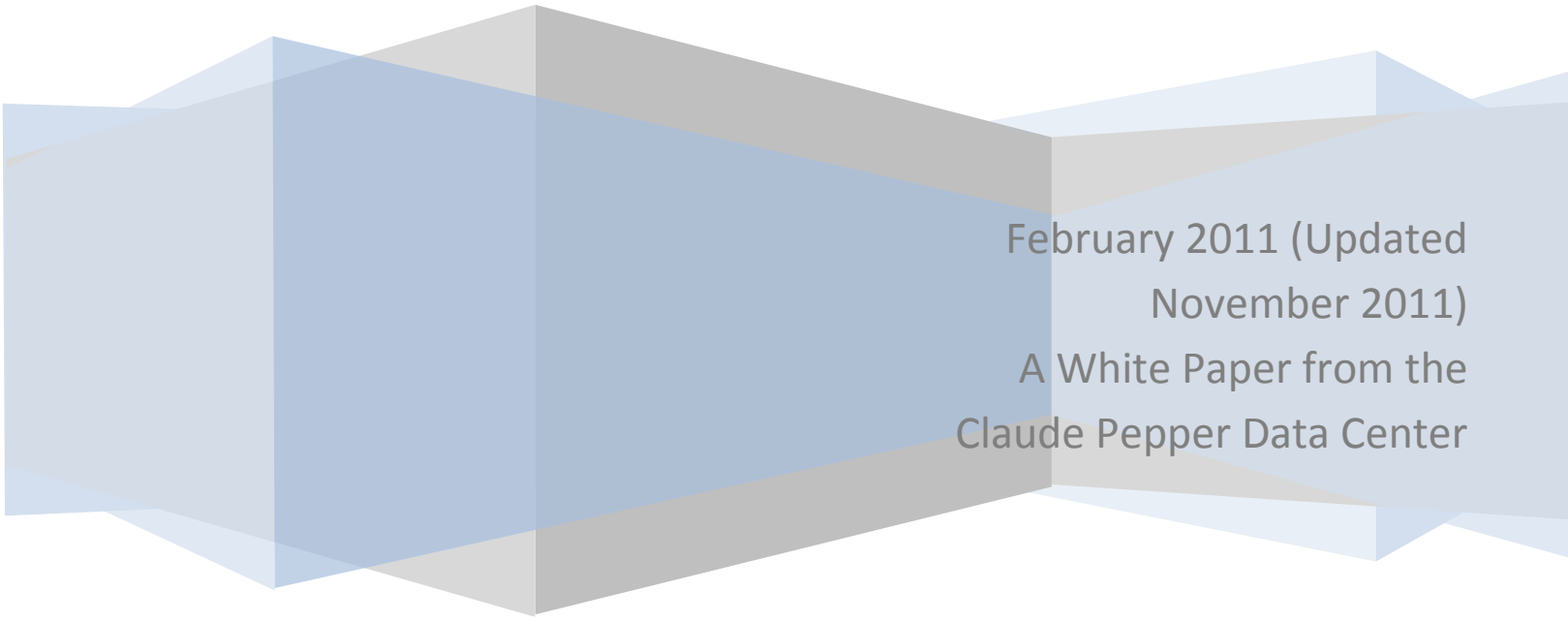
Medicaid Managed Long-Term Care in Florida: A Roadmap

Glenn E. Mitchell II, Ph.D.

Larry Polivka, Ph.D.

Lisa Rill, Ph.D.

Ed Stivers, Ph.D.



February 2011 (Updated November 2011)
A White Paper from the
Claude Pepper Data Center

Executive Summary

The aging of the Baby Boom generation will greatly increase the need for long-term care (LTC) services in Florida and add pressure to develop a more cost-effective system. Creation of a more effective LTC system will hinge on the State of Florida successfully confronting two major challenges.

The first challenge to long-term care policy makers is the huge projected increase in the older population over the next few years. This increase would double the need for long-term care services in 30 years.

The second challenge is the fiscal shortages facing the states and federal government. These deficits are likely to remain chronic over an extended period of time.

Meeting these challenges will require the State to create a more balanced long-term care system which is both more affordable and better designed than the current system to meet the growth in long-term care needs.

A recent proposal before the Florida Legislature for meeting these challenges was to shift the balance of LTC services to the less expensive home- and community-based services (HCBS) by developing a statewide managed LTC program at the local or regional level, operating under a capitated rate. This approach has been implemented in some form in 6 or 7 states including Florida with the Nursing Home Diversion (NHD) program. Other states have used both Health Maintenance Organizations (HMO) and aging network-based managed LTC strategies.

Regardless of which managed LTC strategy might be adopted, Florida should be prepared to address a common set of policy and administrative issues.

- It cannot be assumed that a major expansion of HCBS, whether through a managed LTC design or an expansion of the current system, will qualitatively reduce the Medicaid funded nursing home population. Florida's current nursing home population constitutes 2% of those aged 65 or older. This reflects successful state efforts to contain the growth of the nursing home population through the continuing Certificate of Need (CON) moratorium on new nursing home beds and the expansion of the Medicaid waiver-funded HCBS program especially NHD since 2000.

  Consideration should be given to expansion of HCBS programs. The number of persons needing LTC services and who are likely to be Medicaid eligible is set to increase. More HCBS slots will be required to provide the care needed.

- Plans for the future of Florida's LTC services system should not rely excessively on extensive utilization of assisted living. The typical profile of long term residents in assisted living and nursing homes is substantially different and likely will remain so. Regulatory and funding changes could turn assisted living into a slightly less regulated and slightly (if at all) less expensive version of nursing home care. This would undermine the greater autonomy, privacy and choice that have characterized assisted living over the last 20 years.

- Assisted living has gradually developed the capacity to serve a more impaired resident population, but it may now be approaching the threshold of resident impairment necessary to maintain its distinct difference from living in a nursing home.

  Assisted living facility (ALF) licensure in Florida underwent considerable change two decades ago, resulting in the introduction of the Extended Congregate Care (ECC) license. Current regulations and statutes leave many nursing home residents ineligible for admission to an assisted living facility. Other criteria require that ALF residents be discharged as their health status changes. This is done to prevent ALFs from becoming poorly resourced nursing homes. The fact that ALFs are permitted to provide certain services also does not mean all are willing (or even able) to provide more intensive care. There are, for example, ALFs that can continuously monitor dementia residents who wander. There are many more that cannot.

  Expanding the range of permissible services for ALFs would require more staff and greater regulatory oversight, which would reduce the cost differences between ALFs and nursing homes. Changes to the regulatory framework that encourage rebalancing will require careful deliberation to ensure that they do not compromise resident safety.

- As the role of assisted living in the publicly supported LTC system expands, the State should be prepared to require the routine collection of more data on resident characteristics, services provided, quality of care and quality of life outcomes and costs. The systematic gathering of information will increase provider costs and raise payment rates, but the same rationale that justifies the extensive data gathering efforts in nursing homes increasingly applies to assisted living facilities. Policy makers and the public need to know more about the relative costs and outcomes of the state's wide range of LTC options. Uniform data systems are critical to the development of any strong program monitoring initiative.

- Mandatory enrollment in managed LTC is probably a necessary requirement for achieving a reasonable level of cost-effectiveness. This would inevitably entail a substantial loss of freedom for consumers in choosing the kind of care and service provider they might prefer. Florida has an obligation to ensure a competitive network of providers, if consumers will be required to join a Managed Care Organization (MCO) to receive Medicaid LTC services.

- The State of Florida will need to seriously consider setting a loss ratio minimum for MCO contracts for any type of managed LTC system. Without minimums or floors for services, service providers may face the risk of below-costs reimbursement rates.

