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EXAMINING MEDICAID MANAGED LONG-TERM SERVICE AND SUPPORT PROGRAMS: KEY ISSUES TO CONSIDER

EXECUTIVE SUMMARY

There is increased interest among states in operating Medicaid managed long-term services and support (MLTSS) programs rather than paying for long-term services and supports (LTSS) on a fee-for-service basis, as has been the general practice. This issue brief examines key issues for states to consider if they are contemplating a shift to covering new populations and LTSS benefits through capitated payments to traditional risk-based managed care organizations (MCOs). It draws on current literature as well as discussions conducted during the spring and summer of 2011 with a variety of respondents – federal and state officials, researchers, representatives from managed care organizations, service providers, and consumer advocates.

Experience with and evidence about the impact of Medicaid MLTSS is limited. Relatively few states currently use capitated models to manage care for the elderly or individuals with disabilities, the populations most likely to require LTSS. Research to date indicates that relative to fee-for-service programs, MLTSS programs reduce the use of institutional services and increase access to home and community-based services, but there is little definitive evidence about whether the model saves money or how it affects outcomes for consumers.

Program design is an important component of state MLTSS initiatives, and establishing high quality MLTSS programs is not a simple process. The extent to which MLTSS programs cover institutional services, medical care, or behavioral health services, in addition to community-based LTSS, affects MCOs' ability to coordinate services and manage costs effectively. Other significant program features to consider are whether enrollment in Medicaid MLTSS plans is mandatory or voluntary and whether the MCO is sponsored by a commercial, non-profit, or governmental entity. In light of budget shortfalls, and particularly if government downsizing is occurring, states may have diminished capacity to develop, implement, and monitor new MLTSS initiatives. It is important for planning and start-up periods to be long enough to allow state agencies to collaborate to make complex program design choices, to work with CMS to obtain the authority to operate new programs, and to consult with stakeholders, including consumers, providers, and MCOs.

Community-based organizations play a vital role in ensuring an adequate supply of LTSS, and it is important to consider their role in a managed long-term care system. These entities often have long-standing ties with consumers by making LTSS referrals or providing services. In a managed care environment, community-based organizations in some states function as MCOs or participate in MCO provider networks.

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Strong state oversight of MCOs is essential, and quality measures are needed. When states delegate functions to MCOs, they cannot cede responsibility for management and guidance, especially for the very vulnerable populations that require LTSS. Significant components of effective oversight include explicit contract language about plans' responsibilities, early attention on the part of states to determining how performance will be measured, and ongoing feedback from consumers and providers to help monitor program operations. A major challenge is that few quality measures for LTSS have been developed or tested, though particular states and plans have data and experience that could help inform efforts to create national standards. Data that are publicly available in a timely manner and relevant locally are most useful.

Certain program features promote a shift to more community-based and better-coordinated services. The array of services for which MCOs are responsible and at risk may affect their ability to coordinate services effectively or achieve diversions from institutions or transitions from institutions back to the community. Flexibility to provide a broad service package, autonomy for MCO service coordinators, and clear state expectations regarding options for consumers to direct their own services, along with detailed requirements for plans' roles in facilitating these options, can improve care coordination and make plans more aware of the full range of services and supports that consumers may need. The switch to managed care also raises questions about who bears responsibility for and has the capacity to address the lack of affordable accessible housing alternatives and inadequate pools of qualified formal caregivers, which continue to be significant barriers to keeping people who need LTSS in the community. Interest on the part of MCOs as well as a shift in states to thinking about broad service delivery systems has led to some activity, but solving the housing and workforce issues will require substantial investment and coordination among multiple government agencies and payers through demonstration projects, training programs and competitive compensation for workers, and other innovative arrangements.

CONCLUSION

The development and expansion of Medicaid MLTSS programs is receiving a great deal of attention in states as they strive to deliver services in a weak economy. Federal initiatives aimed at better coordinating services and lowering costs for beneficiaries dually eligible for Medicare and Medicaid also contribute to heightened interest. Efforts to improve the quality of services and deliver them in a more efficient manner are worthy goals, but if MLTSS programs are to succeed, careful design based on a thorough understanding of the strengths and needs of the various populations that use them is important. Efforts to incorporate aspects of current home and community-based service programs that are considered effective are also important. The vision and responsibility for Medicaid MLTSS programs rests with states. It is essential for states to have time, expertise, and financial resources to consult with stakeholders, shape programs, attend to administrative details, clarify expectations, and monitor program operations so that they can strike the right balance between managing care and managing costs.

INTRODUCTION

The Medicaid program plays a prominent role in paying for long-term services and supports in the U.S., accounting for almost half of spending in 2009, 48 percent of $264 billion. Medicare spending for long-term services and supports (LTSS), which is limited to short-term post-acute care, and private health insurance accounted for 12 percent and seven percent of LTSS spending, respectively.[i] Total spending is expected to increase as the population ages and the demand for LTSS grows.

Long-term services and supports financed by Medicaid have changed significantly in the last two decades. The federal and state governments have sponsored initiatives to help consumers better understand their options and to help support more services in community-based settings. Opportunities for consumers to direct their own services have become more common. Community-based services and supports accounted for 45 percent of all Medicaid LTSS spending in 2009, up from 27 percent in 1999.[ii]

Against this backdrop, there is increased interest among states in operating managed long-term services and support (MLTSS) programs rather than paying for LTSS on a fee-for-service basis, as has been the general practice. In Medicaid, the term managed care may refer to different types of arrangements:

- In arrangements with risk-based managed care organizations (MCO) or health plans, states contract with MCOs to provide a comprehensive package of benefits to enrolled Medicaid beneficiaries, primarily on a capitated basis. The state pays a per-member-per month premium to the plan.
- Primary Care Case Management Programs pay certain primary care providers a monthly case management fee for a group of patients assigned to them. Other services are generally reimbursed on a fee-for-service basis.
- Non-comprehensive prepaid health plans are at financial risk for providing specific types of services such as dental or mental health services.

