Managed Long-Term Care

Kacey Heekin
Larry Polivka

Section 1. Introduction

The population of older adults in the U.S. is increasing steadily. The progressive growth of this demographic, in both number and proportion, is historically unparalleled and can be attributed to the aging of the baby boomers and longer life spans.[1] The number of Americans aged 65 years or older will likely double over the next 25 years.[2] Thus, the Centers for Disease Control and Prevention (CDC) predict that by 2030, older adults will constitute approximately 20% of the U.S.'s population.[3] As a result of the continuous expansion of the older adult population and the high frequency of chronic disease within this group, there is, and will continue to be, an increased need for long-term care (LTC) services. Estimates predict that approximately two-thirds of older adults in the U.S. will eventually require some form of LTC for an average of three years.[4] It is important to note that many adults under the age of 65, such as those with various disabilities, also heavily rely on long-term services and supports (LTSS). The Kaiser Commission on Medicaid and the Uninsured posits that of the over 10 million Americans that require LTSS, approximately half are people under the age of 65 with disabilities.[5]

In addition to the increased need for LTSS in general, there is also an increased need for cost-effectiveness during the development and distribution of these LTSS. Fiscal pressure throughout the past decade has tightened federal, state, and local budgets. Currently, the primary payer for LTSS is Medicaid.[6] LTSS can be incredibly expensive; nursing home care averages $74,800 per year, assisted living facilities (ALFs) average $39,500 per year, and home health services average $21 per hour.[7]

During the development and distribution of the LTSS, individuals' service preferences should also be considered. Many individuals favor home and community-based services (HCBS) over institutional services (e.g., nursing homes). HCBS include case management, personal care, therapies, respite care, and caregiver/family training. HCBS can also result in better quality of life. Thus, it is important for LTC systems to offer substantial HCBS options. Several states have made progress in providing greater access to HCBS for people in need.[8]

All of the aforementioned factors have culminated in the rapid expansion of and transition to managed LTC programs. Managed LTC refers to the delivery of LTSS through capitated plans/arrangements.[9] Such plans are designed to control costs while maintaining/increasing access

[1] Centers for Disease Control and Prevention. (2013). *The state of aging and health in America 2013*. Atlanta, GA: Centers for Disease Control and Prevention, US Department of Health and Human Services.

[2] Ibid.

[3] Ibid.

[4] Engquist, G., Johnson, C., Lind, A., & Barnette, L. P. (2010). *Policy brief: Medicaid-funded long-term care: Toward more home- and community-based options*. Center for Health Care Strategies, Inc.

[5] Kaiser Commission on Medicaid and the Uninsured. (2012). *Medicaid facts: Medicaid and long-term care services and supports*. Washington, DC: Kaiser Family Foundation.

[6] Ibid.

[7] Ibid.

[8] Fox-Grage, W., & Walls, J. (2013). *State studies find home and community-based services to be cost-effective*. Washington, DC: AARP Public Policy Institute.

[9] Centers for Medicare and Medicaid Services. (2013). *Guidance to states using 1115 demonstrations or 1915(b) waivers for managed long term services and supports programs*. Centers for Medicare and Medicaid Services.

to LTSS. These plans also tend to promote the utilization of HCBS over institutional services, when possible. However, despite the potential benefits of managed LTC programs, continued shifts toward these programs should not be made without caution. Research is needed to evaluate whether managed LTC programs result in beneficial cost-savings, impede or improve access to and/or affect quality of LTSS, and are able to be supported by current resources and infrastructures. The hasty growth of managed LTC systems will have major impacts on a significant number of people (e.g., consumers, caregivers, providers, etc.), and so the potential positive and negative outcomes of these programs must be carefully examined.

Section 2. Historical Analysis of Managed Long-Term Care

Several decades ago, the health care system was dominated by fee-for-service (FFS) care, wherein providers typically receive a fee for each delivered health service. This type of care, however, instigated financial problems; it allowed for some providers to arrange unnecessary services to make monetary gains. Under the FFS systems, health care costs rose increasingly and uncontrollably. Policy makers became alarmed with these exponential health care cost increases and sought mechanisms for restriction. Managed health care became one possible solution. The employment of managed health care expanded with the Health Maintenance Organization Act of 1973. This act helped support the development of health maintenance organizations (HMOs) and set standards throughout the health care industry.

There has been a continuous transition from FFS care to managed care in various sectors of the public health care system. It is important to note that approval for all state health system transitions must be obtained from the Centers for Medicare and Medicaid Services (CMS). Managed care programs were initially reluctant, however, to include older adults and individuals with disabilities in their plans because of the associated complex and high-cost needs. Thus, managed long-term service and supports (MLTSS) systems have lagged behind other managed care systems in terms of progression. Recently though, the expansion of MTLSS programs has been quite extensive.

> The development of the MLTSS market was initially hampered by a very limited supply of organizations that had both the experience and ability to accept risk for LTSS. However, the supply of organizations that have decided to develop this product line has increased greatly since 2004, giving most States a larger selection of organizations with which to contract. (Saucier et al., 2012, p. 2)[10]

> Because people with disabilities, particularly those using LTSS, are an expensive population for state Medicaid programs… the interest by states in using managed care to potentially cut costs is not surprising. (Hall et al., in press)[11]

The enactment of policy that promotes consumer-centered delivery styles, payment models to better coordinate care for individuals dually eligible for Medicaid and Medicare, and the usage of

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[10] Saucier, P., Kasten, J., Burwell, B., & Gold, L. (2012). *The growth of managed long-term services and supports (MLTSS) programs: A 2012 update*. Prepared for the Centers for Medicare & Medicaid Services. Truven Health Analytics.

[11] Hall, J. P., Kurth, N. K., Chapman, S. L., & Shireman, T. I. (in press). Medicaid managed care: Issues for beneficiaries with disabilities. *Disability and health journal*.

HCBS has supported and coincided with the expansion of MLTSS.[12] For example, the 1999 court case, *Olmstead v. L.C.*, resulted in the ruling that placing individuals in nursing homes when they could be cared for in less restrictive environments is a violation of the Americans with Disabilities Act (ADA). Additionally, in 2006, the Money Follows the Person (MFP) grant that was endorsed as a part of the Deficit Reduction Act (DRA) provided enhanced Federal Medical Assistance Percentage (FMAP) reimbursement for individuals who transition to community care after having been in a nursing home for more than six months. In 2010, the passing of the Affordable Care Act (ACA) extended the MFP program and also increased other federal incentives for states to develop HCBS by offering reimbursements to the states for certain expenditures on HCBS (e.g., through the Balancing Incentive Program and the Community First Choice Option).

