Choice Systems Change Grants program, and, most recently, the Deficit Reduction Act of 2005, are among the major drivers for both encouraging and assisting states to transition to a more rebalanced system of long-term care supports. States have moved aggressively to design and implement programs that establish additional alternatives to institutional care, create more options for self-direction in home and community care, and promote opportunities for people living in institutions to return to the community.

Concurrently, states turned to managed care for Medicaid long-term care beneficiaries. For the most part, rebalancing long-term care was not a prime reason for using managed care, but at least one state suggested it was a goal. To varying degrees, states pursue Medicaid managed long-term care (MMLTC) as a way to:

States have many reasons for interest in MMLTC beyond rebalancing towards more community care. But MMLTC need not be incompatible with rebalancing, if carefully planned and monitored.

1. Control the rapid growth of Medicaid long-term care costs by reducing hospitalizations, emergency room visits, and nursing home placements and utilization. States anticipate significant savings opportunities by contracting with managed care organizations (MCO) that have the financial incentives to (a) provide needed services to enrollees with complex needs (including persons with physical and mental disabilities or multiple chronic conditions) in the lowest-cost setting; (b) slow or limit the progression of chronic conditions; and (c) avoid crises that lead to costly interventions.
2. Increase Medicaid enrollees' access to home and community based services and reduce the number of enrollees in nursing facilities and other institutional settings.
3. Facilitate budget predictability, since capitation allows states to predict costs by paying one fixed fee for each enrollee.
4. Use capitated payments to limit the state's financial risk, by shifting it to the MCO.
5. Allow states to distance themselves from potential fallout on service decisions, particularly service denials.
6. Consolidate efforts, reduce fragmentation in the long-term care system, and coordinate existing LTC programs and waivers. Accountability may also increase when MCOs are responsible for both coordinating service use and delivering care.

In addition, in the case of dually eligible consumers, states may hope to improve Medicaid's return on investment by capturing some of the savings to Medicare that come from better long-term care, and to improve the coordination of care sponsored by two separate programs with different rules.

Focus

This topic paper examines the interplay of these two important developments in the Medicaid program: the shift in long-term care from institutional settings to home and community-based services (i.e., rebalancing), and the growth in the provision of Medicaid long-

term care services through managed care plans or organizations. We are interested in the intended and unintended consequences of managed care. For example, whereas the dominant policy approach to LTC reform promotes more alternatives and greater choice, managed care may adversely affect rebalancing if a service delivery approach manages provider and consumer decisions by restricting choices. Concepts at the heart of managed care -- more cost-effective professional decision-making and restrictions on consumer choice -- may be at odds with the principles of consumer-direction and greater consumer autonomy that are integral to a rebalancing agenda. Consumers and disability advocates, in particular, fear that MMLTC has the potential for substantially undermining the consumer focus and basic values underlying long-term care supports.³ On the other hand, if a managed care organization is provided with a clear policy goal, incentives to perform, and flexibility, it is possible that managed care could operate outside preconceptions about where frail elders and persons with disabilities are best served and develop innovative ways to deliver multiple community services.

Method

This paper relies on information gathered for the state case studies conducted for the Rebalancing project in 2005 and updated in 2006, supplemented by a review of websites and other materials. These included but were not limited to: dedicated web sites for specific Medicaid Managed Long-Term Care (MMLTC) programs; internal and independent evaluations of MMLTC programs; relevant legislation, Requests for Proposals, and program planning materials; and a literature review. We also conducted structured phone interviews about managed long-term care initiatives with state government officials in each of the targeted states (Florida, Minnesota New Mexico, and Texas), based on a brief questionnaire.⁴ A glossary at the end of the Topic Paper provides a guide to the acronyms used throughout.

MMLTC in Perspective

Managed care has a longer history for acute care than for long-term support services.

Managed care has a longer history and larger role in Medicaid for primary and acute care service delivery than for long-term care. Federal laws that allowed states, initially only with a waiver (1981 Omnibus Reconciliation Act) and then without a waiver (1997 Balanced Budget Act), to require certain Medicaid beneficiaries to enroll in managed care fueled the rapid growth in Medicaid managed care, which is now Medicaid's dominant service delivery model.⁵ However, many states initially exempted or excluded Medicaid long-term care beneficiaries (i.e., most persons who are eligible due to age or disability) from their managed care programs. These resource-intensive beneficiaries were not enrolled in managed care programs due in part to fears of under-treatment, restricted access to needed services and providers, and poor quality.⁶ As a result, although

³ To assure that MMLTC programs respond to the needs and interests of persons with disabilities, ADAPT and the America's Health Insurance Plans (AHIP) issued in March 2007 a set of the principles that ADAPT and AHIP believe should be part of any integrated managed care delivery system that may be developed.

⁴ The bulk of our materials were assembled by September 2007 but some items have been updated during site visits conducted in November and December 2007.

⁵ Kaye, N (2005). *Medicaid Managed Care: Looking Forward, Looking Back*. Portland, ME, National Academy for State Health Policy. On web at http://www.nashp.org/Files/mmc_guide_final_draft_6-16.pdf, last accessed Dec 15, 2007.

⁶ Palsbo, SE & Mastal, MF (2006). *Disability Care Coordination Organizations – The Experience of Medicaid Managed Care Programs for People with Disabilities*. (Hamilton, NJ, Center for Health Care Strategies). On Web at http://www.chcs.org/publications3960/publications_show.htm?doc_id=367162, last accessed Dec 15, 2007.

nearly 70 percent of all Medicaid recipients (about 29 million enrollees) were covered by managed care programs in 2003, nearly all of these were acute care beneficiaries; fewer than 3 percent of Medicaid beneficiaries who received long-term care in 2003 received it through managed care programs.⁷ All states except Wyoming and Alaska used managed care for at least some of their acute care paid by Medicaid. The penetration of managed care in Medicaid for acute care and long-term care has changed little since 2003.

Finally, the Program of All Inclusive Care for the Elderly (PACE) is a long-standing model of capitated Medicare and Medicaid for older persons dually eligible for Medicare and Medicaid, operating in relatively small programs as a result of a partnership among provider organizations, CMS, and States (see Exhibit 1).

Enrollment in MMLTC may soon increase significantly with the planned expansion of existing or implementation of new programs, including Florida Senior Care, Minnesota Senior Care Plus, New Mexico Coordinated Long Term Services, Texas STAR+PLUS and MyCare Vermont (all discussed below). MMLTC programs started slowly and relatively late. The first MMLTC program, Florida's Frail Elder Program, was implemented in 1987. Despite similar early initiatives in a few states (such as the Arizona LTC System, implemented in 1988), interest in MMLTC did not significantly expand until the late 1990s and even since then, the overall penetration rate for MMLTC programs has remained low; most programs are in 7 states (AZ, FL, MA, MN, NY, TX, WI) of which 3 are in our study, and most are relatively small.⁸ Medicaid cost increases of over 50 percent in the past 4 years and provisions in the Medicare Modernization Act of 2003 (MMA) for the creation of "Special Needs Plan," including managed care plans targeting specific groups such as dual eligibles, are among the developments that have sparked renewed interest in states to expand or implement new MMLTC programs. As a result, states are turning to managed care to provide LTC services (integrated to various degrees with primary and acute care) to populations with more complex needs, including younger adults with disabilities and the elderly.