The focus of this report is on the first type of arrangement, risk-based MCOs. Currently, 11 states – Arizona, Florida, Hawaii, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, Washington, and Wisconsin – operate capitated managed long-term service and support programs. In addition, 29 states operate Program of All-Inclusive Care for the Elderly (PACE) programs, daycare-based programs for frail elderly beneficiaries who qualify for Medicare as well as Medicaid. Nationally, the PACE program enrolls only about 20,000 people. [iii]

This issue brief draws on current literature and on discussions conducted during the spring and summer of 2011 with a variety of respondents – federal and state officials, researchers, representatives from managed care organizations, service providers, and consumer advocates. For proponents of MLTSS, the approach is attractive from a financial standpoint for its potential to deliver services in a more cost-effective manner and for its predictability; states have a better sense up-front about how much their programs will cost. Interviewees observed that MLTSS arrangements can help change the balance of care in favor of community-based services and hold promise for better service coordination and integration as compared to the traditional fee-for-service delivery model. Another advantage often cited is that managed care organizations can be a good new source of data on quality, outcome, and cost.

Other respondents contend that although a managed care approach has potential to improve the availability and delivery of long-term services and supports, this cannot occur unless sufficient funds are available to support the appropriate scope and amount of high quality services and supports. They worry that as states are under pressure to balance budgets, the managed care approach may be attractive primarily as a cost-cutting strategy, and the promise of better services and supports may not be fulfilled or the community-based systems that have been developed may be undermined. They are concerned that MCOs could accept low capitation payments but then fail to provide adequate services, particularly community-based services. Some interviewees are wary of the involvement of for-profit plans in MLTSS programs. They note, also, that states do not have a great deal of experience to draw on and evidence regarding cost and quality is inconclusive. Interviewees with experience in MLTSS caution that establishing a high quality program is a complex process that requires initial investments of time and other resources to ensure that new arrangements will be effective and viable over the long term.

This issue brief examines key issues for states to consider if they are contemplating a shift to include new populations and benefits for long-term services and supports in managed care models.

KEY ISSUES

Experience to date can be instructive as states think about using managed care models for long-term services and supports. Interviewees familiar with MLTSS programs consistently say that investments in the program planning process and attention to state-specific details of program operations are factors that increase the likelihood that states will realize the advantages that a managed care approach may offer.

Experience with Medicaid MLTSS is limited

State Medicaid programs have substantial experience using capitated models, but they have more experience with some populations than others. Managed care arrangements account for about 40 percent of spending on medical services for children and adults, but only for 7 percent of spending for the elderly and 13 percent of spending for individuals with disabilities, the populations most likely to need complex services. Managed care payments account for only 6 percent of spending for Medicaid beneficiaries using any long-term services or supports.[iv] The number of Medicaid LTSS beneficiaries covered under managed care arrangements increased from just over 68,100 in 2004 to approximately 173,600 in 2008.[v] Only 11 states operate capitated MLTSS programs.

Interest in managed long-term services and supports has accelerated with the recent launch by the Centers for Medicare and Medicaid Services (CMS) of several initiatives aimed at better coordinating services and lowering costs for people who are dually eligible for Medicaid and Medicare benefits. Dual eligibles are more likely to be hospitalized, to use emergency rooms, and to require long-term services and supports than other Medicare beneficiaries.[vi] In April 2011, the Medicare-Medicaid Coordination Office and the Center for Medicare and Medicaid Innovation at CMS initiated the State Demonstrations to Integrate Care for Dual Eligible Individuals, which gave awards to fifteen states to design person-centered delivery and payment models to better coordinate services for Medicare-Medicaid enrollees, including LTSS.[vii] In July, 2011, the agency announced an opportunity for states to test new payment and financing models – a capitated approach and a managed fee-for-service approach – to support state efforts to integrate services for dually eligible beneficiaries.[viii]

An estimated two-thirds of Medicaid beneficiaries who receive long-term services and supports are dually eligible. They may benefit from new demonstrations and policies designed to promote better financing and service integration. A variety of interviewees consulted for this report point out, however, that clarity regarding options for other Medicaid beneficiaries who need LTSS but are not dually eligible is also needed. They suggest that revisions of Medicaid regulations related to managed care and long-term services and supports are also desirable.

Evidence about the impact of MLTSS is limited

The potential for savings is a key factor that has piqued policymakers' interest in establishing MLTSS programs, but many interviewees caution that while it is necessary to consider how to better manage program costs, shifting to a managed care model is not guaranteed to save money, particularly in the short-term. The predictability associated with managed care is often viewed as a factor that can help control costs, but other factors such as the scope of covered services, the rates states negotiate with plans, and the numbers of people who qualify for and seek services also affect program costs.

Evidence of reductions in the use of certain higher cost services such as preventable emergency room visits, the length of hospital stays, and the use of institutional services suggests that managed care may be associated with less spending, but two reviews of Medicaid managed long-term service and support programs report that cost studies are inconclusive.[ix] [x] Among interviewees currently involved with Medicaid MLTSS, some note that with relatively few programs operating and program design differing among the programs, it is difficult to draw conclusions about the financial implications of establishing and operating Medicaid MLTSS programs. Moreover, in instances where savings have been demonstrated the reasons for the savings are not always clear. Researchers point out, for example, that in programs with voluntary enrollment, groups of participating and non-participating beneficiaries may not be comparable.