> States have made progress in providing greater access to home and community-based services (HCBS) for people with low incomes. (Fox-Grage and Walls, 2013, p. 1)[13]

> Over the last two decades, Medicaid funding for HCBS programs has increased steadily and by 2007, approximately 43 percent of Medicaid LTSS dollars were dedicated to these programs… (Engquist, 2010, p. 1)[14]

MLTSS systems, and managed care systems in general, currently continue to grow.

> Three factors are driving states to accelerate managed care enrollments: (1) severe budget constraints resulting from the deep, prolonged economic recession; (2) the impending expansion of Medicaid rolls in 2014 under the Patient Protection and Affordable Care Act, hereinafter referred to as the Affordable Care Act (ACA); and (3) the need to control outlays on behalf of the most expensive segment of the Medicaid population–seniors and people with chronic diseases and disabilities. (National Council on Disability, 2013, p. 9)[15]

> MLTSS grew significantly between 2004 and 2012. The number of States with MLTSS programs doubled from 8 to 16, and the number of persons receiving LTSS through managed care programs increased from 105,000 to 389,000.

> By 2014, the number of States projected to have MLTSS programs is 26. This is based on States that have actually completed planning documents and submitted formal proposals or waiver applications to CMS. (Saucier et al., 2012, p. 1)[16]

Continuous evaluation of these developing and emerging MLTSS programs will be of critical importance in the next few years.

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[12] Kaiser Commission on Medicaid and the Uninsured, supra, note 5.
[13] Fox-Grage & Walls, supra, note 8.
[14] Engquist et al., supra, note 4.
[15] National Council on Disability. (2013). *Medicaid managed care for people with disabilities: Policy and implementation considerations for state and federal policymakers*. Washington, DC: National Council on Disability.
[16] Saucier et al., supra, note 10.

Section 3. Positive Outcomes Associated with Managed Long-Term Care

As previously mentioned, one of the driving forces behind the shift to managed LTC has been the pressure to reduce and control LTSS costs. Managed LTC, at least in theory, has the potential to generate cost savings. Case management/care coordination mechanisms, for example, within managed LTC plans could reduce of the use of unnecessary and/or inappropriate services. Furthermore, managed LTC plans facilitate greater utilization of lower-cost services (e.g., HCBS) instead of higher-cost institutional services (e.g., nursing homes), which encourages an expansion of HCBS. Engquist et al. (2010)[17] states that Medicaid can, on average, provide HCBS for three individuals for the same cost as providing nursing home care for one individual.

> Medicaid spending on home and community-based services (HCBS) has grown dramatically in recent years, but little is known about what effect these alternatives to institutional services have on overall long-term care costs. An analysis of state spending data from 1995 to 2005 shows that for two distinct population groups receiving long-term care services, spending growth was greater for states offering limited noninstitutional services than for states with large, well-established noninstitutional programs. Expansion of HCBS appears to entail a short-term increase in spending, followed by a reduction in institutional spending and long-term cost savings. (Kaye et al., 2009, p. 262)[18]

Fox-Grage and Walls (2013)[19] examined 38 studies that evaluated publicly funded HCBS programs. This review states that:

> The studies consistently provide evidence of cost containment and a slower rate of spending growth as states have expanded HCBS. (Fox-Grage and Walls, 2013, p. 1)[20]

However, overall findings on the cost-effectiveness of the transition from FFS care to managed LTC tend to be mixed and inconclusive.

> Experts generally agree that well-designed managed care initiatives can lead to important efficiencies in the delivery and financing of health care services. But studies differ on the extent of cost savings achieved by shifting form a fee-for-service to a managed care format. (National Council on Disability, 2013, p. 9)[21]

Regardless of the cost savings, or even the lack thereof, managed LTC programs positively allow for increased budget predictability on Medicaid costs, through capitated payments, for state governments and for increased flexibility for rebalancing service expenditures.[22]

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[17] Engquist et al., supra, note 4.
[18] Kaye, H. S., LaPlante, M. P., & Harrington, C. (2009). Do noninstitutional long-term care services reduce Medicaid spending?. *Health Affairs*, *28*(1), 262-272.
[19] Fox-Grage & Walls, supra, note 8.
[20] Ibid.
[21] National Council on Disability, supra, note 15.
[22] Engquist et al., supra, note 4.

Medicaid managed LTC (MMLTC) has clearly resulted in the reduction of the usage of higher-cost services besides just nursing homes, including emergency rooms and hospital care.[23] Yet, managed LTC programs have also been shown to potentially result in improved access to care, especially increased access to HCBS.[24]

Managed LTC programs have been shown to potentially result in higher quality of care. The case management/care coordination components within managed LTC plans can help to ensure that consumers' conditions are not overlooked by providing comprehensive care and can effectively handle the multiple disorders and medications/treatments that are prevalent for consumers in these long-term care populations. To reiterate, managed LTC programs tend to emphasize increased access to HCBS. This is beneficial from a quality of care perspective because numerous individuals already prefer HCBS over institutionalization and HCBS can have positive effects on quality of life.

> In recent years, a few independent evaluations have been conducted for CMS, which have shown modest to positive benefits for MMLTC consumers. (Saucier and Fox-Grage, 2005, p. 10)[25]

Ideally, there is increased accountability for the managed care organizations (MCOs), which is dictated by embedded quality improvement processes within some of the programs. MCOs must strive to maintain federal and state standards.

Consumers tend to have favorable views of the MCOs responsible for disseminating the LTSS. States' consumer and family surveys and corresponding studies that are a part of the quality management programs indicate that consumer satisfaction levels for most MMLTC programs have been high.[26]

Overall, more empirical analyses are needed to help clarify and assess the magnitude of the impact of managed LTC on costs, quality of care, and other outcomes.

Section 4. Negative Outcomes Associated with Managed Long-Term Care

Some of the positive outcomes associated with managed LTC have been extensively questioned. Opponents of managed LTC, for example, argue that the cost reductions are linked to lack of access to care, decreases in quality of care, and shifting to other sources/sectors (e.g., family members and caregivers).