- The State of Florida should consider the development of a strong case management component to be a priority for any managed LTC model that might be adopted. The managed LTC experience in Arizona, Massachusetts, Minnesota, Tennessee, Texas, and Wisconsin clearly indicates that the effectiveness of the managed care approach to administering LTC services is dependent on rigorous professionalized care management that systematically puts the interests of the consumer first.

- The relative absence of LTC services in rural areas of the State is likely to continue under a managed LTC system, barring some requirement that MCOs operating in urban areas also include members living in rural communities. Arizona officials discovered that for-profit MCOs would not extend coverage to rural areas without this kind of requirement.

- Many LTC experts point to the inherent conflict of interests when providers also control points of access to care and determine what services a consumer will receive and from whom. Arizona has addressed this issue by making state employees responsible for these access processes. In Arizona and Wisconsin, the Aging Resource Centers (ARC) and Aging and Disability Resource Centers (ADRC) handle the consumer choice counseling. Other states allow enrollees to choose a health plan from specific organizations and the types of services provided depend on which organization the individual selects.

- The development and administration of any type of managed LTC system is a complicated and patience-testing task and success is dependent on the participation and support of many organizations and actors. Managed care approaches based on primary/acute care models are not very applicable to the delivery of LTC services, because LTC services are characterized by many more moving parts, intricate human and organizational relationships, longer time periods over which care is often provided, and a focus on maintaining functional capacities rather than curing a treatable medical condition.

  Involving a broad range of LTC stakeholders in the planning and development of a managed LTC system will help design a program that is responsive to the realities of LTC and that will gain the support of critical stakeholders in the LTC community. It is especially important that the planning and development process be informed by the full participation of professionals and advocates from the entire continuum of LTC providers and patient advocacy organizations, including nursing homes, assisted living facilities, and Florida's aging network.

Foreword

The mission of the Claude Pepper Data Center is to provide Florida policymakers with accurate and relevant information on different subpopulations, especially the aged. Consistent with that mission, we have prepared this white paper to assist legislators and other policymakers with their deliberation on the future of long-term care in Florida. This white paper takes no position on the proposed policies; it instead raises important considerations related to possible reshaping of long-term care in Florida.

There have been recent proposals before the Florida Legislature to rebalance facility-based long-term care (LTC) from nursing homes to community care -- including Home and Community-Based Services (HCBS) and assisted living facilities (ALFs). Florida legislators have also expressed interest in managed care as a cost-saving alternative for Medicaid LTC services.

Six states (Arizona, Massachusetts, Minnesota, Tennessee, Texas, and Wisconsin) have practical experience with Medicaid managed LTC. The focus in each state varies between a mix of for-profit and not-for-profit managed care organizations (MCOs).

Managed care is not a sure remedy against increasing care costs. Allowance for administrative expense and profit can offset (and even exceed) expected cost-savings. In addition, rigorous accountability for outcomes is necessary to prevent cost-savings that result from inadequate care. Consumers also need relevant information to select a provider that best suits their needs.

A proposal during the 2010 regular session of the Florida Legislature assumed that nursing home residents receiving Intermediate Care I/II services could instead receive appropriate care in an ALF. This white paper will examine that assumption.

It is clear that considerable overlap exists between the frailty and impairment of Florida's ALF and nursing home populations. A nursing home resident, however, is not necessarily a candidate for assisted living. Their need for medical care is often too great. An ALF resident who requires only occasional nursing services of low intensity and duration is very different from most nursing home residents.

In theory, some nursing home residents receiving custodial care could be appropriately served in ALFs. There is considerable, important variation in the frailty and impairment levels among persons receiving intermediate care services. Not all of the individuals can be safely cared for in just any residential setting. In practice, shifting to ALFs increasingly for intermediate care services will be a challenge in many areas of the State. There are large areas of the State that are unserved or underserved due to lack of available ALF beds. One reason this occurs is that many assisted living providers are not willing to accept Medicaid reimbursement rates for assisted living. There are also significant differences in staffing and regulatory oversight of ALFs compared with nursing homes that will require change, if higher acuity residents are to be cared for in an ALF setting.

Table of Contents

List of Tables

Introduction

Passage of the Affordable Care Act left many policy questions related to the delivery and funding of LTC largely unanswered. The individual states, such as Florida, face serious demographic and economic challenges that require them to consider dramatic changes in how LTC services are organized, funded, and delivered.

Nearly two-thirds of Americans over age 65 will require long-term care. This includes care in their home, adult day health care, assisted living facility services, or some form of nursing home care. Many believe that LTC services are limited largely to the aged. However, 40 percent of people currently receiving long-term care services are persons younger than 65.[1]

Florida faces severe economic challenges, including the costs of facility-based LTC. Median cost in the U.S. for nursing home care increased by 4.5% annually over the past five years. The median annual cost of care for a nursing home resident was $60,225 during 2005. By 2010, median cost had risen to $75,190.[2] The U.S. median cost for assisted living facilities was $3,185 per month in 2009[3], or about half the cost of nursing home care.

A proposal during the 2010 Florida Legislature assumed that nursing home residents receiving primarily custodial services could instead receive appropriate care in an ALF. Assisted living provides personal care and basic health services for people who require assistance with activities of daily living (ADLs), such as bathing and dressing. *Assisted living is not an alternative to nursing home services for most current nursing home residents. It is an intermediate level of care, appropriate for individuals who want greater independence and do not require constant nursing care or intensive medical attention.*

The "typical" longer term (six months or longer) nursing home resident is not likely to be a candidate for assisted living, given the current regulatory framework and funding levels. Their need for medical care is too great.[4] During the 2010 session, the Florida Legislature considered elimination of Limited Nursing Services (LNS) licenses for ALFs. This same proposal would have required Medicaid providers have only a basic ALF license and a signed agreement with a nursing home or nursing service for 24 hour on-call availability. An ALF resident who requires only occasional nursing services of low intensity and duration is very different from the "typical" nursing home resident. If Florida is to rely more on residential care and less on institutional care, then increased funding, regulatory standards for medical care oversight and monitoring of ALFs are required to ensure that residents receive all of the care they need. It should be noted, however, that significant increases in regulatory requirements and staffing standards will not

[1] U.S. Department of Health and Human Services, National Clearinghouse for Long-Term Care Information, 10/22/08.

[2] *Genworth 2010 Cost of Care Survey*, April 2010.

[3] Ibid.

[4] See 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, 483- 494. Long-term nursing home residents had greater impairment in terms of activities of daily living (ADLs) than Medicaid HCBS participants, especially with regard to transitioning, eating, and toileting.

only increase cost, but will also tend to blur the distinction between nursing homes and ALFs in terms of day-to-day life.

It is also important to note that the trend in costs for assisted living has changed considerably in recent years. Efforts by the State of Florida to transition nursing home residents back to the community and to delay or divert admission to a nursing home have required ALFs to offer a wider range of care. Many ALFs now provide services to residents who need continual supervision – while still providing a lower level of care to their healthier individuals. As the range of care among ALFs becomes broader, so will the range of monthly costs. U.S. median for ALF care increased annually on average by 6.7% between 2005 and 2010. Between 2009 and 2010, the increase was 12% (among nursing homes, the costs increased by 5.1%). As a consequence, over the past 10 years, the costs of ALF relative to nursing home care have increased from approximately 50% to 63% in 2010. Table 1 provides a comparison of the rates for various LTC services.