Researchers and officials also note that when dually eligible beneficiaries are enrolled in MLTSS programs, the impact on both Medicaid and Medicare must be studied to determine whether lower costs are a reflection of cost savings or cost shifting. Researchers say that one challenge to expanding enrollment in integrated care programs is that initial financial investments are required to establish the programs. While there is the potential for savings from avoiding nursing home use for example, the savings will not accrue immediately.[xi]

Respondents make a strong argument that even if savings are achievable they are not necessarily desirable unless they are accompanied by better, or at least equivalent, outcomes. High consumer satisfaction has been reported in studies of several programs as has increased access to home and community-based services, but very little information on functional outcomes is available. Results from studies regarding costs and outcomes in Medicaid managed care programs for individuals with disabilities – who may or may not need long-term services and supports – have also been limited and mixed.[xii]

Researchers note that little detailed evaluation has been conducted. Furthermore, because evaluations have been specific to particular types of beneficiaries or to certain counties or states – and because program design differs significantly from state to state – results may not be generalizable. CMS activities to better integrate Medicare and Medicaid services are expected to include evaluation components geared to measuring outcomes, but results will not be available for some time. Among the 15 states that received grants to develop service delivery and payment models that integrate care for dual eligibles, some number may be chosen to move to an implementation phase in 2012, pending CMS approval of the design and available funds.[xiii]

Program design matters

Even among the relatively small number of states that currently operate Medicaid MLTSS programs, arrangements differ, reflecting factors such as legislative direction and the way that care, service, and insurance systems have developed over time. Thus, it is important to understand how particular programs operate in order to gauge whether successes or limitations in one state are pertinent for others. Important dimensions on which programs differ are discussed below.

Service integration and risk

When MCOs are at risk for providing more types of services, the potential to coordinate services is greater, and there are fewer opportunities to shift costs to other payers. The consistent feature among the models currently in use is that MCOs are at risk for all community-based long-term services and supports. But the combinations of other services for which MCOs are at risk vary (see Table 1).

- In the most fully integrated programs, MCOs are at risk for the management of all long-term services (community-based and institutional) as well as for medical services. This model is used, for example, in the Arizona *ALTCS*, Hawaii *QExA*, New Mexico *CoLTS*, and Tennessee *CHOICES* programs.
- In another model, MCOs provide all long-term services (community-based and institutional), but other services may be provided by different MCOs or on a fee-for service basis. In New York's *Managed LTC* program, for example, Medicaid covers physician and inpatient care on a fee-for-service basis. Beneficiaries who are also eligible for Medicare may have physician and inpatient services covered on a fee-for-service basis or they may be enrolled in Medicare Advantage (MA) plans, managed care organizations offered as an alternative to the fee-for-service Medicare program.
- Minnesota's *Senior Health Options* program covers home and community-based LTSS and medical services. The state pays for institutional services on a fee-for-service basis, but as an incentive for MCOs to keep consumers in the community, plans are required to pay for first 180 days of institutional services if one of their members is receiving services in the community and transitions to a nursing facility.[xiv]
- The Texas *STAR+PLUS* program also has a financial incentive for MCOs to keep consumers out of nursing facilities. Currently, the program does not pay for most nursing home or inpatient hospital services.

Table 1: Design Features for 11 Capitated Medicaid MLTSS Programs

State	Program	Target Population	Mandatory or Voluntary Enrollment	Scope of Services in Addition to Community-Based LTSS	Integrated with Medicare
Arizona	ALTCS	Frail elderly; people of all ages with disabilities, except developmental disabilities	M	Institutional LTSS; medical	N
Florida	Nursing Home Diversion	Frail elderly	V	Institutional LTSS; medical	Y
Hawaii	QExA	Frail elderly; people of all ages with disabilities, except developmental disabilities	M	Institutional LTSS; medical	N
Massachusetts	Senior Care Options	Frail elderly	V	Institutional LTSS; medical	Y
Minnesota	Senior Health Options	Frail elderly	V	Limited institutional LTSS*; medical	Y
New Mexico	CoLTS	Frail elderly; people with disabilities, expect developmental disabilities	M	Institutional LTSS; medical	N
New York	Managed Long-Term Care	Primarily frail elderly; some younger adults with physical disabilities**	V	Institutional LTSS; limited medical**	Y
Tennessee	CHOICES	Frail elderly; younger adults with physical disabilities	M	Institutional LTSS; medical	N
Texas	STAR+PLUS	Frail elderly; younger adults with physical and mental disabilities	M	Limited institutional LTSS; limited medical***	N
Washington	Medicaid Integration Partnership	Frail elderly; younger adults with disabilities****	V	Institutional LTSS; medical	N
Wisconsin	Family Care	Frail elderly; younger adults with physical or developmental disabilities	V	Institutional LTSS*****	Y

* Medicaid pays for institutional LTSS beyond 180 days on a fee-for-service basis.
** Age of eligibility and scope of medical services may differ by plan. Medical services that are not covered by the plan are covered on a fee-for-service basis by Medicaid or, for dually eligible beneficiaries, by Medicare MA plans.
*** Medicaid pays for institutional LTSS beyond 120 days and for in-patient hospital services on a fee-for-service basis.
**** The program operates in only one county in Washington.
***** Medical services are covered on a fee-for-service basis by Medicaid or, for dually eligible beneficiaries, by Medicare.