⁷ Saucier, P., Burwell, B., & Gerst, K (2005). *The Past, Present and Future of Managed Long-Term Care*. (Report prepared by Thomson/MEDSTAT for Office of Disability, Aging, and LTC Policy, Assistant Secretary for Planning and Evaluation, April 2005). On web at <http://aspe.hhs.gov/daltcp/reports/mltc.htm>, last accessed Dec 12, 2007. .

⁸ Saucier, P., Burwell, B., & Gerst, K (2005). See Reference # 7.

Exhibit 1. Overview of the PACE Program in 8 States

The Program for All-Inclusive Care of the Elderly (PACE), modeled after the On Lok Senior Health Services program in San Francisco, was an early model to integrate the financing and delivery of services for persons eligible for both Medicare and Medicaid (“dual eligibles”). PACE programs combine funding from Medicare and Medicaid into a single pool of funds and bear the financial risk to provide a full range of health and supportive services to enrollees. Although open to all Medicaid and Medicare enrollees age 55 and older who meet nursing facility level of care criteria, in practice the vast majority of PACE enrollees are dual eligibles. PACE enrollees generally receive some services in an adult day health setting. A distinguishing feature is the requirement that PACE programs create interdisciplinary provider teams to provide health and long-term support services in an integrated fashion according to individualized health care plans. PACE programs are fully at risk for all costs of enrollees, and have a track record of serving about 90% of enrollees in the community.

As of December 2007, 42 PACE programs were operating in 22 States; 23 States including 6 of the States in our study have completed the requisite Medicaid State Plan amendments to operate PACE.⁹ CMS listed 36 PACE Organizations operating as permanent providers with Provider agreements that include approval to provide the Medicare Part D benefit.¹⁰ PACE programs are typically small, serving only a few hundred people and about \$15,000 consumers all told, about half of whom have dementia.¹¹

Of the 8 states in the Study, only Minnesota has no current plans for a PACE program. Arkansas and Vermont both are developing PACE programs with the help of 2005 CMS grants for Rural PACE development, but neither programs yet operate as a PACE site. PACE is part of the array of services in Florida (operating in the Miami area), in Washington (with a small program in the Seattle area), in New Mexico (with a program in Albuquerque and in Texas (with a well-established program in El Paso and a new one in Amarillo).

Detailed discussion of PACE is beyond the scope of this topic paper. We note, however, that Pennsylvania is rapidly expanding its managed long-term care through conscious encouragement of the PACE model, which there is called LIFE (Living Independently for Elderly), partly to avoid confusion with the acronym for the pharmaceutical assistance program there. As of December 2007, there were 7 operational LIFE programs and 2 in the pre-planning stage and about 1/10th of Pennsylvania’s elderly HCBS waiver consumers received their services through PACE. State officials are presently considering ways State policy can encourage further expansion of PACE and a tight connection between the LIFE sites and low-income housing.

Taxonomy of MMLTC Programs

General consensus is lacking on the definition of “managed care.” The term has been used to refer to (1) an ever-evolving collection of management techniques (e.g., utilization review, disease management) designed to influence the delivery of services to a defined population, (2) an “insurance mechanism” (i.e., capitation) consisting of periodic payments to a organization which then uses the money to provide health care to all its members,¹² and (3) the

⁹ See National PACE Association website at <http://www.npaonline.org/website/>, last visited 12/11/2007

¹⁰ See <http://www.cms.hhs.gov/PACE/LPPO/list.asp>, last visited 12/11/2007.

¹¹ See Mukamel, DB, Peterson, DR, Temkin-Greener, H, Delevan, R, Gross, D, Kunitz, SJ & Williams, TG (2007). Program characteristics and enrollees’ outcomes in the Program of All-Inclusive Care for the Elderly (PACE), *The Milbank Quarterly*, 85 (3), 499-531.

¹² Herr, A & Neill, C (2007). *ADRCs’ Potential Role in Managed Long-Term Care*. (ADRC-TAE Issue Brief, prepared by The Lewin Group, June 2007. On web at <http://www.adrc-tae.org/tiki-index.php?page=TAEIssueBriefs>, last accessed December 16, 2007.

organizations themselves, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs), that adopt such management techniques and capitation. Although there is no consensus definition for managed long-term care, Medicaid managed long-term care is often defined as a contractual agreement between a Medicaid agency and a managed care organization (MCO) contractor (or other entity) under the terms of which the contractor accepts financial risk through a capitated payment for providing long-term care benefits to Medicaid beneficiaries.¹³

Similarly, there is no single model for MMLTC Programs. They can be categorized based on the types of care they address: Medicaid acute care, Medicaid long-term care (institutional care, home and community based care or both), and Medicare services. Depending on the scope of the services for which the managed care organization assumes financial risk, Medicaid managed care programs can be categorized as shown in Table 1.

Table 1: Managed Care Classified by Populations Covered

Category	Example
Medicaid acute care only	In all states, except AK and WY
Medicaid long-term care services only	FL Diversion waiver
All Medicaid services (acute and LTC)	TX Star+PLUS
All Medicaid and Medicare services for dually eligible	PACE programs
All Medicare and some/most Medicaid Services	MN MSHO & MnDHO

The coverage of services under these arrangements is summarized in Table 2. When managed care coverage and fee-for-service co-exist (Columns A and B) and for consumers dually eligible for Medicaid (Column C), coordination needs to occur between managed care and fee-for-service providers. Note too that even when Medicaid long-term care services are capitated, managed care plans may not be at risk for nursing homes or may be at risk only for a finite number of months.

LTC consumers may be in a Medicaid managed care plan for their acute care only; they may be in managed care for their LTC only; they may be in managed care covering all Medicaid services (with Medicaid under fee-for service); and dually eligible consumers may be in managed care for both Medicare and Medicaid.

Beyond variations in the types of services for which the contracted MCO assumes financial risk through capitation, states' MMLTC programs differ on fundamental characteristics such as who is eligible, whether participation is mandatory or voluntary,¹⁴ the geographic area covered (statewide or restricted to certain areas), the degree of integration of Medicaid and Medicare, and the type of organization the state contracts with to provide services. Each of these reflects complex policy choices. Eligibility can be open to all people in need of long-term care services or variously limited, for example, by age, type of disability, or needed level of care. Mandating enrollment ensures a large program and large enrollment but is politically unpopular. Statewide programs promote equity but are difficult to implement in rural areas that have few if any managed care organizations.

¹³ Saucier, P., Burwell, B, & Gerst, K 2005. *The Past, Present and Future of Managed Long-Term Care*. See Ref 7.