The purpose of this white paper is to provide pertinent information regarding the possible reshaping of LTC in Florida. There are four main sections to this paper. First is a description of Florida's LTC environment (with specific focus on Nursing Facilities and ALFs). The second section explains federal and state regulations for nursing facilities and ALFs in select states. Section three discusses the critical considerations for the rebalancing of Florida's LTC. The final section identifies the practices and lessons from the managed LTC programs in six states that have over a decade or more of experience with developing and implementing innovative Medicaid managed long-term care systems: Arizona, Massachusetts, Minnesota, Tennessee, Texas, and Wisconsin. The paper concludes with 12 mileposts that we believe will be critical to a successful implementation of Medicaid managed long-term care in Florida.

Table 1
Genworth Cost of Care Survey 2011

		Minimum Rate	Maximum Rate	Median Rate	Median Annual Rate	Six-Year Annual Growth Rate
USA	Homemaker Services	$9[1]	$34[1]	$18[1]	$41,184	2%
	Home Health Aide	$10[1]	$34[1]	$19[1]	$43,472	1%
	Adult Day Care	$15[2]	$160[2]	$60[2]	$15,600	n/a
	Assisted Living Facility	$674[3]	$9,500[3]	$3,261[3]	$39,135	6%
	Nursing Home (semi-private)	$85[2]	$826[2]	$193[2]	$70,445	5%
	Nursing Home (private)	$89[2]	$826[2]	$213[2]	$77,745	4%
Arizona	Homemaker Services	$15[1]	$23[1]	$18[1]	$41,184	1%
	Home Health Aide	$15[1]	$24[1]	$19[1]	$44,044	1%
	Adult Day Care	$62[2]	$96[2]	$80[2]	$20,800	n/a
	Assisted Living Facility	$1,550[3]	$5,500[3]	$3,000[3]	$36,000	4%
	Nursing Home (semi-private)	$145[2]	$235[2]	$175[2]	$63,875	3%
	Nursing Home (private)	$162[2]	$300[2]	$217[2]	$79,114	4%
Florida	Homemaker Services	$11[1]	$26[1]	$17[1]	$38,896	2%
	Home Health Aide	$12[1]	$26[1]	$18[1]	$41,184	1%
	Adult Day Care	$35[2]	$96[2]	$60[2]	$15,600	n/a
	Assisted Living Facility	$674[3]	$6,663[3]	$2,663[3]	$31,950	5%
	Nursing Home (semi-private)	$159[2]	$292[2]	$210[2]	$76,778	5%
	Nursing Home (private)	$169[2]	$360[2]	$230[2]	$83,950	5%
Massachusetts	Homemaker Services	$17[1]	$25[1]	$23[1]	$51,480	3%
	Home Health Aide	$18[1]	$28[1]	$25[1]	$56,628	3%
	Adult Day Care	$48[2]	$81[2]	$60[2]	$15,600	n/a
	Assisted Living Facility	$1,900[3]	$7,323[3]	$4,950[3]	$59,400	5%
	Nursing Home (semi-private)	$200[2]	$412[2]	$320[2]	$116,800	4%
	Nursing Home (private)	$220[2]	$474[2]	$345[2]	$125,925	4%
Minnesota	Homemaker Services	$15[1]	$26[1]	$22[1]	$50,336	2%
	Home Health Aide	$15[1]	$30[1]	$26[1]	$58,916	2%
	Adult Day Care	$44[2]	$119[2]	$66[2]	$17,051	n/a
	Assisted Living Facility	$1,051[3]	$9,150[3]	$3,100[3]	$37,200	5%
	Nursing Home (semi-private)	$154[2]	$253[2]	$185[2]	$67,583	6%
	Nursing Home (private)	$161[2]	$278[2]	$210[2]	$76,796	7%

[1]Hourly Rate
[2]Daily Rate
[3]Monthly Rate

Table 1 (cont.)

		Minimum Rate	Maximum Rate	Median Rate	Median Annual Rate	Six-Year Annual Growth Rate
Tennessee	Homemaker Services	$11[1]	$22[1]	$17[1]	$37,752	2%
	Home Health Aide	$11[1]	$23[1]	$17[1]	$38,896	1%
	Adult Day Care	$30[2]	$110[2]	$50[2]	$13,000	n/a
	Assisted Living Facility	$1,300[3]	$5,300[3]	$3,080[3]	$36,960	8%
	Nursing Home (semi-private)	$111[2]	$215[2]	$170[2]	$62,050	4%
	Nursing Home (private)	$125[2]	$237[2]	$181[2]	$65,883	4%
Texas	Homemaker Services	$10[1]	$28[1]	$17[1]	$38,896	2%
	Home Health Aide	$10[1]	$28[1]	$18[1]	$41,070	2%
	Adult Day Care	$15[2]	$80[2]	$30[2]	$7,800	n/a
	Assisted Living Facility	$1,100[3]	$7,650[3]	$3,210[3]	$38,520	5%
	Nursing Home (semi-private)	$85[2]	$280[2]	$127[2]	$46,355	4%
	Nursing Home (private)	$100[2]	$380[2]	$165[2]	$60,225	3%
Wisconsin	Homemaker Services	$16[1]	$27[1]	$20[1]	$44,616	3%
	Home Health Aide	$16[1]	$29[1]	$21[1]	$46,904	2%
	Adult Day Care	$20[2]	$96[2]	$59[2]	$15,210	n/a
	Assisted Living Facility	$1,324[3]	$7,000[3]	$3,550[3]	$42,600	6%
	Nursing Home(semi-private)	$150[2]	$332[2]	$218[2]	$79,475	5%
	Nursing Home (private)	$165[2]	$379[2]	$241[2]	$87,783	5%

[1]Hourly Rate
[2]Daily Rate
[3]Monthly Rate

Florida's Long-Term Care Environment

Florida Medicaid participants receive LTC through a collection of mandatory state plan services, optional state plan services, fee-for service HCBS waivers, and managed care waivers. The assorted waivers differ dramatically in the populations they serve, covered benefits, enrollment requirements, and geographic availability.

Under federal Medicaid rules, states must offer certain services, known as mandatory benefits. States also have the flexibility to offer other services, known as optional benefits. After receiving permission from the Center for Medicare and Medicaid Services (CMS), states may also implement waivers that "waive" certain Medicaid requirements (such as freedom of choice to select providers); although, the provisions that may be waived do vary by type of waiver. HCBS waivers, as a primary feature, offer services that are not available to non-waiver participants that are provided in a participant's home or in a community-based setting as an alternative to institutional services. Florida's HCBS waivers that serve predominantly the aged require participants to have demonstrated a continuing need for skilled nursing care or supervision (i.e., meet nursing home level of care requirements). With some exceptions, children with complex medical problems, adults with specific physical disabilities (such as spinal cord injury) or conditions (such as AIDS), and persons with intellectual and developmental disabilities (IDD) are served with a different array of HCBS waivers.

While states vary in regard to the optional services they cover, all of the states offer HCBS waiver and intermediate nursing home care services.

Table 2 summarizes the Florida Medicaid experience for skilled nursing home care and for the optional benefits especially relevant to a discussion of LTC services.[5]

Florida's HCBS expenditures (including home health, and HCBS waivers) for the aged and disabled (excluding people with IDD) accounted for 20% of all Medicaid LTC optional services in 2009. In 2002, only 7% of Florida Medicaid LTC services were HCBS. The national average, however, was 34% in 2009. Nursing home expenditures in Florida grew from $1.87 billion to over $2.4 billion during the same time.[6]

The primary purposes for Medicaid HCBS waivers are to prevent or delay institutional placement (for example, residency in a nursing home) and to enhance quality of life by enabling individuals with physical and/or cognitive impairments to receive needed care while they remain at home or in a community-based residential setting (e.g., ALF, family care home, etc.).

[5] The counts of participants are not unduplicated. Medicaid participants can move among mandatory and optional benefit services during a year.