> Studies on the cost-effectiveness of MMLTC programs are mixed and inconclusive. Utilization studies support the theory that relatively expensive hospital and nursing

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[23] Saucier, P., & Fox-Grage, W. (2005). *Issue brief: Medicaid managed long-term care*. Washington, DC: AARP Public Policy Institute.

[24] Saucier, P., Burwell, B., & Gerst, K. (2005). *The past, present and future of managed long-term care*. Washington, DC: US Department of Health and Human Services.

[25] Saucier & Fox-Grage, supra, note 23.

[26] Ibid.

home services are reduced and replaced with more community-based services, but aggregate savings are elusive. (Saucier and Fox-Grage, 2005, p. 9)[27]

Managed LTC programs have been criticized for potentially decreasing access to and/or quality of care. Costly, yet necessary, services may be denied to consumers on managed LTC plans. Certain individuals truly require full-time care that would be best provided in nursing homes (instead of in ALFs or with HCBS). It is important to note that ALFs should not always be substitutive for nursing homes, especially for residents who require more intensive care. Alternatively, certain individuals may require more HCBS than MCOs are willing to provide and thus end up discontentedly in nursing homes. Additionally, offered services may be compromised by cost-reducing motivations.[28] Consumer preference/choice must be respected by MCOs.

LTC plans may be especially difficult for MCOs to handle because of the special needs of the individuals with chronic disease and disability and because of the importance of the non-medical aspects of care in addition to traditional medical care. Hall et al. (in press)[29] surveyed individuals in Kansas with disabilities using Medicaid LTSS as they transitioned to managed care.

> Respondents encountered numerous disability-related difficulties, particularly with transportation, durable medical equipment, care coordination, communication, increased out of pocket costs, and access to care.

> Despite an overall satisfaction rating of 64%, a number of important issues were raised related to provider networks, covered benefits, transportation, communications, and care coordination. Within these broad categories, lack of disability cultural competence and awareness of a range of accessibility issues were especially problematic. (Hall et al., in press).

Managed LTC programs have also been criticized for potentially increasing limitations on consumers' choice of providers. Not all existing LTSS providers may decide to integrate into a MCO's provider-network. If enrollment in MMLTC is mandatory, then MCOs, states, and other agencies must ensure a competitive network of providers and services.

The movement from FFS care to managed long-term services and supports (MLTSS) poses several possible transitional complications, including the interruption of LTSS during the initial transfer and provider issues.[30]

> While states recognize the need to support their LTSS providers in the transition from FFS to MLTSS, tight implementation schedules and lack of resources can preclude states from offering much assistance to providers during the transition process. (Burwell and Kasten, 2013, p. 3)[31]

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[27] Ibid.
[28] Saucier et al., supra, note 24.
[29] Hall et al., supra, note 11.
[30] Saucier, P., Burwell, B., & Halperin, A. (2013). *Consumer choices and continuity of care in managed long-term services and supports: Emerging practices and lessons*. Washington, DC: AARP Public Policy Institute.
[31] Burwell, B., & Kasten, J. (2013). *Transitioning long term services and supports providers into managed care programs*. Prepared for the Centers for Medicare & Medicaid Services. Truven Health Analytics.

MCOs can encounter their own specific challenges in the shift to MLTSS. Examples of such challenges which have been listed by Burwell and Kasten (2013)[32] include: a general lack of understanding of the LTSS market/provider community and of experience in payment methods for LTSS services, in negotiating contracts with small non-profit entities/sole proprietors, and in contracting for consumer-directed services; and legal liability concerns over consumer-directed services.

Providers can also face issues in the shift to MLTSS. Examples of such issues which have been listed by Burwell and Kasten (2013)[33] include: more complex contracting processes; increased need to assess risk in contract negotiations; increased focus on accurate pricing; new billing practices; and various licensure/credentialing requirements. Providers may also experience disruption in continuity of care, and thus patient relationships, more extensive administrative expenses and burden, and lower reimbursement rates for services. Managed care programs are additionally associated with increased technological/information systems difficulty.

Careful monitoring of MLTSS programs on access to and quality of care outcomes is essential.

Section 5. Examples of (State) Managed Long-Term Care Programs

The number of state managed LTC programs has expanded rapidly and significantly throughout the past decade. In 2004, there were eight states with MLTSS programs, including: Arizona, Florida, Massachusetts, Michigan, Minnesota, New York, Texas, and Wisconsin.[34] By 2012, that number doubled to 16, with eight additional states developing MLTSS programs, including: California, Delaware, Hawaii, New Mexico, North Carolina, Pennsylvania, Tennessee, and Washington.[35] Saucier et al. (2012)[36] comprehensively reviewed the 16 states with these programs and found that:

> MLTSS arrangements are very diverse… They include programs with capitated payments for limited Medicaid benefits, capitated payments for comprehensive Medicaid benefits, and capitated payments for comprehensive Medicaid and Medicare benefits.

> The States are about evenly split on type of enrollment. Eight States have mandatory enrollment, seven have voluntary enrollment, and one has both types.

> States use three major types of contractors: private for-profit; private not-for-profit; and public or quasi-public. Private for-profit contractors have the largest share of enrollment nationally, at 44 percent.

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[32] Ibid.
[33] Ibid.
[34] Saucier et al., supra, note 10.
[35] Ibid.
[36] Ibid.

About half of the MTLSS programs include only persons at the institutional level of care (in HCBS programs and institutions).

Fifteen of the 16 States place their contractors at risk for all or some of the cost of institutional services.

Twelve of the 16 States offer consumer-directed options through their MLTSS programs.

Most states have incorporated LTSS-specific measures into their quality management programs, though the lack of nationally endorsed set of measures has resulted in highly unique approaches from State to State. (Saucier et al., 2012, p. 1-3)[37]

Saucier et al. (2012)[38] further found that 16 states have plans to implement new MLTSS programs by 2014, including California, Florida, Idaho, Illinois, Kansas, Massachusetts, Michigan, Nevada, New Hampshire, New Jersey, New York, Ohio, Rhode Island, South Carolina, Virginia, and Washington.