¹⁴ Medicaid managed care can be mandatory, but Medicare (and hence combined dual programs) is always voluntary

Table 2: Variations in Managed Care Coverage for LTC Consumers

A. Medicaid Acute Only	B. Medicaid LTC Only	C. All Medicaid Services	D. Medicaid & Medicare
LTC consumers may be covered under managed care for hospital and ambulatory services and other acute-care & related services (e.g. Medicaid prescription drugs) in the State Plan. Consumer deductibles & copays would be covered for Medicare consumers. Behavioral health may be covered or carved out. LTC remains fee-for-service.	All HCBS services under the Medicaid State Plan and waiver services relevant to the populations covered, and Nursing Home State Plan services. By program design the MCO may have limited or no risk for nursing care.	All services in Column A and Column B.	All services in Column A, and in Column B, plus all Medicare covered services. This includes Medicare acute care, post-acute care, and drugs.

Integrating Medicare and Medicaid, programs with vastly different rules, has proved daunting. For instance, only 3 of the 14 states that received Medicare/Medicaid Integration Project (MMIP) grants were successful in creating integrated care demonstration projects.¹⁵ Only a few MMLTC programs, such as the Minnesota Senior Health Option (MSHO), fully integrate Medicaid and Medicare. However, the provision in the Medicare Modernization Act of 2003 (MMA) allowing health plans to be designated as Medicare Advantage Special Needs Plans, a special designation that allows a health plan to limit enrollment to one of several populations of special needs individuals, offers new opportunities to integrate Medicare and Medicaid.

To successfully operate an MMLTC program, an organization must have experience in managing long-term care and the capacity to take on significant financial risk; presently, few organizations have both. Most organizations with expertise in long-term care are smaller community organizations without managed care experience and without the resources to take on the financial risk of MMLTC. On the other hand, only a few large MCOs have experience in LTC. Only two national organizations, Evercare (part of United HealthGroup) and AmeriGroup, have a significant share of the MMLTC enrollment.

Managed LTC Programs in Targeted States

Overview

Table 3 summarizes managed long-term care involvement in all 8 states. Three states in the Rebalancing project, Florida, Minnesota, and Texas, are in the vanguard of state MMLTC initiatives. Two other Rebalancing states, New Mexico and Vermont, have developed proposals to implement statewide MMLTC programs within the next year. We concentrate on these 5 states in this topic paper, reviewing their existing and proposed managed long-term care

¹⁵ Palmer, L & Somers, S (2005). *Integrating Long-Term Care: Lessons from Building Health Systems for People with Chronic Illnesses*. (Hamilton, NJ, Centers for Long-Term Care Strategies, October 2005). On web at http://www.chcs.org/usr_doc/CHCSBHSFINAL.pdf, last accessed December 15, 2007.

programs, examining the major policy decisions, and analyzing the role of managed care in advancing their rebalancing agendas.

Table 3: Overview of Managed Long-Term Care in 8 States

	Summary of Activity
AR	No tradition of Medicaid managed care in acute sector. Managed care in LTC is limited to developing a rural PACE model. Efforts to coordinate acute and LTC are being developed through a Medicaid State Plan primary care case management demonstration.
FL	Built on strong penetration of managed care in acute Medicaid and fee-for-service programs, Florida has several managed care initiatives in long-term care, including a PACE site, a Frail Elders Program, and an expanding Medicaid Nursing Home Diversion program that manages Medicaid LTC services for the elderly. Florida is planning a pilot of expanded Medicaid acute and long-term care managed care in several counties.
MN	With a strong tradition of managed care in Medicaid and fee-for-service, Minnesota has developed its mandatory Senior Care Plus program that capitated Medicare & Medicaid acute and LTC services. It has also developed MNDHO, a Medicaid managed care program for people with physical disabilities.
NM	New Mexico has used a managed care carve-out for behavioral health. The State is working on developing a fully integrated Medicare and Medicaid program covering both acute care and long-term care. New Mexico also has a PACE site.
PA	Pennsylvania's main initiative is encouragement of PACE programs, called LIFE (Living Independently for Seniors). Seven (7) operational LIFE programs and 2 in planning stages deliver acute and LTC to dually eligible persons over 55. The State plans a close connection between its expanding LIFE programs and senior housing.
TX	Texas STAR+PLUS, a well-established Medicaid managed long-term care and acute care program operating in Houston is now expanded to 4 multi-county areas in the State. Texas is also developing an integrated non-capitated primary care case management program in the Dallas area. Texas also has 2 PACE programs, in El Paso and in Amarillo.
VT	Under a CMS comprehensive planning grant, Vermont is developing a model for integrating acute and long-term care, MyCare Vermont. It also is developing a rural PACE site, which will likely be part of MyCare Vermont.
WA	Washington has several small-scale voluntary capitated pilots: a capitated Medicaid program for SSI recipients under age 65 that emphasizes inclusion of mental health services; and a capitated for people 65 in Seattle where the managed care organization is fully at risk for nursing home care. It also has a PACE site in Seattle.

Florida

The Frail Elder program, implemented in 1987, is a small managed LTC program implemented in just 2 urban counties in southeast Florida -- Broward and Dade. Eligibility in this voluntary program, initiated as a §1115 waiver and converted to 1915 (a)/(c) in 1990, is open to Medicaid enrollees over age 21 (though most enrollees are 65 and older) who meet nursing facility level of care criteria and live in their own home or with a caregiver. It provides acute and LTC services, but nursing facility coverage is limited to the end of the fiscal year in which the enrollee enters the nursing facility. Program enrollment was 3,803 in fiscal year 2004/2005, with total expenditures of \$51 million (average cost of \$13,394/client).

The Florida Long-term Care Community Diversion pilot program (commonly called the Nursing Home Diversion program) was implemented under §1915 (a)/(c) authority in 1998 for dually eligible Floridians age 65 and older and now operates in 25 counties. Unlike Florida's

other HCBS waivers, the Diversion program covers both acute and LTC (HCBS and nursing facility care).¹⁶ As its name implies, the Diversion program is designed to divert people in the community from entering nursing homes and restricts eligibility to individuals who meet NF-level of care criteria but can be “safely served” in home or community settings.¹⁷ Enrollment in the Diversion program has grown rapidly (from 2,800 in 2004 to 9,280 in fiscal year 2005/2006) and total expenditures in FY 05/06 were \$130 million (average cost \$17,658/client).

Forecasting a significant expansion in the state for Medicaid managed long-term care, the Florida legislature approved in 2005, and substantially revised in 2007, the Florida Senior Care Program, a pilot project under §1915 (b)/(c) for enrollees age 60 and older and dually eligible recipients of all ages. Unlike the Diversion program, enrollees in Senior Care are not required to meet NF-level of care criteria. This voluntary program will first be made available in the Miami and Orlando areas (total number of eligibles about 141,000) and is scheduled for implementation in May 2008. Florida Senior Care will integrate all acute and long-term care. Health plan and MCO participation in the program will be open to any willing, qualified provider who meets the requirements in the state’s request for proposals, which is not yet issued.