Behavioral health services

Program administrators point out that financing and delivery models can affect efforts to manage and coordinate behavioral health services with other services. Behavioral health services may be "carved out" of the MLTSS program and provided by a separate behavioral health organization or on a fee-for-services basis. Even when one MCO is responsible for medical and behavioral services, it may have a subcontract with a behavioral health organization. This is a significant issue given that a substantial portion of the population that qualifies for Medicaid LTSS needs behavioral health services. Among beneficiaries dually eligible for Medicaid and Medicare, for example, 26 percent of the elderly and 44 percent of individuals with disabilities have mental illness.[xv]

Mandatory or voluntary enrollment

Another notable design feature is whether enrollment in Medicaid MLTSS programs is mandatory or voluntary. Some respondents maintain that mandatory enrollment is necessary so that program participation will be robust enough to attract MCOs, warrant investments on the part of states and plans, and help ensure financial viability. They note that the size of the program may affect MCOs' ability to coordinate services or achieve savings. Others maintain that beneficiaries should have the freedom to choose whether to enroll in a managed care organization. This issue is particularly significant for dual eligibles, who are not required to enroll in managed care plans for their Medicare-covered benefits under current law. CMS must grant authority when states propose to make enrollment mandatory.[xvi]

Target populations

Medicaid managed LTSS programs differ in the combinations of populations they enroll. For example, enrollment in the Minnesota *Senior Health Options* program is limited to beneficiaries who are 65 and older. Hawaii's *QExA* program covers people 65 and older and people of all ages with disabilities except those with developmental disabilities, who continue to receive services under a separate waiver program. The Wisconsin *Family Care* program serves all types of eligible Medicaid beneficiaries, including those with developmental disabilities. Programs also differ in terms of whether they require that participants meet nursing home level of care criteria set by the state.

Integrated programs for dually eligible beneficiaries

The most fully integrated programs blend Medicaid and Medicare financing and service delivery. Currently, there are two models for fully integrated care. The first is the PACE program, a daycare-based program for frail elderly beneficiaries. In the second model, Special Needs Plans (SNPs) that target services to dual eligibles have contracts with state Medicaid programs and receive payments from Medicare and Medicaid. SNPs are Medicare Advantage plans that limit enrollment to subgroups of Medicare beneficiaries. Generally, they cover medical services; few cover long-term services and supports. In 2009, fewer than 120,000 dually eligible beneficiaries were in SNPs that fully integrate Medicaid and Medicare.[xvii] Enrollment in fully integrated SNPs is expected to increase; by January 2013 all new SNPs that enroll the dually eligible population are required by law to have contracts with state Medicaid programs.

Plan sponsorship

MLTSS programs have contracts with different numbers of managed care organizations. Also, MCO sponsorship differs. State Medicaid programs have contracts with for-profit and not-for-profit MCOs. Commercial insurers, entities such as county governments, or provider-based organizations operate plans. Large national commercial MCOs account for a substantial portion of MLTSS enrollment. Several respondents observe that sizeable initial investments are required to establish MLTSS plans, which means that practically speaking, the market will likely continue to be dominated by large national plans. A mixture of commercial and non-profit provider-sponsored plans operates in states such as New York and Massachusetts. In Minnesota all of the health plans are nonprofit entities. In the Wisconsin *Family Care* program, private non-profit organizations or Family Care Districts, groups of counties, function as MCOs. Plan sponsorship differs among the MCOs that have contracts with the Arizona *ALTCS* program. The New Mexico *CoLTS* program has contracts with two national commercial MCOs.

Establishing high quality MLTSS programs is not a simple process

A recurring theme among individuals with MLTSS program experience is that the goals of providing better-integrated high quality services in a more cost-effective manner are not likely to be achieved if the timelines for program design and implementation are short and hasty decisions are made as a result. They advise that planning and start-up periods must be sufficiently long to allow state agencies to collaborate to make complex program design choices, to work with CMS to obtain the authority to operate new programs, and to consult with stakeholders. Experts note that these activities are time and resource intensive. MLTSS programs in New Mexico, for example, held monthly meetings with stakeholders over a two-year period prior to the start of the program.

In most states, multiple agencies have administrative responsibilities pertinent to the development of MLTSS programs. They develop health policies, set budgets, regulate insurance, determine financial and functional eligibility for Medicaid long-term services and supports, oversee institutional and home and community-based services, and have expertise in services for particular population groups such as the elderly, younger people with disabilities, or individuals with mental retardation or other developmental disabilities. During the program development phase, respondents observed that collaboration must occur not only among those agencies in each state, but also between state Medicaid programs and CMS.

Several interviewees make the point that an important factor for program planners to take into account – not only for rate setting purposes, but also for program design – is the characteristics of the populations that will be enrolled. They suggest that states look beyond the administrative categories that are generally used to group beneficiaries receiving long-term services and supports and consider other factors that may affect abilities and needs. One program administrator reports, for example, that by matching data from the agency that administers the mental health system with data on Medicaid enrollees receiving nursing facility services, program administrators had a better sense of which services would be most appropriate to offer and were able to make the case for providing specialized mental health services in a pilot program.

Concerns about limited state resources

Some respondents express the concern that if government downsizing is occurring, states may not have the staff or expertise to develop, implement, and monitor a new program. The option of contracting with large well-capitalized MCOs that already participate in MLTSS programs in other states may be appealing if states can benefit from these organizations' past and ongoing efforts and investments in developing systems. Officials note, however, that states are unique and the learning curve may be steep even for organizations that provide MLTSS in other states. For example, it is important for MCOs to understand different claims processing systems and sets of eligibility rules and procedures in each state and to become familiar with existing providers as they develop provider networks. Even established MCOs need a strong state-specific working knowledge of Medicaid LTSS programs. Officials who have experience establishing programs point out that this is something that cannot be accomplished overnight. Also, they caution that to create successful programs, states must have management experience and expertise in rate-setting. States may have to invest in new data systems and infrastructure to ensure that they maintain responsibility for program integrity. Some respondents say that this is particularly important when the MCOs involved have profit as well as more traditional program goals.