Saucier et al. (2013)[39] reviewed states' Medicaid MLTSS programs on consumer choice and continuity of care. System transitions in Kansas, New York, and Wisconsin were critically evaluated. The key findings from this review include: the three states successfully developed designated "transition periods" to aid LTSS consumers during the transfer of systems; LTSS consumers did not experience major changes in responsibility for their service plans during the transition; MLTSS prioritized protecting consumer choices; lack of sufficient/timely investment in consumer education strategies could significantly influence informed decision making, and consumer choice overall; transitioning the care coordination aspect to MLTSS programs can prove especially challenging; and MLTSS programs are still evolving.[40] This review also ascertained the following lessons: there is a large demand for plan information surrounding the actual transition date; state policies regarding consumer choices are limited; greater standardization during the transition process could benefit LTSS providers; outreach methods, such as public forums and mailings, should be employed and expanded; the implementation of continuity of care policies can be difficult; continuity of care coordination needs to be explored; and technical assistance in relation to billing is definitely required by LTSS providers.[41]

Lipson et al. (2012)[42] reviewed states' abilities to monitor the performance of MLTSS programs. The oversight practices in eight states with MLTSS programs, including Arizona, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, and Wisconsin, were critically evaluated. This review found that:

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[37] Ibid.
[38] Ibid.
[39] Saucier et al., supra, note 30.
[40] Ibid.
[41] Ibid.
[42] Lipson, D. J., Libersky, J., Machta, R., Flowers, F., & Fox-Grage, W. (2012). *Keeping watch: Building state capacity to oversee Medicaid managed long-term services and supports*. Washington, DC: AARP Public Policy Institute.

All of the states used the skills and resources of many other organizations to enhance or strengthen their MLTSS oversight capacity. Partners included (1) external quality review organizations (EQROs), which evaluate the quality of care provided to beneficiaries and help MCOs to improve their quality, and, in four states, review MCO care management and care coordination processes; (2) state staff in health, aging, or disability departments, who provide expertise in monitoring LTSS provider networks and LTSS quality; and (3) consumers or consumer advocacy groups, which help design, monitor, and evaluate program performance.

State capacity to oversee MLTSS program performance requires staff with the right mix of skills and experience, as well as information system expertise. (Lipson et al., 2012, p. 2)[43]

Lipson et al. (2012)[44] further found that the states differed in how they carried out the core oversight practices for their MLTSS programs. This review separated the practices into the categories of norms, promising practices, and caution flags. The promising practices, divided into the four core areas of contract monitoring and performance improvement, provider networks and access to services, quality assurance and improvement, and member education and consumer rights, respectively, are:

Using software tools or onsite IT audits to review MCO submission of all required data and reports on schedule; offering financial incentives or bonuses to plans that meet or exceed performance targets.

Using visits, calls, and "mystery shoppers" to ensure that all providers on MCO network lists are actually available and accessible to enrollees.

Using real-time service-monitoring tools, such as electronic visit verification systems, to monitor home care delivery; analyzing encounter data and other information to create a comprehensive set of quality indicators; and posting up-to-date information on MCO quality indicators on state websites.

Operating ombudsman programs specifically dedicated to investigating and resolving MLTSS member problems. (Lipson et al., 2012, p. 2-3)[45]

There are a couple of other considerations in relation to state MLTSS programs, which are important to note. First, there are various methods through which states can enact MLTSS programs.

States can implement MLTSS using an array of managed care authorities, including a 1915(a) voluntary program, a 1932(a) state plan amendment, a 1915(b) wavier,

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[43] Ibid.

[44] Ibid.

[45] Ibid.

or a section 1115 demonstration. Any of those managed care authorities can be 'paired' with state plan HCBS benefits offered under 1905(a), 1915(i), 1915(j) or 1915(k) or an HCBS waiver under 1915(c). Additionally, section 1115 demonstrations can be used alone to authorize both the managed care delivery system as well as the HCBS benefits offered through that delivery system, when these reforms are part of a larger demonstration project. (Centers for Medicare and Medicaid Services, 2013, p. 2)[46]

Second, states must consider their own demographic compatibility (e.g., rural and urban areas, geography, population, and network of service providers) and data collection arrangements in relation to those of states with existing MLTSS programs before making systemic comparisons/adaptations. For example:

… Some states have extensive rural and sparsely population areas where building the infrastructure to support certain HCBS services is not possible or practical. In order to provide HCBS in rural communities, states must either limit the availability of certain services or redesign them to ensure their financial viability. (Engquist et al., 2010, p. 4)[47]

Overall, there is much variation in not only state managed LTC program structure, but also experience. Some states have been operating such programs for many years, whereas others have just recently transformed their programs. Arizona and Wisconsin are two states with well-established managed LTC programs and solid program evaluation data.

Arizona's managed LTC program, the Arizona Long Term Care System (ALTCS), was implemented in 1988 for the developmentally disabled (DD) population and in 1989 for the elderly or physically disabled (EPD) population.[48]

ALTCS offers a complete array of acute medical services, institutional services, behavioral health services, home-and-community-based services (HCBS) and case management services for all eligible persons. (Arizona Health Care Cost Containment System, 2005, p. 8)[49]

ALTCS was designed to maximize the cost-effectiveness of HCBS and to effectively ensure that the individuals eligible for ALTCS are at risk of institutionalization.[50] The first evaluation of the cost-effectiveness of the ALTCS HCBS occurred in 1992 and a follow-up study was completed in 1998. Findings from both evaluations supported the cost-effectiveness of the program, even with a higher HCBS cap during the follow-up study.[51] Another report, completed by Laguna Research Associates in 1996, further emphasized the success of ALTCS in generating cost savings.

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[46] Centers for Medicare and Medicaid Services, supra, note 9.
[47] Engquist et al., supra, note 4.
[48] Arizona Health Care Cost Containment System. (2005). *Arizona Health Care Cost Containment System: Overview: October 1, 2004 through September 30, 2005*. Arizona Health Care Cost Containment System. Retrieved from http://www.azahcccs.gov/reporting/Downloads/AHCCCSOverview_2005.pdf
[49] Ibid.
[50] Ibid.
[51] Ibid.