Minnesota

Minnesota has long embraced managed care for its Medicaid program and is now moving aggressively to include the few Medicaid beneficiaries not yet enrolled in managed care. Through contracts with MCOs in 63 counties and county-based purchasing plans in an additional 20 counties, Minnesota’s mandatory Prepaid Medical Assistance Program (PMAP) provides Medicaid managed care statewide except in 4 rural counties. Seniors (age 65+) are required to enroll in Medicaid managed care but enrollees with disabilities under age 65 are exempt. Minnesota Medicaid beneficiaries age 65 and older have 3 options for enrolling in managed care: they are required to enroll in either Minnesota Senior Care or, in counties with county-based purchasing plans, in Minnesota Senior Care+;¹⁸ they also have the option of enrolling in the Minnesota Senior Health Options program, a voluntary program for elderly dually eligible enrollees.

- Minnesota Senior Care (MSC). On June 1, 2005, MSC replaced PMAP for enrollees age 65 and older. MSC is a §1115 waiver program that covers the same services as PMAP (except prescription drugs for dual eligibles are covered by Medicare part D) and also covers the first 90 days of nursing facility care for enrollees not residing in a nursing facility at the time of enrollment.
- Minnesota Senior Care+ (MSC+). MSC+, similarly implemented on June 1, 2005, adds home and community based waiver services and an additional 90 days of NF care (for a total of 180 days) to the basic MSC benefits. MSC+, also a §1115 waiver program, operated in 25 counties as of July 1, 2007 and is being phased in statewide
- Minnesota Senior Health Options (MSHO). MSHO, implemented in 1997 under §1915 (a)/(c) authority, provides a combined Medicaid and Medicare benefit and fully integrates acute and long-term care (as with MSC+, MSHO covers home and community based services and 180 days of NF care). A key feature of MSHO is to match each enrollee

¹⁶ The Medicare services can be provided as a separate capitated program or fee-for-service

¹⁷ OPPAGA. 2006. *The Nursing Home Diversion Program Has Successfully Delayed Nursing Home Entry*. OPPAGA Report No. 06-45

¹⁸ The mandate does not apply to the 4 counties that have not yet converted to prepaid health care delivery.

with a “care coordinator” who is the enrollee’s primary contact person for both care planning and service access.

Following the expansion in 2005, MSHO is now available in 83 of the state’s 87 counties, contracts with 9 prepaid health plans, and enrolls the majority of the state’s elderly Medicaid enrollees. As of January 2007, MSHO enrollment was about 35,000 (including over 12,000 seniors in the Elderly Waiver program), compared to a combined enrollment in MSC and MSC+ of about 10,000. Among the state’s future plans are to require the EW enrollees still in FFS (about 9% of enrollees in June 2007) to participate in managed care.

Minnesota also has a separate managed care program for Medicaid enrollees under age 65 with disabilities. Patterned after MSHO, the Minnesota Disability Health Options Program (MnDHO) is voluntary, authorized under §1915 (a)/(c), integrates Medicare and Medicaid financing, provides all Medicare and Medicaid acute and LTC care services (HCBS and NF), and assigns a “health coordinator” to each enrollee. Eligibility is limited to physically disabled adults and the program is available only in the 10-county Twin Cities metro area. As of January 2007, MnDHO enrollment was about 750. A distinguishing feature of MnDHO is the program’s inclusion in its 6 core principles of program design the principle of enrollee self-direction; namely, “the managed care system strives to include a maximum level of enrollee choice and self-direction.”

Texas

Several features distinguish Texas’ managed long-term care program, STAR+PLUS, the first combination §1915 (b)/(c) waiver program. It is among the most population-inclusive, including all persons above the age of 21 who qualify for Medicaid by virtue of SSI. And the program is mandatory, although managed care is only mandated for Medicaid services. STAR+PLUS enrollees who are not eligible for Medicare receive all acute and LTC services through a managed care organization. Dual eligibles, in contrast, are required to enroll in managed care for their Medicaid services but only *encouraged* to enroll in the same managed care organization for Medicare services. Thus, many dually eligible enrollees receive Medicaid long-term care services from a STAR+PLUS managed care organization but continue to receive acute care services from the Medicare provider of their choice.

STAR+PLUS was initiated in 1997 in Harris County (Houston and surrounding area) and expanded on January 1, 2007 to 22 counties in the Harris, Nueces, and Travis Service Delivery Areas of Texas. Total enrollment in April 2007 had reached 130,000.¹⁹ As with Minnesota’s MSHO and MnDHO programs, care coordination is seen as a cornerstone of the STAR+PLUS program. The MCO must link all enrollees receiving long-term care services with a care coordinator who is responsible for coordinating all services, developing an individualized care plan, and authorizing long-term care services.

¹⁹ See MacLaggen, C. HMOs accused of delaying payment in Medicaid program: Home care providers say STAR+PLUS billing process doesn’t work. April 6, 2007. Austin- American Statesman. <http://www.statesman.com/news/content/region/legislature/stories/04/06/6starplus.html>

In 2005, plans to expand STAR+PLUS to other areas of Texas were strongly opposed by provider organizations, including the Texas Medical Association and the Hospital Association,²⁰ and resulted instead in the development of the Integrated Care Management (ICM) program, a non-capitated, primary care case management model (identified by Texas as a “managed fee-for-service” model) which will be implemented in the Dallas and Tarrant service areas in 2007. Enrollment in ICM is mandatory for the same populations as for STAR+PLUS and will cover acute and LTC services. However, both Medicare and Medicaid services will be paid through FFS and a service coordinator will provide a link between the two programs. About 80,000 Medicaid enrollees in the 2 service areas are eligible for the ICM program.

New Mexico

New Mexico is developing a managed long-term care program to be implemented in July 2008 (pending Federal approval of the §1915 (b)/(c) waiver application submitted in July 2007). The state proposes a geographic roll-out of the eventual statewide program, beginning with the Albuquerque metro area and ending, 12 months later, with the state’s most rural areas. The Coordinated Long-term Services program would provide acute and long-term care for a projected 38,000 Medicaid enrollees, including persons with disabilities and enrollees age 65+ who participate in the state’s HCBS waivers, nursing home residents, Personal Care Option beneficiaries, and dual eligibles who do not need nursing facility level of care. The program will fully integrate Medicare with Medicaid and have mandatory enrollment for the Medicaid component. Other program parameters, including a proposed consumer-direction component, are still under development.

Vermont

In 2004 Vermont was awarded a Real Choice Systems Change grant for comprehensive system reform. It has used that funding to systematically plan and test its new managed long-term care program, MyCare Vermont, which will provide acute and long-term care through “a comprehensive interdisciplinary service delivery system that addresses both health and social needs.”²¹ In 2005, Vermont received CMS funding to develop a rural PACE model; ultimately the PACE program, located in Colchester, VT.