[6] Higher nursing home staffing requirements imposed by the Florida Legislature drove a large portion of this increase.

Table 2
The Use of Certain Medicaid Services in Florida in FY 2009-2010

Benefit	Average Monthly Number of Services	Average Monthly Cost per Service	Total FY 2009-2010 Expenditures
Hospital Insurance Benefits (dually eligible recipients)	15,189	$747.26	$136,201,944
Skilled Nursing Home	10,167	$5,733.00	$699,448,505
ICF-I Nursing Home	30,943	$5,314.73	$1,973,444,829
ICF-II Nursing Home	1,202	$5,442.01	$78,495,484
Medicare Part D	307,061	$66.97	$246,759,766
Supplemental Medical Insurance	620,704	$139.38	$1,038,188,128
State Mental Hospitals	49	$14,008.06	$8,236,742
ICF/MR Sunland	735	$11,450.85	$100,996,473
ICF/MR Community	2,006	$9,500.10	$228,686,522
Hospice	13,673	$1,983.29	$325,409,675
Home & Community Based Services*	714,187	$124.92	$1,070,582,824
Adult Living Facility	7,239	$346.56	$30,104,972
Dialysis Center	10,994	$131.84	$17,393,152
Assistive Care Services	14,194	$164.81	$28,071,859
Capitated Nursing Home Diversion	16,978	$1,531.83	$312,088,961
Private Duty Nursing Services	79,877	$192.12	$184,150,170
*See Appendix for individual services			

Note: For any nursing home, Medicaid pays the same rate for Skilled, ICF-I and ICF-II. The apparent differences in amount paid per month are due to rate differences from one nursing home to another. Persons receiving Skilled Care evidently are located in facilities with higher per diem rates.

Sources: Medicaid Services and Expenditures Forecast, Social Services Estimating Conference (17 December 2010); Nursing home residents and potential cost savings measures, Office of Program Policy Analysis and Government Accountability, Presentation to the Florida Senate Subcommittee on Health and Human Services Appropriations. January 2011.

To be eligible for the following HCBS waivers, individuals must meet the medical and financial criteria to qualify for Medicaid nursing home services. Each waiver has additional eligibility criteria.

In FY 2009-2010, the Florida Department of Elder Affairs administered five Medicaid LTC waiver programs for seniors:

- Aged and Disabled Adult Waiver;
- Alzheimer's Disease Waiver;
- Assisted Living for the Elderly Waiver;

- Channeling Waiver;
- Comprehensive Adult Day Health Care Waiver; and
- Nursing Home Diversion Waiver.

The Florida Department of Elder Affairs also administers the Program of All-Inclusive Care for the Elderly (PACE), an optional State Plan service which provides Medicare and Medicaid services, managed by a single provider who receives capitated Medicare and Medicaid payments. PACE primarily provides multidisciplinary care management and services at an adult day health care center. PACE also delivers some home services.

The Channeling Waiver provides services only in Broward and Miami-Dade counties. The Adult Day Health Care Waiver provides services in only Lee and Palm Beach counties. The Nursing Home Diversion waiver operates in 46 counties. PACE currently operates in Miami-Date, Lee and Pinellas counties. All other waivers are approved to operate statewide, although providers might not be readily available in some areas of the state.

HCBS waivers provide services such as case management, personal care, therapies, respite care, and caregiver/family training to help participants remain in their home or in a community setting and reduce the stress and burden on caregivers. The services are available statewide through the state's service-provision network for the elderly.

Medicaid LTC waivers are funded through a combination of state general revenue, federal Medicaid dollars, and the Tobacco Settlement Trust Fund. For Fiscal Year 2009-10, the Legislature appropriated the amounts shown in Table 3 for certain Medicaid services for the aged.

Table 3
Appropriations for Certain Medicaid Services for FY 2009-2010

Waiver	General Revenue	Medicaid Funds	Tobacco STF	Total
Nursing Home Diversion[1]	$109,434,313	$228,743,416		$338,177,729
Aged & Disabled Adult	20,217,055	58,980,275	$8,000,000	87,197,330
Assisted Living for the Elderly	6,379,591	23,786,017	5,000,000	35,165,608
Channeling	4,757,166	9,943,596		14,700,762
Alzheimer's Disease	1,624,540	3,395,669		5,020,209
Comprehensive Adult Day Health Care	630,003	1,316,855		1,946,858
Total	$143,042,668	$326,165,828	$13,000,000	$482,208,496

[1] The appropriation for the NHD Waiver includes $10,278,683 for the Program of All-inclusive Care for the Elderly
Source: Government Program Summaries, Office of Program Policy Analysis and Government Accountability.

In addition to major increases in HCBS waiver expenditures since 2002, Florida has implemented several initiatives designed to facilitate LTC rebalancing. These include the integration of intake and referral services for the elderly and adults with disabilities through a single point of access system (Aging & Disability Resource Connections) and a rapid expansion of Florida's managed LTC program (i.e., Nursing Home Diversion).

Along with the expansion of HCBS waiver programs since 1995, Florida's nursing home population growth has also been constrained by a legislatively imposed freeze on the awarding of Certificate of Need (CON) for additional Medicaid-funded nursing home beds since 2001. The average Medicaid monthly nursing home caseload was 45,573 in FY 1995-96, 47,058 in FY 2000-01 and 42,661 in FY2009-10. The CON freeze has contributed to a steady increase in the nursing home occupancy rate, which is now approaching 90% on a statewide basis.

Florida's progress in rebalancing has been uneven. Access to HCBS alternatives has progressed faster in more urban counties and slower in the more rural counties. This is especially true for the managed long-term care program, Nursing Home Diversion, which serves approximately one-half of Florida's counties (generally the most urban counties and adjoining counties).[7]

According to several recent assessments of state initiatives to create more balanced long-term care systems, creating and integrating organizational structures at the state and service delivery levels to administer all public long-term care resources (nursing home and HCBS funds) is probably the most important single factor in the development of HCBS-oriented long-term care systems (Kassner, Reinhard, Fox-Grage, Houser & Accius, 2008;[8] Kane, Kane, Priester & Homyak, 2008;[9] Alecxih, 2008;[10] Gage, Brown, Katutsky, Moore and Auerbach, 2002;[11] and Eiken, Nadash & Burwell, 2006).[12]

Consolidating responsibility and accountability for all state long-term care services in a single administrative structure makes it possible to manage a global budget which includes all long-term care-related resources and allows states to transfer funds among programs. This capacity enhances a state's ability to serve people in the setting they prefer that meets their care needs. Many long-term care policy experts consider this the most important factor in the creation of more balanced long-term care systems (Kassner, Reinhard, Fox-Grage, Houser & Accius, 2008;[13] Kane, Kane, Priester & Homyak, 2008).[14] Only two states (Oregon and Washington) have fully integrated control over all long-term care programs and funds, including the Medicaid Nursing Home Program in their state aging and adult services

---

[7] Kearns, W, Mitchell, G, & Kwak, J. Urban/Rural Disparities in HCBS Case Planning and Service Delivery: The Florida Experience. Unpublished article, University of South Florida, 2006. (see http://www.fdhc.state.fl.us/Medicaid/quality_management/workgroups/nursing_home/4_history_fl_nf.pdf)

[8] Kassner, E., Reinhard, S., Fox-Grage, W. Houser, A. & Accius, Coleman, B. et al. (2008, July). *A balancing act: State long-term care reform*. AARP Public Policy Institute. http://www.aarp.org/ppi (accessed Aug. 5, 2008).

[9] Kane, R.A., Kane, R.L., Priester, R. & Homyak (2008). *Research on state management practices for the rebalancing of state long-term care systems: Final report.* Submitted to the Division of Advocacy and Special Initiatives, Centers for Medicare & Medicaid Services: Washington, DC.