Cost of the program as compared to a traditional Medicaid program is… 16 percent less per year for the long-term care program for its first five years. (Arizona Health Care Cost Containment System, 2005, p. 30)[52]

The 2012-2013 external quality review (EQR) annual report for ALTCS revealed the following findings: ALTCS EDP Contractors are continuously working toward improving the quality of and delivery of services to their consumers; ALTCS has implemented a comprehensive system to monitor provided care, however performance measures have demonstrated only marginal improvements; and ALTCS EPD Contractors have identified targeted improvement opportunities.[53] This report specifically identified that all ALTCS EPD Contractors exceeded Arizona Health Care Cost Containment System's (AHCCCS's) Minimum Performance Standards (MPSs) for the *Initiation of HCBS* performance measure, however two of the three Contractors experienced sharp declines in the *Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Participation* performance measure.[54]

The 2012 HCBS report for ALTCS indicates that the percentage of EPD ALTCS members residing outside of institutional settings has increased over the last 11 years from 49% in 2001, to 73% in 2012.[55] The evaluators attribute this success to ALTCS's promotion of the values of choice, independence, self-determination, dignity, and individuality and AHCCCS's adoption of the following five principles: member-centered case management; consistency of services; accessibility of network; most integrated setting; and collaboration with stakeholders.[56]

Since September, 2011, members living in their own home increased from 50.08% to 50.29%. At the same time, the proportion of members residing in alternative residential settings increased from 21.75% to 22.44%... This continues the shift in placement for E/PD members towards more community-based placements. Since 2007 the proportion of members residing in their own homes increased from 45% to 50%, while the proportion of the members residing in institutions declined from 36% to 27%. (Division of Health Care Management, 2013, p. 18)[57]

The April 1, 2014-June 30, 2014 quarterly progress report for ALTCS found relatively recent improvements within the ALTCS program.[58] Such improvements include: the implementation of a new member-directed option, Agency with Choice, which allows consumers more opportunity for directing their own care; the incorporation of competency standards, training curriculum and

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[52] Ibid.

[53] Arizona Health Care Cost Containment System. (2014). *2012-2013 external quality review annual report for ALTCS EPD and DES/DDD contractors*. Phoenix, AZ: Health Services Advisory Group.

[54] Ibid.

[55] Division of Health Care Management. (2013). *Arizona Health Care Cost Containment System: Annual HCBS report CY 2012 (10/1/11 – 09/30/12)*. Arizona Health Care Cost Containment System. Retrieved from http://www.azahcccs.gov/reporting/Downloads/HCBS/AnnualHCBS_CMSReportCYE2012.pdf

[56] Ibid.

[57] Ibid.

[58] Arizona Health Care Cost Containment System. (2014). *AHCCCS quarterly report: April 1, 2014 through June 30, 2014*. Arizona Health Care Cost Containment System. Retrieved from http://www.azahcccs.gov/reporting/Downloads/QuarterlyProgressReports/2014/CMS_QuarterlyReport_Apr_to_Jun2014.pdf

testing protocol into service specifications for attendant care, personal care, and housekeeping, including in-home caregivers; and the development of an alternative residential audit tool (a tool used to monitor conditions for residents in nursing homes and certain HCBS facilities such as ALFs and group homes) that includes review standards for resident's rights, medical records, service/care plans, advanced directives, and medication administration, to standardize the oversight process and potentially reduce provider burden.[59]

Wisconsin's managed LTC program, Wisconsin Family Care (FC), was originally piloted in a limited number of Wisconsin counties in 1999.[60] The FC pilot counties achieved many successes including: the elimination of the wait lists for HCBS; the institution of interdisciplinary care management teams; the augmentation of consumer involvement; and the development of an innovative quality assurance and improvement system that seeks direct input from members through the Member Outcome Tool.[61] Some initial issues that were encountering during the piloting process include: delays in the approval of the initial Medicaid waivers to establish the mandatory enrollment and limit the allowable providers to the case management organizations (CMOs); disparate information technology (IT) systems at the local and state levels; and freezes on non-Medical Assistance CMO enrollment.[62] The *Wisconsin Family Care Final Evaluation Report*, in 2003, revealed that the FC program increased choice and access to care for its consumers and that existing enrollees did not experience a decline in service levels during the first year of the program.[63] The *Second Independent Assessment of Family Care*, in 2005, supported many of these findings and further revealed that the FC program continued to improve the quality of care received; earlier problems with timely processing of enrollments were addressed and cost-effectiveness was improved through improving fiscal management and introducing efficiencies/cost-saving measures. [64]

> Analyses compared Family Care members' health status, health care costs and long-term care costs to those of carefully matched comparison groups of similar individuals receiving fee-for-service Medicaid services in the remainder of the state. The results revealed favorable effects of Family Care on both cost and quality. Family Care produced better results for members' health and levels of functioning, more visits to primary-care physicians, and less use of nursing facilities. While results for individual services are mixed (Family Care increases spending for some and decreases spending for others), Family Care restrained growth in overall long-term care costs and in total Medicaid spending for individuals enrolled in the program. (APS Healthcare, Inc., 2005, p. 1)[65]

Specifically, average individual monthly long-term care costs for FC members (outside of Milwaukee) were $250 less at baseline and $722 less at the end of the study period than those of

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[59] Ibid.
[60] Alecxih, L. M. B., Olearczyk, B., Neill, C., & Zeruld, S. (2003). *Wisconsin Family Care final evaluation report*. Prepared for Wisconsin Legislative Audit Bureau. The Lewin Group.
[61] Ibid.
[62] Ibid.
[63] Ibid.
[64] APS Healthcare, Inc. (2005). *Second independent assessment of Family Care*. Madison, WI: Wisconsin Department of Health and Family Services.
[65] Ibid.

the matched comparison group.[66] Average individual monthly Medicaid costs for FC members (outside of Milwaukee) were $452 less than those of their comparison group at the end of the two-year study period.[67]

It is important to note that FC is relatively unique in comparison to other state managed LTC programs in that it relies primarily on public or quasi-public organizations (in addition to non-profit organizations) as its MLTSS contractors.[68]

The 2012-2013 Wisconsin Medicaid managed LTC EQR discovered that FC improved its overall results in the practice of care management compared to the previous year.[69] Furthermore:

> Consistent with the results of past reviews, managed long-term care organizations demonstrated strength related to compliance with enrollee rights and standards.
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> Managed care organizations also continued to perform strongly related to compliance with grievance systems standards.
>
> Over the past several years, managed care organizations have consistently performed well in addressing members' identified needs and including members and their supports in care management processes.
>
> Managed care organizations have demonstrated the ability to meet requirements related to the early stages of performance improvement projects by developing methodically sound study topics, study questions, and study indicators. (MetaStar, 2013, p. 5)[70]

Continued provision of technical assistance was recommended as a method to facilitate the procurement data to drive quality improvements.[71]

FC members are also surveyed to provide data to stimulate quality improvements. The overall response rate for the FC members surveys administered in 2012 was 38%, which is slightly higher than it has been in the past.[72] The question on the survey that received the highest percentage of "Always" responses in the FC program was "My care manager listens to my concerns"; the question on the survey that received the lowest percentage of "Always" responses in the FC program was "I understand information my care manager shares with me."[73]

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[66] Ibid.