Input from stakeholders is essential

Respondents from states where MLTSS programs are operating emphasize that input from consumers and providers is important during the program design phase not only so that programs will be well accepted but also so that they will operate effectively. Including MCOs in early discussions will also help ensure that programs are well designed and that practical details related to program operations are considered.

Consumer priorities.

Experience in states indicates that "managed care" may be a term that causes concern among consumers even before programs are introduced. Individuals with disabilities who are accustomed to managing their own lives are apprehensive about program changes that may put someone else in charge. They may also object to the notion that they need "care" as opposed to a set of services and supports to function independently. Some have spent years advocating for established programs and therefore are wary of change. They are concerned, for example, that new policies may limit consumers' ability to develop service plans and direct services. Or, they fear that relative to the current range of available benefits, plans may be more prescriptive and less flexible in what is offered.

A particular concern is that new arrangements will use a medical model rather than the social service model to which beneficiaries are accustomed. Another view, however, holds that as a result of the emphasis on the social model in recent years, some LTSS programs are not sufficiently linked to medical services. Some respondents argue that truly integrated programs should have both medical and social components and note that MCOs may be able to develop a fuller complement of services and coordinate services more effectively than many existing LTSS waiver programs. There is a shared view that a broad benefit package is needed.

Respondents make the point repeatedly that beneficiaries who need long-term services and supports have some common characteristics and needs, but also that subgroups of beneficiaries require different types and balances of medical and social supports and services. Consumers are wary about the prospect of a "one-size-fits-all" approach on the part of MCOs and note in discussions about all aspects of a managed care approach, that different policies and practices may be needed for different populations such as the frail elderly or younger people with disabilities.

Consumers want assurances that provider networks in managed care plans will have the expertise and capacity to provide the broad array of services and supports that people with disabilities often need. They stress that continuity of care is of paramount importance for people with complex conditions and seek assurances that they will not have to change providers when managed care programs are implemented or if changes do occur, that appropriate polices will be in place to facilitate transitions. Respondents have suggested transition periods of 30 to 90 days. In Tennessee, at implementation, CHOICES beneficiaries who had been receiving services under a waiver program received the same services from existing providers for 30 days regardless of whether the providers participated in the CHOICES network.[xviii]

Network capacity is defined broadly by consumers to include an adequate number and geographic distribution of primary and specialty providers who are accepting new patients without long waits for appointments. In addition, consumers want to know that facilities will be accessible to people with disabilities and that linguistic and cultural accommodations will be available when needed.

***Provider issues**.*

In advance of a shift to MLTSS, providers have questions about whether they will be included in networks, how much and how they will be reimbursed, and about the administrative ramifications of new arrangements including apprehension about possible new rules and procedures established by MCOs. If they participate in more than one MCO network, they may be subject to different sets of rules and procedures and may have to enter into contracts with multiple managed care organizations. Concerns about a potential loss of autonomy and about whether the new arrangements will be compatible with their established mission are also common.

In response to both consumer and provider opinions about the desirability of maintaining established services and supports, states have taken steps to protect providers, at least initially. When Texas *STAR+PLUS* was established, the state mandated a three-year transition period when MCOs were required to contract with any willing provider that had been providing LTSS services in the Medicaid fee-for-service system. In Tennessee, *CHOICES* plans were required to offer contracts to all nursing facilities that were currently operating. In addition, the state set provider rates for long-term care services to give some reassurance that MCOs would not cut reimbursement rates.[xix]

Community-based organizations play a vital role

The impact of changing to a managed care system on community-based organizations that have historically been involved with Medicaid long-term services and supports is an issue often raised by consumers and providers. Organizations such as Area Agencies on Aging, Centers for Independent Living, or Aging and Disability Resource Centers have been active in advising and assisting consumers about long-term services and supports, making referrals, and in some cases providing services. Many are viewed as trusted entities in the community.

They may have the capacity to help people whose first language is not English or may have links to cultural groups in the community.

In a few states, community-based organizations function as MCOs. For example, as the Wisconsin *Family Care* program was developed, counties and the Area Agencies on Aging they operate had the opportunity to become managed care organizations. As the program expanded, pilot counties worked with neighboring counties to form Family Care District MCOs that serve regional service areas. Respondents point out that this may be more difficult to accomplish under current circumstances, however. Although community-based providers may have an interest in becoming managed care organizations, relatively few have the resources to meet financial and regulatory requirements, particularly if the time frame for establishing programs is short.

Legislative mandates are intended to provide certain protections for community-based organizations. In Massachusetts, MCOs must contract with Aging Services Access Points, which provide community service coordination. New legislation in Florida that seeks to vastly expand Medicaid MLTSS requires that MCOs offer providers who are part of the Aging Services Network the opportunity to participate in MCO networks. Respondents note, however, that the functions these groups perform may change. In Tennessee, for example, Area Agencies on Aging and Disability remain the single point of entry for consumers seeking Medicaid-financed long-term services and supports. But for those already enrolled in Medicaid *CHOICES*, the MCOs facilitate access to long-term services and supports. Also, the MCOs are now responsible for functions such as building provider networks that previously had been the responsibility of the Area Agencies on Aging and Disability.