[10] Alecxih, L. (2008). Can *home and community-based services be expanded without busting the budget?* Presented by the Lewin Group at the 2008 National Academy for State Health Policy Conference: Tampa, FL.

[11] Gage, B., Brown, D., Katutsky, G., Moore, A & Auerbach, D. (2002). *Creating more balanced long-term care systems: previews of case studies on the role of the national aging services network.* Prepared by Research Triangle Institute for the Administration on Aging: Washington, DC.

[12] Eiken et al. supra.

[13] Kassner, E., Reinhard, S., Fox-Grage, W. Houser, A. & Accius, Coleman, B. et al. (2008, July). *A balancing act: State long-term care reform*. AARP Public Policy Institute. http://www.aarp.org/ppi (accessed Aug. 5, 2008).

[14] Kane, R.A., Kane, R.L., Priester, R. & Homyak (2008). *Research on state management practices for the rebalancing of state long-term care systems: Final report.* Submitted to the Division of Advocacy and Special Initiatives, Centers for Medicare & Medicaid Services: Washington, DC.

agencies. In other states, including Florida, the management of long-term care programs is split between departments of aging/senior services (home- and community-based programs) or aging and disability services agencies *and* the agency, division or departments housing the Medicaid program. The Medicaid program, in effect, controls on average 70 to 80% or more of all long-term care resources. Table 4 provides a list of the savings per dollar invested for each of the HCBS programs in Florida.[15]

Table 4
Risk Adjusted Cost Savings of Home and Community Based Programs in Florida

Program	Savings per Dollar Invested
Nursing Home (NH-XIX)	$0.00
Nursing Home Diversion Program (NHD-XIX)	$1.28
Assisted Living Waiver (ALW-XIX)	$2.55
Program for All Inclusive Care for the Elderly (PACE-XIX)	$0.32
Alzheimer's Disease Initiative (ADI-GR)	$3.55
Aged and Disabled Adult Waiver (ADA-XIX)	$1.42
Adult Day Health Care Waiver (ADC-XIX)	$0.49
Channeling Program (CHN-XIX)	$0.94
Community Care for the Elderly (CCE-GR)	$3.04
Home Care for the Elderly (HCE-GR)	$4.42
Older Americans Act Programs (OAA-FED)	$2.87
Local Service Program (LSP-GR)	$1.33

An alternative method of integrating long-term care authority, a method that does not require a single state agency with complete control over policy and all long-term care funds, is to develop a managed LTC program at the local or regional level and operate it under a capitated rate based on all major long-term care funding sources, including Medicaid nursing home funds. The capitation rate could be constructed through negotiation between representatives of the aging network, under the leadership of the state aging unit and the state's Medicaid office and then incorporated into a contract. Wisconsin has taken this approach with the Wisconsin Family Care Program, and the Arizona Long Term Care System (ALTCS) has operated a Medicaid managed long-term care system statewide for several years.[16]

[15] Neu, Ed. 2011. *Overview of Service Demand and Funding*. Department of Elder Affairs.

[16] Weissert W.G., Lesnick, T., Musliner, M. & Foley, K.A. (1997). *Toward a strategy for reducing potentially avoidable hospital admissions among home care clients.* Medical Care Research and Review. 54(4): 439-55.

Statutory and Regulatory Environment

Federal Nursing Facility Regulations

Overview

States uniformly impose requirements on any facility holding itself out to be a "nursing home" or "nursing facility" through the licensing process. In addition, any nursing facility that participates in the Medicare or Medicaid programs is required to meet specific federal requirements. These requirements are referred to as Conditions of Participation (COPs) and facilities that meet these requirements are referred to as "Medicare certified."

Medicare requirements, specified in Title XVIII of the Social Security Act (SSA), define a single type of nursing facility – a skilled nursing facility. This is because Medicare pays only for skilled care or rehabilitation.

Medicaid requirements, specified in Title XIX of the SSA, define a nursing facility as a facility which may provide skilled care or rehabilitation, or care "above the level of room and board," often called "custodial care" or "intermediate care."

In order to be Medicare certified, a facility must meet nursing home COPs (minimum standards). The COPs are specified in 42 CFR Part 483, Subpart B – Requirements for Long Term Care Facilities. Requirements cover administration of the facility, services that must be provided, staffing, resident rights and quality oversight. Federal requirements for nursing care specify that a nursing facility provide sufficient staff and services to attain or maintain the highest possible level of physical, mental and psychosocial well-being of each resident. A nursing facility must ensure the presence of one registered nurse (RN) for eight consecutive hours, seven days per week and one RN or licensed practical nurse for the two remaining shifts.[17]

Medicare certification is required in most states, even if a facility participates in the Medicaid program but not the Medicare program. Ninety-five percent of United States nursing homes are Medicare certified and participate in both Medicare and Medicaid. Only 2.8 percent are Medicaid-only facilities and 2.25 percent are Medicare-only.

Medicaid Coverage of Nursing Home Services

In order for state Medicaid programs to receive the federal share of the cost of any Medicaid services (including nursing facility services), a state must have a method to ensure that these services are provided only to those Medicaid eligible persons who need them.[18] The federal government also requires that prospective residents be screened for the presence of a serious mental illness or mental retardation (or related condition) and if present, be assessed in order to determine if nursing home

[17] Federal Nursing Home Reform Act (NHRA), as part of the Omnibus Budget Reconciliation Act (OBRA) of 1987

[18] The person must also be Medicaid eligible and receive the services from a qualified nursing home enrolled in a state's Medicaid program.

admission is appropriate. This screening and assessment is referred to as preadmission screening and resident review or PASRR. PASRR is a two-step process as described in the PASRR section of this report.

Nursing Facility Level of Care Criteria

Level of care (LOC) is a classification system used to determine a person's need (medical necessity) for specific services. LOC is generally used to determine need for residential or institutional services, such as hospitals, nursing homes, and intermediate care facilities for persons with mental retardation (ICFs/MR). LOC is a requirement imposed by programs (such as Medicare and Medicaid) and companies (such as insurance companies) that pay for this care in order to ensure the care is necessary and should be reimbursed.

The Medicare program covers skilled nursing facility care only for a stay in that facility following a stay in a hospital, and for a limited period of time following the hospitalization. Skilled nursing facility care is care that requires the involvement of skilled nursing or rehabilitative staff in order to be given safely and effectively. Skilled nursing and rehabilitation staff includes registered nurses, occupational therapists, licensed practical and vocational nurses, physical and occupational therapists, speech-language pathologists, and audiologists.

Prior to 1987, there were two levels of care covered by Medicaid - intermediate and skilled. Different staffing requirements applied to these two levels of care. In 1987, federal law revised Medicaid nursing home requirements so that all nursing homes were required to provide 24/7 nursing coverage by, at a minimum, licensed practical nurses and the distinction between intermediate and skilled levels of care for survey and certification purposes was ended.

Care Provided in Nursing Facilities

Today, most Medicaid nursing homes provide skilled care that consists of nursing care and rehabilitative services as well as intermediate or "custodial" services. The distinction between skilled and intermediate care continues in some states in part because Medicare covers only skilled care (and only under specific circumstances).

Skilled nursing services are services that may only be provided by or under the supervision of a licensed nurse. Rehabilitative services consist of therapy services provided by licensed therapists, such as physical therapists, speech language pathologists and respiratory therapists and may also include rehabilitative services performed by nurses as permitted by their license.

Intermediate care services generally require the oversight of a licensed nurse and include intermittent nursing care and hands-on non-skilled care provided by nurse's aides. These services are above the level of room and board, which distinguishes assisted living (or board and care facilities) from a nursing facility; however, in some states the line between a nursing home and assisted living facility has become increasingly narrow.