[67] Ibid.

[68] Saucier et al., supra, note 10.

[69] MetaStar. (2013). *Wisconsin Medicaid managed long-term care external quality review: Family Care, Family, Care Partnership, and Program of All-Inclusive Care for the Elderly: State fiscal year 2012-2013.* Prepared for Wisconsin Department of Health Services. Madison, WI: MetaStar.

[70] Ibid.

[71] Ibid.

[72] Wisconsin Department of Health Services. (2014). *2012 Family Care member survey results: Includes Family Care, Family Care Partnership, and PACE programs.* Madison, WI: Wisconsin Department of Health Services, Division of Long Term Care, Office of Family Care Expansion.

[73] Ibid.

The 2012 annual report on Wisconsin's LTC programs states that the Wisconsin Department of Health Services (DHS) worked to improve the efficiency and cost-effectiveness of the FC program by changing the process MCOs use for approving a member's services and by increasing the flexibility for MCOs in assigning care management staff.[74] In 2012, MCOs also worked to implement projects to avoid unnecessary emergency rooms visits, hospitalizations, and nursing home placements, including managing medications and preventing falls projects.[75]

Evaluators agree that the FC program has demonstrated a system that increases quality of care while controlling costs.[76] Successes of this program include:

> A capitated rate payment structure that drives Managed Care Organizations to continuously improve and provide the most cost-effective care.

> The creation of equal access to long-term care services in an individual's home, community-based settings, or nursing homes. This access ensures that the level of service matches a member's needs, which is demonstrated to delay entry into nursing homes and reduce long-term care service costs.

> The Family Care program generates efficiencies through economies of scale as the Managed Care Organizations (MCOs) develop regional and comprehensive provider networks that increase the variety of services available to member at negotiated, competitive rates.

> Reformed funding and service models that reward innovations in quality care and cost control. (Wisconsin Department of Health Services, 2013, p. ii)[77]

Additionally:

> The Department has focused on areas such as medication compliance, dementia care, mental health and challenging behaviors, and chronic disease self-management that can reduce the need for high cost services and admissions into hospitals, emergency rooms, and nursing homes. The Family Care program incorporates these efforts along with the capability of managing costs.

> The Family Care program's managed care model provides quality care for less cost that the Fee-For-Service system and legacy waiver programs. Family Care members also have lower Medicaid expenditures than members of legacy waiver programs. Further, the average Medicaid costs for Family Care members have been declining annually. The impact of Family Care's service and funding models reach

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[74] Wisconsin Department of Health Services. (2014). *Long-term care in motion: Wisconsin's long-term care programs: 2012 annual report*. Madison, WI: Wisconsin Department of Health Services, Division of Long-Term Care.

[75] Ibid.

[76] Wisconsin Department of Health Services. (2013). *Joint committee on finance: Long-term care expansion report*. Madison, WI: Wisconsin Department of Health Services.

[77] Ibid.

beyond the services that managed care organizations manage directly: the average cost of physician, hospital, personal care, and other acute and primary care services for Family Care members have also declined over the last three years. (Wisconsin Department of Health Services, 2013, p. 43-44)[78]

In contrast to Arizona and Wisconsin, California, Tennessee, and New Mexico are three states that have recently reformed existing/transitioned to managed LTC programs.

California's Medicaid program, Medi-Cal, transitioned many of its seniors and persons with disabilities (SPDs) from FFS care to mandatory Medicaid managed care between 2011 and 2012.[79] The Kaiser Commission on Medicaid and the Uninsured (2013)[80] evaluated this transition and determined that although managed LTC systems can increase access to care in the long-term, initial disruptions in care during the transition period can be significant. This review further revealed some of the major challenges Medi-Cal faced during the transition, including: issues during the data transfers due to incomplete or out-of-date beneficiary contact information and patient privacy provisions; barriers to recruiting both primary care and specialty providers with expertise in complex care; serving a population with more complex and frequent care coordination needs with primary care providers reporting insufficient training in care coordination; and lack of reimbursement for some providers and capitation rates potentially not covering actual SPD costs.[81]

Tennessee's reformed managed LTC program, TennCare CHOICES, was launched in 2010.[82] TennCare CHOICES was designed to improve quality and coordination of care and to expand the availability of HCBS.

> The new CHOICES program utilizes the existing Medicaid MCOs to provide eligible individuals with nursing facility services or home and community based services. Tennessee is now one of the few states in the country to deliver managed Medicaid long-term care and the only state to do so in a manner that does not require enrollees to change their MCO. (Bureau of TennCare, p. 7)[83]

Since the program's implementation, TennCare has had more members choose HCBS, a trend that is expected to continue.[84]

New Mexico's new Medicaid program, Centennial Care, was fully implemented in 2014.[85] Centennial Care is a comprehensive delivery system for Medicaid that integrates physical,

[78] Ibid.

[79] Kaiser Commission on Medicaid and the Uninsured. (2013). *Issue brief: Transitioning beneficiaries with complex care needs to Medicaid managed care: Insights from California*. Washington, DC: Kaiser Family Foundation.

[80] Ibid.

[81] Ibid.

[82] Bureau of TennCare. *Fiscal year 2009-2010 annual report*. Nashville, TN: Bureau of TennCare.

[83] Bureau of TennCare. *2013 annual update report: Quality assessment and performance improvement strategy*. Nashville, TN: Bureau of TennCare.

[84] Bureau of TennCare, supra, note 82.