Community-based organizations worry that their funding may be cut if some of the functions they traditionally have performed are subsumed by managed care organizations. They also comment that established entities may lose experienced staff when large national plans hire service coordinators from the community and rely on their expertise to develop a community presence. Some respondents make the point that if local organizations are weakened, consumers in the community who do not qualify for Medicaid but who rely on these organizations may lose a valuable resource. In discussing the viability of existing organizations, some say that it may be in states' interest to ensure that there is an adequate supply of organizations that have historically provided assistance and services in case MCOs or other providers with whom states have established contracts leave the market.

Strong state oversight is essential

Observers note that an advantage of working with MCOs is that they can be held accountable and can work with states to improve operations in ways that individual providers cannot. But they also note that this assumes that expectations are clear, that measures and standards are in place, that plans submit relevant data, and that states analyze and use the data as the basis for plan guidance and contract changes.

Many respondents emphasize that when states delegate functions to plans, they cannot cede responsibility for management and guidance. They observe that states have played and must continue to play a vital role in developing and promoting a vision to ensure that very vulnerable populations receive optimal services and supports. They point out that regardless of the way the delivery system is structured, states are ultimately responsible for ensuring that high quality long-term services and supports are available for Medicaid beneficiaries. Respondents stress that ongoing monitoring and oversight of MCOs is particularly important in a system that mandates managed care enrollment because there is limited to no opportunity for beneficiaries to vote with their feet.

Contract language

A common sentiment among respondents is that effective oversight in a managed care environment can best be achieved with explicit contract language about what plans must do and when and how they must report results and with early attention on the part of states to determining how performance will be measured. Plan representatives say they are particularly eager to understand states' expectations, and several interviewees warn against generic contracts, advising states instead to write contracts that reflect their particular circumstances and expectations. In guidance prepared by CMS, the agency notes that managed care arrangements can promote the use of community-based services and provide data to measure quality, but also cautions that such accomplishments require that carefully constructed contract language and incentives be in place.[xx]

Metrics to monitor performance

In the absence of standard outcome measures for long-term services and supports, many states rely on process measures. They may, for example, require that MCOs demonstrate that members have had a level of care determination, that they were given a choice between institutional or community-based services, or that they were visited at certain intervals. Performance Improvement Projects (PIPs) are also cited as activities that can be used to promote improvement in the delivery and use of services by managed care plan members. Health plans undertake PIPs to focus on achieving specific goals for plan members. To date, most PIPs have been geared to medical measures such as increasing cancer screening rates, controlling blood pressure, or promoting aspirin therapy for members with certain conditions. In the Wisconsin *Family Care Program*, MCOs have been required to conduct at least one PIP annually. The focus of this project must be related to long-term services and supports, whether that is a clinical or functional outcome area, or a quality of life outcome related to self-determination and choice, community integration, or health and safety.[xxi]

Consumer and provider feedback

Another observation related to oversight is that Aging and Disability Resource Centers, which interact with both consumers and providers, already play a crucial but informal role in sending information about plan performance back to the state. One respondent suggested that the ADRC role could be expanded in this regard, though there is variability in sponsorship, structure, and capacities of ADRCs across states. The role of state ombudsmen is also cited as an important aspect of program oversight.

The use of ongoing feedback from consumers and providers to help monitor program operations is also mentioned frequently, with respondents cautioning that there must be opportunities for meaningful engagement and incentives for plans and states to act when consumers or providers raise issues. States typically conduct consumer satisfaction surveys. The use of advisory groups is also common. Some observers suggest that states as well as plans should convene advisory groups so that state officials can hear directly from consumers and providers. Another suggestion is that consumers, rather than representatives or spokespersons from consumer groups, be recruited for advisory boards to obtain unfiltered feedback. Focus groups are another means of hearing directly from consumers and providers. Regardless of the methods used to obtain input, respondents stress that both the concerns and the steps taken to address them should be made public.

Quality measures are needed

A challenge that respondents familiar with program operations mention repeatedly is that few quality measures for long-term services and supports have been developed or tested. No national standards exist. MCOs routinely use the Health Plan Employer Data and Information Set (HEDIS) to measure quality, but HEDIS measures are geared to primary care and preventive services and do not provide much relevant information about the quality of long-term services and supports. Experts say that for the most part, quality measures tend to be clinically oriented, but there is also a need to develop measures that will provide information about quality of life.

Activity with regard to the development of quality measures is occurring on the federal level, but for the most part it does not pertain specifically to long-term services and supports.[xxii] Experts suggest that more federal sponsorship and support, in partnership with national quality organizations, would be helpful in establishing LTSS outcome measures and standards. They also note that particular states and plans have data and experience that could help inform efforts to create national standards.

In thinking about the development of measures and standards, respondents concerned with quality make a number of points. They explain that population-specific measures are needed. For example, the reasons for emergency department visits may be very different for the elderly than for younger individuals with developmental disabilities. Respondents noted that these differences should be taken into account in developing and using the measures so that realistic goals and appropriate standards can be devised for each group. Respondents emphasized that decisions about desired outcomes must consider what can realistically be achieved by plans, and program design must be taken into account. MCOs that are not at risk for nursing facility care, for example, cannot be held accountable for the length of an admission. Similarly, in order to develop complete measures for dually eligible beneficiaries, Medicare as well as Medicaid data are needed. States have not had ready access to Medicare data, but a new CMS initiative has established a process for state Medicaid agencies to request Medicare data for dually eligible beneficiaries to support care coordination.[xxiii]

Finally, respondents concerned with quality stress that to be most useful, information must be available in a timely manner to the public as well as to other stakeholders and should be relevant locally. For example, aggregated data from national or region managed care plans may not reflect local operations or circumstances.