Persons with Mental Illness in Nursing Facilities

Over a quarter of all nursing home residents have a mental illness. When comparing schizophrenia, bipolar disorder, depression and anxiety, Grabowski and colleagues found schizophrenia and bipolar

disorder to be the most disabling and most frequently associated with institutionalization.[19] The findings further indicate that at the national level, 27.4 percent of residents had one or more of the four diagnoses, while only 2.7 percent had either schizophrenia or bipolar disorder. The rates of schizophrenia and bipolar disorder among nursing home residents ranged from 1.2 percent in Wyoming to 3.7 percent in Illinois. If 50 percent or more of a nursing home population has a primary diagnosis of a mental illness, then that facility is considered an Institute for Mental Diseases (IMD). IMD's are not covered by Medicaid in Florida; therefore, the nursing home would lose its Medicaid provider status.

In 1987, Congress enacted the Preadmission Screening and Annual Resident Review requirements as part of the Omnibus Budget Reconciliation Act (OBRA). The intent was to ensure that persons entering nursing facilities with a mental illness or mental retardation or related condition, receive services appropriate to their needs. An annual review is no longer required so it is now referred to as PASRR.

PASRR

A Medicaid-certified nursing facility may not admit an applicant with a serious mental illness (MI) or with mental retardation (MR) or a related condition, unless the individual is assessed and found to be appropriate for nursing home placement. PASRR applies to anyone entering a nursing home who has or may have MI or MR, not just Medicaid recipients.

There are two levels of PASRR screening – Level 1 and Level 2.

> **Level 1** screening identifies individuals who are suspected of having a mental illness or mental retardation, or have a diagnosis of either, and who need to be subjected to further screening in order to be sure their needs can most appropriately be met in a nursing home.[20]
>
> **Level 2** screening consists of administration of an assessment to determine whether an individual requires the level of services provided in a nursing home and to determine if they also need "specialized services." Specialized services are the services needed related to a diagnosis of MI or MR. Persons determined to need specialized services as a result of a mental illness are generally those who have serious and persistent mental illness, rather than a person who has underlying depression that can be managed with medication and basic support. Diagnoses related to mid- to end-stage dementia are not considered diagnoses of mental illness.

When a person is determined to need specialized services, the state must provide these services. Some states permit specialized services to be provided to nursing home residents. Other states specify that these services are only available in an inpatient hospital or in an ICF/MR. The following section illustrates the specific requirements in each of the seven reviewed states.

Summary

While the federal government will only provide matching funds for Medicaid nursing home services when these services are determined necessary, each state develops the criteria used to determine necessity (level of care). States determine necessity based on clinical criteria, functional criteria

[19] David C. Grabowski, et al. Mental Illness in Nursing Homes: Variations Across States. Health Affairs. May – June, 2009. 28(3): 689–700.

[20] These requirements are contained in the Medicaid Manual located at the Center for Medicare and Medicaid Services (CMS) Internet site at: http://www.cms.gov/pasrr.

(capacity to perform activities of daily living) or both. Each state is required to ensure that persons with a mental illness or with mental retardation be screened to ensure nursing home placement is appropriate and to determine any need for specialized services to address their needs related to mental illness or mental retardation. States determine whether specialized services for persons who have a mental illness may be provided to nursing home residents or require placement in an alternate setting.

Federal and State-To-State Comparisons of Nursing Facilities

Level of Care

Each state specifies the medical and functional requirements for Medicaid coverage of nursing home level of care (LOC). Table 5 lists the LOC requirements for Medicare and for Medicaid programs in the seven reviewed states.

Table 5
Nursing Facility Level of Care

State	Nursing Facility Level of Care (LOC) Requirements	
Federal	Must require skilled care that can only be provided in a nursing home: Care that requires the involvement of skilled nursing or rehabilitative staff in order to be given safely and effectively. Skilled nursing and rehabilitation staff includes registered nurses, licensed practical and vocational nurses, physical and occupational therapists, speech-language pathologists, and audiologists.	
Arizona	Must have a score of at least 60 based on the outcome of the preadmission screen (PAS).	
Florida	Skilled: require medical, rehabilitation or nursing service that requires supervision, assessment, planning or intervention by an RN on a daily basis and in the case of rehabilitation services provided by a PT, OT or RT at least 5 days per week.	Intermediate I: requires extensive health related care and service and who are incapacitated physically or mentally. Intermediate II – require limited health related care and service and who are mildly incapacitated or ill to a degree to require medical supervision; individuals must be ambulatory and independent in ADLs and not require administration of psychotropic drugs or exhibit periods of disruptive or disorganized behavior requiring 24 hour nursing supervision.
Massachusetts	Skilled: provides 24-hour skilled nursing care and extensive rehabilitative care and services to the chronically ill as well as those who have been hospitalized and require a short period of medical monitoring and/or rehabilitation before returning home.	Nursing facility: provides 24-hour nursing care, rehabilitative services and activities of daily living to the chronically ill who require supportive nursing care and services.

Table 5 (cont.)

State	Nursing Facility Level of Care (LOC) Requirements	
Minnesota	Requires formal clinical monitoring at least once per day, assistance with at least 4 ADL's, memory or behavioral needs that require intervention, qualifying nursing facility stay of at least 90 days, at risk for falls or neglect at home, sensory impairment that substantially impacts functional ability and maintenance of a community residence.	
Tennessee	Level 1(Intermediate): Nursing Facility Care. The Pre-admission Evaluation form must be approved by the nurses in the TennCare LTC office.	Level 2: Skilled Nursing Facility Care. The Pre-admission Evaluation form must be approved by the nurses in the TennCare LTC office.
Texas	Skilled: Provides institutional nursing care for individuals whose medical condition requires the skills of a licensed nurse on a regular basis. The nursing facility must provide for the medical, nursing, and psychosocial needs of each individual, including room and board, social services, over-the-counter drugs (prescription drugs are covered through the Medicaid Vendor Drug program or Medicare Part D), medical supplies and equipment, personal needs items, and rehabilitative therapies. Daily Medicare skilled nursing facility co-insurance payments are also paid for those who are eligible for both Medicare and Medicaid.	

Table 5 (cont.)

State	Nursing Facility Level of Care (LOC) Requirements	
Wisconsin	Skilled: Services which require the skills of professional personnel such as registered or licensed practical nurses and that are provided either directly by or under the supervision of these personnel. A service is skilled if it can be safely and effectively performed only by or under the supervision of professional personnel.	Intermediate: Basic care consisting of physical, emotional, social and other rehabilitative services under periodic medical supervision. This nursing care requires the skill of a registered nurse for observation and recording of reactions and symptoms, and for supervision of nursing care.
PT: Physical Therapy *OT: Occupational Therapy* *RT: Respiratory Therapy* *ADL: Activity of Daily Living* *LTC: Long-term Care*		

Staffing Requirements

While federal regulations require that nursing homes have specific types of staffing and specify that nurses must be present in the nursing home daily, they do not require a specific number of hours of nursing care per resident per day. While reports have been provided to Congress recommending minimum staffing requirements for nursing homes to be imposed at the federal level, Congress has not enacted such requirements to date.

Some states have established minimum nursing ratios and hours of care. Table 6 presents the nursing staffing requirements in federal regulations and in the seven reviewed states. [21]

[21] The Florida Legislature has increased direct care staffing requirements substantially since 2002. According to an unpublished 2009 assessment by the University of South Florida, Florida Policy Exchange Center on Aging, ". . . quality of care has substantially improved in Florida nursing homes since 2001. Average deficiencies per facility have decreased. Importantly, the citations for serious deficiencies have decreased dramatically and remain lower than the national average. Measures of resident care outcomes have improved . . ."