[85] New Mexico Human Services Department. (2014). *Centennial Care waiver demonstration: Section 1115 quarterly report: Demonstration year: 1 (1/1/2014 – (12/31/2014): Federal fiscal quarter: 1/2014*. New Mexico Human Services Department.

behavioral, and LTC services and aims to provide quality, cost-effective care.[86] According to the first quarter report:

> MCOs report sufficient access to physical health, dental, hospital, long-term care and transportation providers, but the lack of certain specialties (≤90%) was identified in some areas of the State, especially in the rural and frontier areas. (New Mexico Human Services Department, 2014, p. 7-8)[87]

> Based upon individual identified issues and on data received to date in reporting, it has been noted that some categories of providers are having difficulty with billing and the MCOs are having difficulty in paying some categories of providers/services. This appears to be related primarily to those providers and services new to Centennial Care such as long-term care, personal care service agencies, support brokers and behavioral health services. (New Mexico Human Services Department, 2014, p. 24)[88]

Close monitoring of the efficacy of the recent changes in state MMLTC programs is needed. Subsequent evaluations, especially comparative assessments, can help to guide future developments/policy.

Section 6. Managed Long-Term Care in Florida

Florida's managed LTC system has been evolving over the past couple of decades. Managed care for general health services under Florida's Medicaid program began in 1984; Florida's original managed LTC program, the Frail Elder Option, was implemented in 1987.[89] In 1998, another managed LTC option, the Florida Diversion Program, was executed in four Florida counties.[90] Eventually, in 2004, the Frail Elder Option was mandated to be folded into the growing Diversion Program.[91] The Diversion Program, which is commonly referred to as the Nursing Home Diversion program, was continuously expanded until it was authorized statewide in 2010.[92] Two agencies in Florida, the Department of Elder Affairs (DOEA) and the Agency for Health Care Administration (AHCA), monitored the Diversion Program. The Diversion Program has experienced various consequences and achievements. For example, Mitchell et al. (2006)[93] found that the Nursing Home Diversion program had higher hospital utilization rates than non-managed Medicaid-funded HCBS programs and higher costs than the Frail Elder Project, but one of the largest reductions in per member per month days in a nursing home compared to the other HCBS waiver programs.

> The Nursing Home Diversion program has successfully delayed participants' entry into nursing homes. Frail elders participating in the Nursing Home Diversion

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[86] Ibid.
[87] Ibid.
[88] Ibid.
[89] Saucier et al., supra, note 24.
[90] Ibid.
[91] Ibid.
[92] Saucier et al., supra, note 10.
[93] Mitchell, G., Salmon, J. R., 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.

program were more likely to delay entry into a nursing home than similar frail elders who were not enrolled in any Medicaid community-based waiver programs. Program participants also experienced shorter nursing home stays and were more likely to return to their homes to continue program services.

Although Nursing Home Diversion costs have exceeded the Medicaid Program's costs for other frail elders, these cost differences have narrowed due to recent rate reductions. When compared to other waiver programs, the Nursing Home Diversion program has higher costs but is more successful in delaying nursing home placements. Although the state could potentially serve Nursing Home Diversion participants in other programs, doing so could compromise their quality of life and strain the capacity of these other programs. (Office of Program Policy Analysis & Government Accountability, 2006, p. 1)[94]

Another report by the Office of Program Policy Analysis & Government Accountability (OPPAGA) (2010)[95] again supports that the Nursing Home Diversion waiver program had the highest effectiveness in delaying nursing home entry among the three relevant waiver programs (i.e., the Aged and Disabled Adult, Assisted Living for the Elderly, and the Nursing Home Diversion waiver programs), but also the highest associated costs.

In 2011, Florida lawmakers passed legislation to create the Statewide Medicaid Managed Care Program.[96] This program has two parts: the Managed Care Long-Term Care Program and the Managed Medical Assistance Program (MMA). In 2013, mandatory enrollment in the new state managed LTC program was initiated.[97]

Program implementation is occurring in phases across 11 regions of the state. Enrollment began in the first region on August 1, 2013 and will be completed in the last region by March 1, 2014. (Summer, 2013, p. 3)[98]

This program is monitored, again, by the DOEA and the AHCA.

AHCA negotiated contracts with seven managed care organizations (MCO), or plans, comprising six Health Maintenance Organizations and one Provider Service Network… Consumers in each region can choose between at least two plans.

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[94] Office of Program Policy Analysis & Government Accountability. (2006). *The nursing home diversion program has successfully delayed nursing home entry*. Florida Legislature, Office of Program Policy Analysis & Government Accountability. Retrieved from http://www.oppaga.state.fl.us/reports/pdf/0645rpt.pdf

[95] Office of Program Policy Analysis & Government Accountability. (2010). *The state could consider several options to maximize its use of funds for Medicaid home and community-based services*. Florida Legislature, Office of Program Policy Analysis & Government Accountability. Retrieved from http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1033rpt.pdf

[96] Summer, L. (2013). *Launch of Medicaid managed long-term care in Florida yields many lessons for consideration*. Washington, DC: Georgetown University, Health Policy Institute.

[97] Ibid.

[98] Ibid.

American Elder Care, the Provider Service Network, is the only plan operating in every region of the state… (Summer, 2013, p. 3)[99]

Once Florida's new managed LTC program will replace: the Long-term Care Community Diversion Program waiver; the Aged and Disabled HCBS waiver; the Assisted Living waiver; and the Channeling Program waiver.[100]

While some Medicaid beneficiaries already had been receiving long-term care services through managed care plans, the mandatory transition of large numbers of consumers who use long-term care services – the elderly and young adults with disabilities – from fee-for-service to managed care is unprecedented. (Summer, 2013, p. 1)[101]

The Program provides only nursing facility services and HCBS; non-LTSS Medicaid services (such as hospital and physician services) are the subject of a different managed care waiver application, which currently is under review by CMS. (National Senior Citizens Law Center, 2013, p. 2)[102]

The following services will be available under the Program: adult day health care, case management, homemaker, respite, attendant care, intermittent and skilled nursing, medical equipment and supplies, occupational therapy, personal care, physical therapy, speech therapy, transportation, adult companion, assisted living, behavior management, caregiver training, home accessibility adaptations, medication administration, medication management, nutritional assessment and risk reduction, and personal emergency response. (National Senior Citizens Law Center, 2013, p. 6)[103]

Summer (2013)[104] ascertained the following themes from stakeholder interviews following the first phases of implementation of the new managed LTC program in Florida:

A phased launch and other transition policies were helpful, but many details were unclear as operations began.