Certain program features promote a shift to more community-based and better-coordinated services

Based on experience in states, certain policies and practices are generally accepted as desirable for promoting community-based long-term services and supports. These include service coordination, particularly coordination to facilitate smooth transitions among service settings, and the option for consumers to direct their own services. Respondents involved with ongoing initiatives to promote community-based services observe that managed care policies can complement or conflict with such initiatives.

Service coordination

Service coordination is often cited as a key feature of MLTSS programs that promotes effective and efficient delivery of services for populations with complicated medical and social needs. Yet states and MCOs take very different approaches.

Arizona's *ALTCS* program specifies caseload ratios for case managers in their contracts with MCOs, a requirement seen as helping to assure adequate staffing. Caseloads vary by setting, with case managers responsible for fewer members in home-based situations and more in institutional settings. The state also requires that care managers conduct in-person visits and see consumers at least every 90 days.[xxiv] Other states rely on MCOs to develop standards with varying results. For example, plans may set standards internally for the number of visits that service coordinators make each week in urban and rural areas. In other instances, no minimum ratio of coordinators to enrollees is required. One respondent notes that significant differences in charges for service coordination among plans in the same state suggest that the process differs among plans.

Observers note that some states have more requirements and standards for service coordination than others and suggest that this is an area that could benefit from close attention on the part of states. They recommend that states include expectations for person-centered planning, specify who will work with beneficiaries to develop service plans, and also specify the required elements of service plans in contracts with MCOs. Respondents believed that special attention should be given to achieving service coordination with other plans or providers when one MCO does not manage all services. Respondents stressed that states must be sure that MCOs accustomed to coordinating medical services have an appreciation of the full range of services and supports, particularly non-medical supports, when LTSS are included in managed care programs.

A certain level of autonomy for MCO service coordinators and the ability to make referrals, authorize service plans or to make appropriate changes as consumers' statuses or needs change are mentioned frequently as important features for effective service coordination. Also, the flexibility plans have to provide a broad service package including services that formerly could only be covered under certain waivers or were not covered in states – such pest control, air conditioners, security deposits for utilities, furniture, bed linens, or even a wheelchair maintenance and repair service – are seen as being advantageous for consumers. One official notes that this is an area where the state should require consistency across plans so that beneficiaries will have similar experiences and so that standard performance measures, including measures of beneficiaries' experiences with care and quality of life, can be used.

Diversions and transitions

Over the last several years, CMS and states have aggressively promoted policies and practices to divert consumers from nursing facilities or to help those already in facilities make the transition back to the community. When MCOs are responsible and at risk for a broad array of services, they are more able to achieve diversions or transitions.

When providers from different programs or agencies are involved, creating opportunities for them to work together can also help promote diversions or transitions. In Texas, for example, relocation specialists working with the Department of Aging and Disability Services help arrange housing in the community for *Money Follows the Person* program participants and provide transition assistance.[xxv] MCO service coordinators provide other, complementary assistance such as help arranging provider services. Monthly regional community transition team meetings provide an opportunity for the various players to interact. The purpose of the working meetings is to solve individual consumer or systemic problems. *Building Bridges* seminars are another means used in Texas to promote teamwork by introducing community members – such as housing authorities, social service agencies, nursing facilities and community-based long-term services providers – to the *Money Follows the Person* program.

Reimbursement policies can also have an effect on the extent to which diversions and transitions occur. In Massachusetts, plans have strong incentives to keep members in the community. If a member enters an institution, the plan continues to receive its community rate for 90 days before shifting to the higher institutional rates. There are also incentives to encourage nursing facility transitions. If a plan transitions a member from an institution to the community, the plan continues to receive its institutional rate for 90 days. [xxvi]

Consumer direction

Respondents suggest that when states think about how to design MLTSS programs, they must consider what types of services or supports consumers can direct. Consumer direction of personal care assistance services, for example, gives people varying degrees of control over hiring, scheduling, training, and paying attendants. In some instances consumers may employ friends or family members. In a "cash and counseling" model, consumers have individual budgets that they use to purchase and manage services and supports. States' expectations regarding the type of consumer direction to be offered and plans' roles in facilitating it are recommended by respondents, as is attention to detail. Interviewees with MLTSS experience say that states should decide whether to require that MCOs inform consumers about the option for self-direction or to require that consumers acknowledge that they have received information about the option. Respondents point out that states must decide whether MCOs should act as fiscal intermediaries. Other important considerations are whether plans' provider networks are sufficiently large to offer real choice for consumers, and whether, if friends or family are providing services, plans or state agencies will be responsible for training and certification activities. Similarly, respondents emphasize that the affiliation and role of individuals such as services coordinators or benefit navigators, who may serve as resources for consumers directing their own services, should be well defined.

Needs persist for adequate affordable housing and a well-trained workforce

The lack of affordable accessible housing alternatives and inadequate pools of qualified formal caregivers continue to be significant barriers to keeping people who need long-term services and supports in the community. The traditional Medicaid programs has not been responsible for community-based housing or workforce development and recruitment, but states have been involved, particularly through waiver initiatives, in attempting to improve circumstances in these two areas. The switch to managed care raises questions about who bears responsibility for and has the capacity to address these issues.

Housing

The lack of affordable accessible housing alternatives continues to be one of the biggest barriers to keeping people who need long-term services and supports in the community. Most of the activity in states related to housing has involved the establishment and use of home and community-based service (HCBS) waiver benefits such as help with payments for the first month's rent or home modifications. State Medicaid programs have worked with other government agencies to obtain housing subsidies for enrollees, but with limited success.