Table 6
Nursing Facility Staffing Requirements

Federal or State	Sufficient Staff	Estimated Variance from Federal Standard for Facility with 100 Beds	Licensed Nursing Staffing Requirements	Nursing Aide or Assistant Staffing Requirements
Federal	To provide sufficient staff and services to attain or maintain the highest possible level of physical, mental, and psychosocial well-being of each resident	N/A	1 RN 8 consecutive hrs/7days/wk and 1 RN/LPN for 2 remaining shifts. Must have 1 RN who is full-time DON (5 days/wk); if fewer than 60 residents, DON may also be Charge Nurse. (For 100 residents, LN .30 hours per resident day (hprd) would be required.)	N/A
Arizona	Nursing services to meet the needs of a resident 24 hrs a day	.44	1 DON RN full-time; For 1-60 average daily census,: DON may provide direct care on regular basis	1 nurse for direct care to not more than 64 residents at all times.
Florida	Sufficient staff to maintain the highest practicable physical, mental, and psychological well-being of each resident	3.9	1 DON RN full-time. If DON has other responsibilities, add 1 full-time RN as Asst. DON. For 121+ residents, add 1 Asst. DON RN. 1 RN/LPN each shift included in: 1 LN hprd (24 hour average). Never below 1:40 LN ratio	2.9 DC hprd (24 hour average) minimum weekly average per day. 1:20 DC ratio

Table 6 (cont.)

Federal or State	Sufficient Staff	Estimated Variance from Federal Standard for Facility with 100 Beds	Licensed Nursing Staffing Requirements	Nursing Aide or Assistant Staffing Requirements
Massachusetts	To meet the needs of residents and assure that measures, treatments and other activities and services are carried out, recorded, & reviewed	3.2	1 DON RN full-time (40 hours) Day and In multi unit facilities: 1 RN FT Day Supervisor for up to two (2) units in the same facility. 1 RN/LPN Charge Nurse 24 hrs/7da/wk per unit 0.6 licensed nurses for Level I and II facilities	2.6 hprd including 0.6 licensed nurses (2.0 ancillary nursing personnel) - Level I. 2.0 hprd including 0.6 licensed nurses (1.4 ancillary nursing personnel) - Level II. No more than 12 hrs/day or 48 hrs/wk regularly.
Minnesota	To meet the needs of residents	2.05	1 DON RN full-time (at least 35 hrs) included in 1 RN/LPN 8 hrs/7 days/week. Designate a nurse responsible for DON duties when DON is absent. RN on call during all hours when an RN is not on duty.	2 hprd including all LNs and NAs for any 24 hour period. For 60+ licensed beds: exclude DON hours. 1"responsible person" awake, dressed, and on duty at all times.
Tennessee	Adequate numbers to provide care as needed	2.0	1 DON RN and 1 RN/LPN 24 hours/7days/week included in 0.4 hprd LNs	2 hprd including 0.4 hprd of LNs time. 2 staff on duty each shift

Table 6 (cont.)

Federal or State	Sufficient Staff	Estimated Variance from Federal Standard for Facility with 100 Beds	Licensed Nursing Staffing Requirements	Nursing Aide or Assistant Staffing Requirements
Texas	To provide care to all residents	LN .40	1 DON RN full-time 40 hrs/wk included in For 1-60 occupancy: DON may be Charge Nurse. 1 RN 8 consecutive hrs/7d/wk and 1 RN/LPN Charge Nurse 24hrs/7days/wk in 0.4 hprd LNs or 1:20 LNs every 24 hrs. Exclude administrative time of licensed staff and DON in a multi-level facility.	No minimum requirement
Wisconsin	Adequate nursing service personnel assigned to care for the specific needs of each resident	3.5	1 DON RN full-time Day and for 1-59 residents: DON RN may be Charge Nurse or other RN. 1 Charge Nurse on duty at all times. 0.65 LN hprd for intensive skilled nursing 0.5 LN hprd for skilled nursing 0.4 LN hprd for intermediate nursing	For intensive skilled nursing care, 3.25 hprd including 0.65 LN hprd. For skilled nursing care, 2.5 hprd including 0.5 LN hprd. For intermediate or limited nursing care, 2.0 hprd including 0.4 LN hprd.

Table 6 (cont.)

Federal or State	Sufficient Staff	Estimated Variance from Federal Standard for Facility with 100 Beds	Licensed Nursing Staffing Requirements	Nursing Aide or Assistant Staffing Requirements
Recommended Optimal		Total daily staff time 3.9 hours per day	Total daily licensed nurse time 1 hour hours per day	Total daily nursing assistant time 2.9 hours per day
DON: Director of Nursing *LN: Licensed Nurse (RN or LPN)* *HRPD: Hours Per Resident Day* *RN: Registered Nurse*		*LPN: Licensed Practical Nurse (also called Licensed Vocational Nurse in some states)* *CNA: Certified Nursing Assistant or Certified Nurse's Aide* *DC: Direct Care/Nurse Assistant Staff*		

Screening and Services for Nursing Home Residents with Mental Illness

States are required to ensure that persons with a mental illness who enter a nursing home are appropriate for admission to the facility and that their needs related to their mental illness can be met while they are a nursing home resident.

A Preadmission Screening and Resident Review (PASRR) must be conducted in order to make this determination. As mentioned earlier, if a person is determined to have a mental illness they must also be assessed to determine if they need "specialized services" to meet their needs related to their mental illness. States must provide specialized services when a person is determined to need these services. The state determines whether persons who need specialized services can receive these services while residing in a nursing home or must receive these services in a different setting. Table 7 below displays the requirements in each of the seven reviewed states.

Table 7
State Specialized Services Requirements for Nursing Homes

State	Requirement
Arizona	If the individual is determined to have a MI and to need specialized services, and is appropriate for nursing home admission, the required services are arranged by Regional Behavioral Health Authorities (RBHAs) and provided to the nursing home resident.
Florida	The Alcohol, Drug Abuse and Mental Health Program Office is responsible for determining the need for specialized services. Specialized services are provided by the Department of Children and Families, to nursing home residents.
Massachusetts	The Department of Developmental Services (DDS) and the Department of Mental Health (DMH) provides continuing care services to Massachusetts residents who cannot get needed services from other agencies or programs.
Minnesota	The State Mental Health Authority (SMHA) must determine whether the person requires specialized services to treat mental illness and must provide or arrange the provision of such services.
Tennessee	The Tennessee Department of Mental Health and Developmental Disabilities (TDMHDD) is responsible for providing services for people with serious mental illness (SMI) or Developmental Disability/Related Condition (DD/RC). The Division of Mental Retardation Services (DMRS) is responsible for people with Mental Retardation (MR).
Texas	When a resident receives approval of a PASRR Level II, they are eligible for the benefit of specialized services. Specialized services include physical therapy (PT), occupational therapy (OT), speech therapy (SP), customized manual wheelchair (CMWC), durable medical equipment (DME), alternate placement services, and vocational training. These services are provided through either the NF or a local MR authority (MRA), depending on the service.
Wisconsin	Nursing home residents who require specialized services may only receive these specialized services as either inpatient psychiatric services or as Specialized Psychiatric Rehabilitative Services (SPRS). SPRS are provided by nursing homes that exclusively serve persons with a mental illness.

Federal Regulations Applicable to Assisted Living Facilities

Assisted living facilities (also called Board and Care facilities and other terms that vary by state) are not regulated at the federal level except that federal law requires states to regulate certain types of facilities that house persons who receive Supplemental Security Income.