More lead time was needed to get contracts and provider networks in place, train staff and resolve billing and payment questions.

More than one-third of enrollees failed to choose a managed care organization, suggesting that more expansive information and counseling efforts are needed.

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[99] Ibid.
[100] Saucier et al., supra, note 10.
[101] Summer, supra, note 96.
[102] National Senior Citizens Law Center. (2013). *Summary of Florida's long term care managed care program*. National Senior Citizens Law Center.
[103] Ibid.
[104] Summer, supra, note 96.

The capacity of community-based organizations to assist consumers is tested as they lose staff to managed care organizations, contend with new administrative requirements and face uncertainty about future roles.

Stakeholders are concerned about whether case managers employed by managed care organizations will be advocates for enrollees or gatekeepers for plans.

The rollout of the Managed Medical Assistance program later in 2014 will affect all Long-Term Care enrollees, adding complexity to their coverage and posing challenges for service coordination.

Outstanding questions about program quality underscore the need for ongoing monitoring by all stakeholders.

Stakeholders question whether two key program goals can be achieved: promoting a shift to community-based services and improving quality while reducing costs. (Summer, 2013, p. 1)[105]

Future monitoring of the Florida Managed Care Long-Term Care Program will be of critical importance. Evaluations of cost-effectiveness and quality of care will be required, and continuous oversight and transparency of data will support program improvement.

Section 7. The Future of Managed Long-Term Care

There has been a major transition from various aging network-administered home and community-based LTC systems to HMO MLTSS, despite the fact that this movement's effect on cost-effectiveness and quality of care has not yet been fully determined. The literature indicates that the aging network, throughout the past 30 years, has done a relatively cost-effective job of developing a solid HCBS infrastructure.[106] Furthermore, many aging network area agencies and providers have demonstrated the capacity to assess older adults' needs, identify appropriate services, and administer cost-effective services within fixed budgets, and they have maintained roles for informal caregivers and created substantial political support.[107] Thus, more research, especially comparative studies, on this conversion is needed to determine efficiency.

Several states have had experiences with the actual process of transitioning to MLTSS from FFS care. If planned adequately, the transition process can be successful and produce minimal to no disruption. The findings from relevant research (e.g., on contracts, protocols, and monitoring systems) should be utilized by states that are planning such programs and will transition in the future. It has been made abundantly clear that stakeholders must be involved throughout the development and implementation processes of a managed LTC system. Realistic goals should be set by all parties involved. Other actions that could be advantageous during this time include: identifying   funding/capacity   shifts;   incentivizing   providers/participants;   insisting   on

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[105] Ibid.

[106] Kwak, J., & Polivka, L. J. (2014). The future of long-term care and the aging network. *Generations*, *38*(2), 67-73.

[107] Polivka, L., & Zayac, H. (2008). The aging network and managed long-term care. *The Gerontologist*, *48*(5), 564-572.

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accountability; ensuring equitable access; and facilitating transparency.[108] Technical support for providers, especially with billing practices and information systems, has also been noted as being of critical importance to a new program's success.

Large-scale quantitative studies are needed to better understand the effect of managed LTC programs on important outcomes such as cost reductions, access to care, utilization rates, and quality of care, especially over the long-term. It is important to note that since there is a lack of a nationally endorsed set of specific quality measures, states take highly unique approaches in their quality management programs.[109] Perhaps national regulation would allow for more comparative quality research between state programs in the future. Comparative research, in general, across different managed LTC systems may distill more applicable information for stakeholders and policy makers, especially since the continuous shift to managed LTC systems seems persistent. Additional research areas on managed LTC programs, such as the effects on caregivers/providers, should be explored.

Improved consumer education on MLTSS plans is also imperative. Case managers and providers must be able to effectively explain MTLSS plans to their consumers. Cultural and language barriers need to be addressed.

Transparency on the efficacy of MLTSS is necessary. State departments, researchers, providers, consumer, policy makers, stakeholders, and the public at large must be able to communicate honestly and openly about the outcomes of managed LTC programs so that everyone can be truly informed and so that a well-functioning system can exist.

Section 8. Conclusion

As the U.S.'s LTC system continues to evolve, the implementation of managed LTC programs is a potentially promising option for containing, or reducing, costs and improving access to care, especially HCBS. However, regulations must be established to ensure that such programs balance containing expenditures with adequately addressing and assessing the LTC needs of the consumers. Specific recommendations for the advancement of managed LTC programs include:

- Expanding LTSS to meet the demands of a growing older adult population
- Exploring the most effective methods to expand managed LTC coverage to individuals with serious and complex needs (especially individuals with physical/developmental disabilities)
- Continuing efforts to integrate services and coordinate care, delivery, and funding within managed LTC systems and to promote access to HCBS in particular
- Analyzing the nature of relevant cost savings to confirm that distribution of costs to other sectors is not occurring
- Gathering empirical, quantitative data to critically analyze the effect of such programs on access to care

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[108] Mitchell, G. E., Polivka. L., Rill, L., & Stivers, E. (2011). *Medicaid managed long-term care in Florida: A roadmap*. Tallahassee, FL: Claude Pepper Data Center.
[109] Saucier et al., supra, note 10.

- Carefully evaluating, and ensuring, the quality of care received under such programs
- Confirming that MCOs and providers are prepared to handle the unique needs of a LTC population
- Ensuring a competitive network of providers and services within such programs
- Lessening administrative burden (e.g., through technical assistance), especially during transitions
- Protecting providers (e.g., through raising reimbursement rates and providing incentives)
- Communicating more effectively with consumers and employing consumer education strategies to guarantee that individuals are able to navigate managed LTC systems
- Ensuring that consumers complaints and grievances are resolved quickly and efficiently
- Modifying/updating data collection systems to maximize efficiency
- Considering specific state demographics before generalizing models/policies
- Collecting reliable data on which to base capitation rates/contact arrangements when designing such programs
- Protecting consumer preference/choice, always
- Increasing program transparency
- Updating and conducting more comparative evaluation research on the emerging managed LTC programs in order to inform stakeholders, providers, policy makers, and the public

Managed LTC systems must provide care that is coordinated and consumer-focused if they are to be successful. It is essential, however, that as more program developments/modifications are made, that well-designed empirical evaluations are conducted to assess the continuing effects of managed LTC, especially on access to and quality of care.