Several respondents say that although MCOs have very limited responsibilities with regard to housing, many MCOs recognize that it is advantageous to keep people in the community and therefore try to be creative about making appropriate housing more available. Some MCOs provide benefits similar to those that have been available through HCBS waiver programs, such as helping with security deposits or paying for pest control. Plans sometimes consult with organizations such as Habitat for Humanity, other foundations, and housing authorities. Some plans urge their service coordinators to make referrals to local organizations and housing authorities, but they note that resources are scarce, and the process of securing assistance with housing is generally very resource intensive.

One state administrator reports that his agency had not been very engaged in activities to help develop housing options in the past, but now, in working with MCOs, the agency thinks about service delivery systems as a whole, and therefore has begun to approach other state agencies and to be more proactive about developing housing options. Another respondent notes, however, that solving this crucial issue will require a substantial investment and coordination among multiple government agencies and payers. He emphasizes that the impacts of housing shortages on programs' ability to arrange for care in the community must be recognized, regardless of which entity is paying for services, and suggests that a demonstration project with federal support might be one approach to help states and plans build on current efforts and expertise to make more progress.

Workforce

In many places, the supply of formal caregivers, particularly those that provide paid services in the home, is not adequate to meet the demand for services. The need for a larger, more stable, higher quality workforce is well recognized. States have grappled with this issue for years as they establish and promote community-based programs.

Policies such as the one in Arizona that allows family members, including spouses, to be paid attendant services caregivers represent one response to provider shortages. Relative caregivers receive training and are certified and employed by home health or attendant care agencies. This policy plays a significant part in the state's ability to provide home and community-based services for a large portion of Medicaid consumers who qualify for LTSS benefits.[xxvii] Other states have similar policies. Still, the problem of an inadequate workforce, particularly in sparsely populated areas, persists.

Several respondents say that when workers are well trained and fairly compensated, they tend to stay in their jobs, thus providing a stable, experienced, professional workforce. In Massachusetts, where personal care attendants now have collective bargaining rights, this is viewed positively by some respondents in terms of developing the workforce. Across the country, bargaining rights are the exception rather than the norm, however.

Respondents observed that states may be in a position to tackle the workforce shortage by combining economic development and LTSS funds to sponsor or invest in training programs for home health aides and other LTSS workers. With MCOs in the mix, there may be new opportunities to expand the pool of qualified workers and connect them to beneficiaries who need their services. The authorizing statute for Tennessee's *CHOICES* program requires that plans develop strategies to help expand the pool of workers. As part of its rebalancing demonstration grant, the state is partnering with the MCOs and with a local university to develop training programs to be offered at community colleges, a certification program for direct support staff, tracks in high school health occupations sciences programs, and a registry of certified workers. In New Mexico, one plan worked with a Native American community to develop their capacity to become transportation and respite care providers eligible for reimbursement.

Some respondents suggest that provider availability and quality may be an aspect on which MCOs choose to compete. But others say the reality of the capitated rates and the pressure to cut costs may preclude the development of training programs and competitive compensation for workers.

CONCLUSION

The development and expansion of Medicaid managed long-term service and support programs is receiving a great deal of attention in states as they strive to deliver services in a weak economy. Recent federal initiatives aimed at better coordinating services and lowering costs for dually eligible beneficiaries have contributed to heightened interest. Efforts to improve the quality of services and deliver them in a more efficient manner are worthy goals, but respondents stressed that if MLTSS programs are to succeed, careful design based on a thorough understanding of the strengths and needs of the various populations that use them is important. Efforts to incorporate aspects of current home and community-based service programs that are considered effective are also important. The vision and responsibility for Medicaid MLTSS programs rests with states. It is essential for states to have time, expertise, and financial resources to consult with stakeholders, shape programs, attend to administrative details, clarify expectations, and monitor program operations so that they can strike the right balance between managing care and managing costs.

This issue brief was prepared by Laura Summer of the Georgetown University Health Policy Institute for the Kaiser Family Foundation's Commission on Medicaid and the Uninsured.

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[i] The sources of support for long-term services and supports in the U.S. in 2009 are: Medicaid (48%), Out-of-pocket (20%), Medicare (12%), Other public (7%), Private health insurance (7%), Other private (6%). Medicaid and CHIP Payment Access Commission, Report to the Congress on Medicaid and CHIP, MACPAC, March 2011.

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[xiv] Tucker, A. and K. Johnson, Examining Rate Setting for Medicaid Managed Long-Term Care. The Hilltop Institute, University of Maryland Baltimore Campus, July 2009.

[xv] The Medicare Payment Advisory Commission, Report to the Congress: Medicare and the Health Care Delivery System, MedPAC, June 2011.

[xvi] Historically, states have applied to operate MLTSS programs using a combination of 1915(b) enrollment authority with 1915(c) home and community-based service waiver authority. A few states, including Arizona and Tennessee, which enroll all beneficiaries in a managed long-term services and support program, operate their programs under section 1115 of the Social Security Act. That approach appears to be more popular now as states seek more flexibility in program design.

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[xxi] Thompson/Medstat, Wisconsin's Consumer Outcome Survey, HCBS Quarterly, Vol 1, Num 6, June 2003.

[xxii] The Adult Health Quality Measures provision in the Affordable Care Act requires that HHS develop a set of quality measures for adults enrolled in Medicaid; the mandate does not include LTSS measures, however. The Measures Applications Partnership, sponsored by HHS and convened by the National Quality Forum, is charged with providing advice on performance measures for public reporting and performance-based payment programs, including measures for some long-term care settings. http://www.qualityforum.org/Home.aspx.

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[xxv] The Money Follows the Person demonstration (MFP) provides financial incentives for states to help Medicaid beneficiaries in institutions make the transition back to the community. http://www.cms.gov/CommunityServices/20_MFP.asp.

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