MyCare Vermont was planned as a statewide program, voluntary for all Medicaid enrollees over age 18 (including dual eligibles). The State planned to require the contracted managed care organization to coordinate and integrate acute and long-term care through an interdisciplinary care team consisting of, at a minimum, the participant (or representative selected by the participant), a Primary Care Provider, Certified Care Manager, and Registered Nurse. A cornerstone of the program is person-centered care, defined as “customized care that is respectful of and responsive to an individual’s circumstances, preferences, needs and values.”²² Originally, Vermont hoped to hold both the Medicaid and Medicare capitation at the State level, but has not received permission from CMS for that model. Thus, the first implementation will be for Medicaid funded services alone. A number of organizations have expressed initial interest in

²⁰ Hospitals feared losing their extra Medicare payments for GME and DSH.

²¹ MyCare Vermont: Resources for Independence through Coordinated Health and Long-Term Care -- Overview. November 28, 2006. <http://ddas.vermont.gov/ddas-projects/hltcip/hltcip-rfp/rfp-documents/mycare-overview>. Accessed August 30, 2007

²² See Ref 21.

pilot work, including an area agency on aging in the rural Northern Kingdom area and the developing PACE project.

Detailed Features in 5 States

Table 4 summarizes key features of the Medicaid managed long-term care programs in Florida and Minnesota. Table 5 summarized the key features in Texas, New Mexico, and Vermont. It is particularly useful to see what kinds of responsibility MMLTC plans have for nursing home services: Florida's Frail Elder Program, for example, covers nursing home care until the end of the contract year during which the client enters a nursing home; Minnesota Senior Care covers up to 90 days of NH care while Minnesota Senior Care Plus and MSC cover an additional 90 days; managed care contractors for Texas' STAR+PLUS program are not required to cover nursing home care. Although none of these plans require that MCOs contract with Area Agencies on Aging for case management or other publicly mandated entities such as lead agencies in Florida, many of the programs do contract with aging network organizations.²³

States' Perspectives on Managed Care

To get a sense of how state officials viewed the role of managed care in the context of their efforts to increase home and community-based services, we interviewed officials from those states that had active programs underway. In a few cases, the programs were still in the planning stages or just getting started. To each respondent we posed three basic questions:

1. What was the State trying to accomplish by using managed care for LTC in the managed care project? What were the criteria of success?
2. How would the State official evaluate the success of the [MC project] using those criteria? [*If too soon to do so; How does the State intend to evaluate the success of the effort?*]
3. What steps, if any, did the State take to give incentives to the MCO to use community care and to encourage consumer-directed care and/or person-centered planning?

The responses are summarized in Table 6. They illustrate variation in emphasis regarding goals and expected outcomes. Florida states an explicit goal to increase community care, and New Mexico would judge more community care as evidence of success. All States put considerable emphasis on better coordination of services and consumer direction.

²³ The details of how MCOs offering MMLTC work with the aging network may change under the proposed new CMS regulations on case management, to be implemented in March 2008. See: <http://a257.g.akamaitech.net/7/257/2422/01jan20071800/edocket.access.gpo.gov/2007/pdf/07-5903.pdf>

Table 4: Medicaid Managed Long-term Care programs in Florida and Minnesota

	Florida NH Diversion	Florida Frail Elder Program	Florida Senior Care	Minnesota MSHO	Minnesota MnDHO	Minnesota MSC / MSC+
Population Served	<ul style="list-style-type: none"> • 65 years or older; • Dual Eligibles; • Meet NF level of care criteria; and • Cannot safely be served with HCBS 	<ul style="list-style-type: none"> • 21 years or older; • Receive SSI; • Meet NF level of care criteria; and • Live in Broward or Dada County 	<ul style="list-style-type: none"> • Medicaid enrollees 60 years or older • Dual eligibles of all ages Not eligible: <ul style="list-style-type: none"> • DD, AIDS, Family, CD, and TBI/spinal cord waiver enrollees; • PACE enrollees; • Residents of institutions for DD 	<ul style="list-style-type: none"> • MA or MA-Medicare enrollee; and • 65 years or older and living in county with at least 1 MSHO plan 	<ul style="list-style-type: none"> • MA or MA-Medicare enrollee; and • 18 to 64 years of age with physical disability 	MA enrollee age 65+
Geographic area	25 Urban and contiguous counties	2 Urban Counties in SE FL (Broward and Dade)	Miami area); Orlando area (4 counties)	Statewide (excluding 4 counties)	Twin Cities metro area (10 counties)	MSC: 58 counties MSC+: 25 counties
Mandatory/Voluntary	Voluntary	Voluntary	Voluntary	Voluntary	Voluntary	Mandatory
Services covered	Medicaid acute Medicaid LTC <ul style="list-style-type: none"> • HCBS • NF 	Medicaid acute Medicaid LTC <ul style="list-style-type: none"> • HCBS • NF only until the end of the contract year during which client enters NF 	Medicaid acute Medicaid LTC <ul style="list-style-type: none"> • HCBS • Excludes NF unless “agency is able to demonstrate how the integration of the funds will improve coordinated care for these services in a less costly manner” (SB 838) 	Medicaid acute Medicaid LTC <ul style="list-style-type: none"> • HCBS • LTC All Medicare services Care coordinator MSHO plan may offer additional services	Medicaid acute Medicaid LTC <ul style="list-style-type: none"> • HCBS • LTC All Medicare services MnDHO plan may offer additional services	MSC: <ul style="list-style-type: none"> • Medicaid acute • Medicaid LTC – only up to 90 days NF care • Care management MSC+: <ul style="list-style-type: none"> • All MSC services, plus • HCBS • Additional 90 days of NF
Links to Medicare	<ul style="list-style-type: none"> • Enrollees must be dually eligible • Capitated rate covers Medicare co-payments, premiums, and deductibles. 	<ul style="list-style-type: none"> • For Dual eligibles, capitated rate covers Medicare coinsurance and deductibles 		<ul style="list-style-type: none"> • Fully integrated model • Dual eligibles were “passively enrolled” into Medicare Part D in 2006 	<ul style="list-style-type: none"> • Fully integrated model 	

Topic Paper # 3: Managed LTC & Rebalancing

	Florida NH Diversion	Florida Frail Elder Program	Florida Senior Care	Minnesota MSHO	Minnesota MnDHO	Minnesota MSC / MSC+
Evidence of effectiveness, efficiency	<ul style="list-style-type: none"> • Delays entry into NH • Shorter NH LOS • Clients more likely to return to community • More costly than other waivers • Higher quality of life²⁴ 		(program implementation subject to Legislative approval)	<ul style="list-style-type: none"> • Reduced ER and short stay NF admissions, reduced hospital LOS • Medicare capitation payments higher than FFS payments • Similar quality for NF residents • Modest benefit in clinical quality • High consumer satisfaction • More flexibility in services than FFS²⁵ 	<ul style="list-style-type: none"> • High consumer satisfaction; • Higher satisfaction with primary care doctor after enrolling in MnDHO; • Effective coordination of health services; • Improved access to preventive and other care; • Improved consumer involvement in care²⁶ 	
Enrollment (year)	9,271 (2007)	3,803 (2005)	Not yet implemented; Total eligibles about 141,000	35,000 (2007)	750 (2007)	10,000 (2007) MSC and MSC+ combined
Implementation date	1998	1987	May 2008 (expected)	1997	2001	1985
Federal Authority (Medicaid authorization)	1915 (a/c)	1115; converted to 1915 (a/c) in 1990	1915 (b/c)	1915 (a/c)	1915 (a/c)	1115

²⁴ OPPAGA. 2006. *The Nursing Home Diversion Program Has Successfully Delayed Nursing Home Entry*. OPPAGA Report No. 06-45

²⁵ Kane, RL, & Homyak, P (2003) *Minnesota Senior Health Options Evaluation Focusing on Utilization, Cost and Quality of Care*. Minneapolis: University of Minnesota School of Public Health, Division of Health Services Research and Policy (Prepared under HCFA Contract No. 500-96-0008/TO3); Kane, RL, Homyak, P, Bershady, B., Lum, Y, & Siadat, MS (2003). Outcomes of Managed Care of Dually Eligible Older Persons. *The Gerontologist* 43 (2), 165-74; Saucier, P, Burwell, B, & Gerst, K (2005) *The Past, Present and Future of Managed Long-Term Care*, See Ref. 7. Minnesota Health Data Institute. *Minnesota Senior Health Options; 2002 Consumer Assessment of Health Care*, MSHO Nursing Home Population. On web at http://www.dhs.state.mn.us/main/groups/healthcare/documents/pub/dhs_id_008300.pdf, last accessed December 15, 2007.

²⁶ Beatty, P & Kroll, T (2002). *The Impact of the Minnesota Disability Health Options (MnDHO) Program on the Healthcare Experience of People with Physical Disabilities in Minneapolis / St. Paul: A Qualitative Analysis*. Washington, DC: National Rehabilitation Hospital Center for Health & Disability Research; Palsbo, S., Beatty, P, Parker, P & Duff, C (2004) *Minnesota Disability Health Options: Expanding Coverage for Adults with Physical Disabilities*. Hamilton, NJ, Center for Health Care Strategies. On web at http://www.chcs.org/usr_doc/mn_disability.pdf, last accessed December 15, 2007.

Table 5: Medicaid Managed Long-term Care programs in New Mexico, Texas, and Vermont.

	New Mexico Coordinated Long-term Services	Texas Star Plus	Texas Independent Care Management	Vermont MyCare Vermont
Population Served	<p>MA enrollees who:</p> <ul style="list-style-type: none"> • Are enrolled in disability or elderly waiver programs • are in nursing facilities, or • Participate in the Personal Care Option <p>Dual eligibles who don't qualify for NF level of care</p>	<p>MA enrollees who:</p> <ul style="list-style-type: none"> • Are age 21+ who <ul style="list-style-type: none"> ◦ meet financial criteria for 1915(c) waiver services; Or ◦ Receive SSI <p>Not eligible:</p> <ul style="list-style-type: none"> • NH or ICF-MR resident; • Waiver enrollee (except CBA); • Child in state foster care 	<p>MA enrollees who are:</p> <ul style="list-style-type: none"> • SSI eligible age 21+; • MAO eligibles who qualify for CBA waiver services; • Over age 20 and eligible for Medicaid because they are in a SS Exclusion Program <p>Not eligible:</p> <ul style="list-style-type: none"> • NH or ICF-MR resident; • Waiver enrollee (except CBA); • Child in state foster care 	<ul style="list-style-type: none"> • MA or MA-Medicare enrollee, and • Over age 18
Geographic area	Statewide. Geographic roll-out over 1 year, beginning with Albuquerque metro area in July 2008	Harris County (Houston), Bexar, Nueces, and Travis service areas (28 counties total)	Dallas and Tarrant service areas (13 counties total)	Statewide
Mandatory/Voluntary	Voluntary	Mandatory, except for children under age 21 receiving SSI	Mandatory, except for children under age 21 receiving SSI	Voluntary
Services covered	<p>Medicaid acute</p> <p>Medicaid LTC</p> <p>All Medicare services</p>	<ul style="list-style-type: none"> • Medicaid acute • Medicaid LTC <ul style="list-style-type: none"> ◦ HCBS • Service coordination. • Optional “value added” services vary by plan 	<ul style="list-style-type: none"> • Medicaid acute • Medicaid LTC 	<ul style="list-style-type: none"> • Medicaid acute • Medicaid LTC <ul style="list-style-type: none"> ◦ HCBS ◦ NF • All Medicare services • “Integrated Services” • Health Promotion and risk assessment • “Flexible services”
Links to Medicare	Fully integrated model	<p>Not integrated with Medicare</p> <ul style="list-style-type: none"> • Enrollment in Medicare does not affect eligibility for Star+Plus • Enrollment in Star+Plus does not change how enrollees receive Medicare acute care services 	Not integrated with Medicare	Fully integrated model

Topic Paper # 3: Managed LTC & Rebalancing

	New Mexico Coordinated Long-term Services	Texas Star Plus	Texas Independent Care Management	Vermont MyCare Vermont
Evidence of effectiveness, efficiency	(Implementation scheduled for July 2008)	<ul style="list-style-type: none"> • Substantial savings projected if program expanded to 51 metro areas in state • Higher consumer satisfaction than for other TX mandatory MC programs²⁷ 	(Implementation scheduled for 2007)	(Implementation not yet scheduled)
Enrollment	Not yet implemented	10,671 enrollees (2004 ASPE) 63,000 (2004 THHSC) 65,000 (2005, Evercare)	Not yet implemented	Not yet implemented
Implementation date	July 2008 (projected)	1998	December 2007 (projected)	Implementation not yet scheduled
Federal Authority (Medicaid Authorization)	1915 (b)/(c)	1915 (b/c)		

²⁷ The Lewin Group (2004). *Actuarial Assessment of Medicaid Managed Care Expansion Options*. Prepared for the Texas Health and Human Services Commission, amended version. January 21, 2004), on web at <http://www.hhsc.state.tx.us/pubs/012104 MMC CostEffAmend.html>, last accessed on December 15, 2007; Texas Health Quality Alliance (2001) *Comparing Medicaid Managed Care Plans in Texas, 2000. Star+Plus Dually Eligible Consumer Study* (Technical Report prepared for Department of Health,, November 28, 2001. On web at <http://www.hhsc.state.tx.us/starplus/reports/2001THQA/CSTechRprtFin112801.pdf>, accessed December 15, 2007.

Table 6: Questionnaire Responses from State Officials

	Florida	Minnesota	New Mexico	Texas	Vermont
Goals	<ul style="list-style-type: none"> Budget neutrality - cost savings not a goal Increase access to HCBS Keep people out of NF Improve quality and care coordination Increase predictability of cost (to state) 	<ul style="list-style-type: none"> For seniors -- better integration of care; simplify and increase access; improve management of chronic conditions For dual eligibles --seamless coordination between Medicare and Medicaid Cost savings 	<ul style="list-style-type: none"> Eliminate fragmentation in LTC system; coordinate existing programs/waivers Keep people out of NF Control growth of Medicaid expenditures 	<ul style="list-style-type: none"> Integrate acute and LTC Help people stay as independent as possible Serve people in the most integrated community-based setting Improve access and quality of care Increase accountability Control costs 	<ul style="list-style-type: none"> Integrate system to addresses both health and social needs Reduce fragmentation Promote “person-centered” care Cost savings
Criteria of success		Better outcomes (clinical and functional) for enrollees	<ul style="list-style-type: none"> Fewer people in NF Increased client satisfaction and (self-reported) QoL Decreased ER utilization 	Higher cost-effectiveness	Increased access to and integration of LTC, health care, and social services
Evaluation	Diversion program – delayed entry to NH; increased enrollee satisfaction; more costly than other FL waivers; conflicting data on NH utilization and overall cost savings	<ul style="list-style-type: none"> Targeted evaluations of specific program components, but no broad evaluations of programs Evidence in MSHO (pre 2005 expansion) of controlling PMPM costs, reduced hospital use, improved care management systems, and reduced emergency room visits 	Evaluation measures (proposed but not yet developed) will include service utilization, client satisfaction and some clinical indicators	Actuarial assessment of StarPlus in Harris county: <ul style="list-style-type: none"> StarPlus is the most cost-effective model for serving SSI population Savings resulted from changes in utilization, not reducing payments to providers 	Evaluation measures and process not yet addressed
Incentives for community care	<ul style="list-style-type: none"> Diversion program specifically designed to keep clients in community and out of NH Program parameters of Senior Care not yet finalized 	<ul style="list-style-type: none"> Health plans receive additional capitation for enrollees in need of HCBS Health plans at financial risk for NH care 	MCOs at financial risk for NH care; no specific incentives to stress community care	Incentives for community care were included in methodology for setting MCO premiums	
Support for consumer-directed care	<ul style="list-style-type: none"> Diversion program does not include CD option Senior Care -- participating health plans required to provide CD option. Will likely include hiring authority but not budget authority for enrollees. Other parameters not yet finalized 	Health plans required to provide CD option, but no specific incentives	Consumer direction will be built into the CLTC program. Parameters are being jointly developed by state and the 2 CLTC managed care vendors. Level of CD in CLTC will likely be “just shy” of the authority granted in state’s MiVia waiver	No reply on questionnaire (At site visit in December it was clarified that Managed Care Plans must offer consumer directed services at the first option.)	A guiding principle for program is to “Allow participants to manage their own services to the greatest extent possible or to the extent they desire”

Program Evaluations

Expectations for Medicaid managed LTC to better coordinate care, reduce fragmentation, and improve health and social outcomes have been high. For instance, capitated managed care organizations are thought to be ideally positioned to integrate the full spectrum of medical, social, and long-term care services. By receiving fixed payments per enrollee, they are also perceived as having the financial incentives to move from an episodic, acute-care model of care toward a more coordinated social model of care for people with disabilities or chronic conditions requiring long-term medical and supportive services. However, evaluations have not yet been completed for all state MMLTC programs. Moreover, the evidence to date of MMLTC's impact has been inconclusive and at times contradictory, especially regarding MMLTC programs' cost-effectiveness and their aggregate cost savings. Several studies indicate managed long-term care programs reduce utilization and thus overall cost of hospital inpatient services and emergency room use. Most of the savings to date, however, seem to come from more aggressive approaches to primary care and case management but in some instances different forms of LTC have been substituted for nursing homes. The actual savings achieved by states depend more on the way the capitation rate is set and not on any specific activity within the control of the MCO. The evaluations of programs in Florida and Minnesota, discussed below, are illustrative.

Florida

An evaluation by the state's Office of Program Policy Analysis and Government Accountability of the Florida Diversion program, the managed care project designed to keep frail older people out of nursing homes, concluded that:

- The program delayed participants' entry into nursing homes
- Program enrollees experienced shorter nursing home stays and were more likely to return to their homes to continue program services than similar frail elders who were not enrolled in any waiver programs.
- The program's costs have exceeded the Medicaid Program's costs for other frail elders, but the cost differences have recently narrowed
- Compared to other waiver programs, the program has higher costs but is more successful in delaying nursing home placements²⁸

Using essentially the same data as the OPPAGA study, the Florida Policy Exchange Center on Aging at the University of South Florida (USF) found, for example, that although hospitalizations for NH Diversion enrollees was rare (e.g., 1/3 had no hospitalizations) enrollment in the Diversion program was associated with more hospital days PMPM compared to other Medicaid LTC clients.²⁹ However, on the question of whether the Diversion program saved money, these two studies reached opposite conclusions (yes, according to the OPPAGA, and no, according to the USF), a result that may be attributed to differences in research question asked and methodologies employed.³⁰

²⁸ OPPAGA. 2006. *The Nursing Home Diversion Program Has Successfully Delayed Nursing Home Entry*. OPPAGA Report No. 06-45

²⁹ Mitchell III G, Salmon JR, Polivka L, Soberon-Ferrer H. 2006. The relative benefits and cost of Medicaid home- and community-based services in Florida. *The Gerontologist*. 46(4):483-494

³⁰ Kane, RL & Kane RA. 2007. We've Looked at Care from Both Sides Now: The Effects of Alternative Evaluation Strategies on Study Conclusions. Draft prepared for CMS, available from Robert Kane, kanx001@umn.edu.

Minnesota

An early analysis of the MSHO program in Minnesota found no significant differences in functional outcome for MSHO enrollees but higher satisfaction among such enrollees and their family members with the care provided through the program.³¹ Follow-up analyses showed only modest evidence of benefit from MSHO compared with two control groups. The authors concluded that the MSHO model “does not appear to generate substantial differences in outcomes across function, satisfaction, and caregiver burden.”³² The MSHO programs’ impact on utilization has been shown to be stronger for nursing home enrollees than community enrollees. There have been no significant differences in hospital admission rates or in hospital days for MSHO community-dwelling enrollees; however, MSHO nursing home enrollees have significantly fewer hospital admissions. MSHO enrollees have significantly fewer hospital days and preventable hospitalizations than the control-in group. MSHO enrollees have significantly fewer emergency room visits and preventable emergency room visits than either control group. The result suggests that MSHO affects the process of care by providing more of some types of preventive and community-care services for community residents.³³

A 2005 evaluation of the MnDHO program concluded that enrollees “report statistically significant improvements in all quality dimensions: health care coordination; self-direction of care and ability to make informed choices about their health care; timely access to needed care; better provider interactions; more pleasant and productive experiences with clinical office staff; and more information but less paperwork.” Thus, in contrast to the more muted evaluation of MSHO, researchers have concluded that the MnDHO program “appears to be meeting its objectives of increasing quality, access, satisfaction and health outcomes.”³⁴

Conclusions and Implications

States are active partners in any managed long-term care programs involving Medicaid. In Minnesota and Texas, managed LTC programs are operated by a unit of government other than the newly consolidated agency largely responsible for long-term care, namely the Division of Continuing Care and the Department of Aging and Disability in Minnesota and Texas respectively. Especially at the outset of program development, States have worked closely with managed care organizations (MCOs) to ensure that major values and principles, such as allowing for consumer directed care and promoting choice, are maintained. For example, New Mexico is

³¹ Kane, RL, Weiner, A, Homyak, P & Bershady, B (2001). The Minnesota Senior Health Options Program. An Early Effort at Integrating Care for the Dually Eligible.” *The Journals of Gerontology Series A: Biological Sciences and Medical Sciences* 56: M559-M566.

³² Kane, R.L., Homyak, P., Bershady, B., Lum, Y., & Siadat, M.S. (2003). Outcomes of Managed Care of Dually Eligible Older Persons. *The Gerontologist* 43 (2):165-74

³³ Kane, R., Homyak, P, Bershady, B, Flood, S, & Hui, Z (2004). Patterns of utilization for the Minnesota Senior Health options program. *Journal of the American Geriatrics Society* 52 (12),2039-2044

³⁴ Palsbo, SE & Ho, PS. (2005). Evaluation of the Minnesota Disability Health Options (MnDHO) Program: Start-up Phase, September 2001 – August, 2004. FINAL REPORT: Part 1: Longitudinal Survey and Expert Interview Results (Prepared for Minnesota Department of Human Services by Center for Health & Disability Research, George Mason University, Uly 2005). On Web at http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Render=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs_id_056789, accessed on December 15, 2007.

working closely with managed care organizations over details of the State's expectations for consumer directed care while the programs are in the planned state.

Among officials in the 8 States, Florida is most explicit that MMLTC is a means towards rebalancing LTC systems. Other States have a variety of goals that may include elements of rebalancing. Texas, for example, cites the advantage of having no waiting lists compared to the waivers as a way that Star+Plus might advance a rebalancing goal, and Minnesota sees various advantages in improved care that might indirectly affect the ability to be in the community. The extent to which MMLTC providers are likely to emphasize community over institutional care will depend on the costs of services in each arena, the amount of financial risk the plans bear for nursing homes or other institutions, and the rules and financial arrangements surrounding disenrollment. In Florida and Minnesota the plans bear varying amounts of risk for nursing home care but those risks are limited.

Most of the cost savings to date seem to come from more aggressive approaches to primary care and care coordination leading to reductions in hospital costs. In some instances different forms of LTC have been substituted for nursing homes; for example, the Florida Diversion Program often utilizes assisted living instead of nursing homes. The actual savings from MMLTC will depend on services for which the MCO is at risk and the capitation rates that have been negotiated. State expectations for MMLTC to better coordinate care and services, reduce fragmentation, and improve health and social outcomes have been high. Evidence of MMLTC's impact on consumer outcomes, however, has been inconclusive and at times contradictory. Still, states seem pleased with their experiences with MMLTC, although little detailed evaluation has actually been done that addresses the outcomes achieved.

The interface between consumer direction and choice, on the one hand, and managed care, on the other hand, remains to be fully determined. Some managed care plans claim they can allow consumer direction by allowing consumers to choose from a list of approved providers; others may provide some allowance to purchase services informally. Minnesota and Texas require that MMLTC organizations offer consumer-directed services, but details about how those choices are presented to consumers and by whom are still under development. On the surface, reconciling the current emphasis on consumer choice with mandatory MMLTC, which applies to some consumer groups in Minnesota and Texas, seems challenging. Presumably, however, case managers can help consumers negotiate choices. To the extent that preferred provider arrangements help dictate where consumers live, consumer choice is diminished.

So far, managed care has been used more extensively with older persons than younger persons with disabilities. For example, the evolution of MMLTC in Minnesota that has addressed the needs of the disabled community (MnDHO) was developed much more slowly and with much greater consumer input than was the case with MSHO, a managed care program for persons age 65 and older. None of the 8 States have so far developed MMLTC for persons with developmental disabilities.

Managed care plans have varied widely in the extent to which they contract with aging network services or other publicly funded service networks. In Minnesota, Florida, and Texas, entry into MMLTC is mediated through the extant care coordination systems, but there are no

requirements to contract with aging or disability networks for ongoing services such as exist, for example, in Massachusetts. Community organizations have some concern that the growth of MMLTC could erode local infrastructures, the managed care organizations may try to take advantage of aging network services without paying for them.

Some concerns have been expressed—particularly in Florida-- that managed care organizations may prefer to deal with assisted living or residential care providers rather than a myriad of in-home services.

In Texas, some consumer stakeholders are concerned that administration of STAR+PLUS in the central office of the Commission for Health and Human Services weakens the consolidation of all long-term care and supports in the Division of Aging and Disability (DADS).

Glossary

Evercare is a branded mode of managed care operated by United HealthGroup. It began as a specialized program under Medicare to serve long-stay nursing home residents but has expanded to include community-dwelling residents under Medicare. Evercare now contracts for MMLTC in several states.

Florida Nursing Home Diversion Program is a demonstration program that uses managed care for the care of persons at risk of nursing home care. It aims to achieve reduced use of nursing homes through substituting other modes of LTC, more effective case management, and better primary care.

Florida Frail Elder Program is a 1915(c) waiver program, implemented in 1987 and operating only in Broward and Dade counties for Medicaid enrollees who meet nursing facility level of care criteria and live in their own home or with a caregiver

Florida Senior Care is a managed care pilot project, integrating acute and LTC, for Medicaid enrollees age 60 and older and dual eligibles of all ages. It will be implemented in May 2008, initially in the Miami and Orlando areas.

LIFE, Living Independently for Elders is the name used in Pennsylvania for PACE programs.

Medicare Advantage is the name now given to authorized managed care plans that provide services to Medicare beneficiaries. Enrollment is MA is voluntary.

MMIP (Medicare Medicaid Integration Program) is a voluntary managed care program for dual eligibles established in June 2005 in 2 counties of Washington State.

MnDHO (Minnesota Disabled Health Options) is the managed care program for dually eligible persons with disabilities in Minnesota.

MSHO (Minnesota Senior Health Options) is the managed care program for dually eligible older persons in Minnesota.

MyCare Vermont is a voluntary managed long-term care program integrating acute and long-term care to be implemented statewide in 2008

PACE (Program for All-inclusive Care of Elders) is a Medicare certified managed care program specifically targeted at dually eligible seniors who are deemed nursing home eligible but live in the community.

PMAP (Prepaid Medical Assistance Program) is the mandatory managed care program for Medicaid recipients in Minnesota. It covers all medical care and selected elements of LTC. In 2005, Minnesota Senior Care (MSC) replaced PMAP for Medicaid enrollees over age 65 and older.

SNPs (Special Need Plans) are Medicare Advantage plans that are eligible for higher capitation rates by virtue of serving defined groups with higher needs.

Texas Integrated Care Plan is a voluntary “managed fee-for-service” program implemented in 2007 in the Dallas and Tarrant service areas.

Texas Star+Plus is a mandatory managed long term care program initiated in Harris County in 1997 and expanded to 22 additional counties in 2007.

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