State-To-State Comparisons of Assisted Living Facilities

Assisted Living Licensure & Staffing Requirements

Section 1616(e) of the Social Security Act, also known as the Keys Amendment, was an outgrowth of abuses in board and care facilities and was enacted by Congress in 1976. It requires States to set standards that assure that SSI recipients do not reside in substandard facilities. Specifically, states must "establish or designate one or more State or local authorities, which shall establish, maintain, and insure

the nursing home enforcement of standards for any category of institutions, foster homes, or group living arrangements in which, (as determined by the State), a significant number of recipients of supplemental security income benefits is residing or is likely to reside. Such standards shall be appropriate to the needs of such recipients and the character of the facilities involved, and shall govern such matters as admission policies, safety, sanitation, and protection of civil rights."

State regulation of assisted living facilities is highly variable. Table 8 notes the types of ALF licenses in each of the seven reviewed states (Our review of ALFs does not include adult foster care or senior apartment complexes, which some states consider a form of assisted living.)

Table 8
Assisted Living Facility Categories

State	License Types
Arizona	Licensing Classifications Assisted living home: provides services to 10 or fewer residents Assisted living center: provides services to 11 or more residents Levels of service: Supervisory care services Personal care services Directed care services
Florida	Standard Extended congregate care Limited nursing services Limited mental health
Massachusetts	Assisted Living Residence must be certified by the Executive Office of Elder Affairs (EOEA)
Minnesota	Class F home care provider: provides nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications solely for residents of one or more housing with services establishments
Tennessee	ACLF license approved by the Board for Licensing Health Care Facilities
Texas	Type A: Minimal Supervision Type B: Moderate level of Supervision Type C (4 bed facility): provides adult foster care services
Wisconsin	Community-Based Residential Facilities Small: 5 to 8 residents Medium: 9 to 20 residents Large: 21 or more residents Classification: Class A ambulatory Class A semi-ambulatory Class A non-ambulatory Class C ambulatory Class C semi-ambulatory Class C non-ambulatory

Table 9 presents the ALF staffing requirements in the seven reviewed states. Only Florida and Texas have detailed requirements for amount of staff hours per number of residents.

Table 9
ALF Staffing Ratio or Hours Requirements

State	Minimum Staffing Ratio or Hours
Arizona	None (must have sufficient staff)
Florida	Facilities shall maintain the following minimum staff hours per week: Number of Residents — Staff Hours/Week 0-5 — 168 6-15 — 212 16-25 — 253 26-35 — 294 36-45 — 335 46-55 — 375 56-65 — 416 66-75 — 457 76-85 — 498 86-95 — 539 For every 20 residents over 95 add 42 staff hours per week. In facilities with 17 or more residents, there shall be at least one staff member awake at all hours of the day and night.
Massachusetts	No specific guidelines for type and number of staff
Minnesota	No minimum staffing requirements
Tennessee	None(must have sufficient staff at least 18 years of age)
Texas	Staff Ratios: 1 to 16 residents for day shift. 1 to 20 residents for evening shifts. 1 to 40 residents for night shifts.
Wisconsin	At least one direct care staff present when residents are in the facility

Rebalancing Long-Term Care

The State of Florida has been exploring opportunities to identify long-term nursing home residents who want to leave the nursing home and return to the community. By the end of July 2010, Florida Medicaid together with its partnering agencies identified and initiated case tracking for more than 2,500 candidates for transition from the nursing home to care in the community. When individuals do transition from the nursing home to the community, in nearly all cases, total Medicaid claims are reduced, on average by nearly 50%.

While the efforts under the nursing home transition project are recent, few individuals among the transitioned population had any subsequent Medicaid fee-for-service nursing home experience and those few exceptions appeared to be limited almost exclusively to short-term stays associated with post-hospital rehabilitation.

As Florida Medicaid moves in the direction of managed LTC, rebalancing between long-term nursing home stays and HCBS alternatives will likely intensify. Managed Care Organizations (MCOs) will have a financial incentive to maintain individuals in HCBS and avoid preventable nursing home stays.[22]

If we take the experience of Nursing Home Diversion as a case study, during the period when it was a demonstration project in three counties, the MCO plans offered participants a wide range of HCBS. Most were served at home, often combined with adult day health care. As the program matured, the areas served had a different mix of service providers. According to regulators at Florida Department of Elder Affairs, the emphasis among its MCO plans shifted to the point where most of the participants were being served in ALFs.

The fact that the State of Florida has identified nursing home residents who want to leave the nursing home and who can be safely and appropriately transitioned back to the community does not mean that assisted living can substitute fully for nursing home care.

A similar issue was raised during the 2010 session of the Florida Legislature. It was noted that many Medicaid nursing home residents receive Intermediate I or Intermediate II care and not skilled nursing services. It was also noted that the description of services for Intermediate I/II in the *Florida Administrative Code* (Rule 59G-4.180 Intermediate Care Services) had considerable overlap with the services that are usual and customary in an assisted living setting. The argument was then made that all of the Intermediate I/II nursing home residents could be served in an assisted living facility. As Mor and colleagues note, however, between 5% (narrow definition) and 12% (broad definition) of new nursing home admissions who remain there long-term meet the definition of "low" care.[23] In the case of Florida, 5% is roughly the percentage of nursing home transition candidates identified.

Some states (Tennessee, for one) have attempted to "tighten the door" by raising level of care requirements, targeting nursing home care to participants with higher acuity needs and at the same

[22] The State of Florida has already demonstrated that some long-term nursing home residents can be transitioned to care in the community through the use of HCBS.

[23] Mor, V., Zinn, J., Gozalo, P., Feng, Z. Intrator, I., and Grabowski, D. 2007. *Prospects for Transferring Nursing Home Residents to the Community.* Health Affairs. 26:8, pp. 1762-71.

time allowing participants with lower risk of institutionalization to receive HCBS. This has proved to be a difficult challenge, however. Maintenance of effort requirements in the American Resource and Recovery Act and the Patient Protection and Affordable Care Act are creating obstacles. States that raise eligibility standards (*e.g.*, by tightening the nursing home LOC requirements) may no longer be eligible for enhanced federal matching funds. For more details, go to the website given below*.

Critical Considerations

Adequate Supply

The discussion during the 2010 session of the Florida Legislature did not adequately answer this fundamental question: what will be the source for all the new assisted living facility rooms that would be required for further rebalancing to occur?

In Florida, there are approximately 675 nursing homes with a total capacity of 82,682 beds. There are approximately 2,929 assisted living facilities with a total capacity of 82,363 beds. From a statewide bed-capacity standpoint, these two types of long-term-care facilities are about equal.[24]

A major challenge for statewide implementation of managed LTC will be the availability of adequate assisted living in the more remote parts of Florida. Table 10 lists the available ALF beds by county. The bed count includes all licensed ALF providers. Many ALFs have available beds, but are not willing to take Medicaid rates.

The Assisted Living for the Elderly Waiver pays for the case management and services that an LNS or ECC can provide plus an allowance for incontinence supplies. Room and board in an ALF is not included. Instead, it is negotiated between the waiver participant and the assisted living facility and then paid for by the resident's personal (and sometimes, family) income. HCBS waivers may not include reimbursement of room and board in almost all situations.

Managed LTC cannot avoid the implications of statewide increased demand for assisted living. Finding affordable assisted living is already a challenge for individuals with long-term care insurance or the personal or family resources to pay for care. Rebalancing from nursing homes to assisted living will likely increase assisted living costs for both Medicaid and private payers, before supply catches up with demand.

Proponents of the argument that assisted living can serve as a replacement for nursing home residents requiring intermediate care assume that all or most assisted living facilities would be willing to accept such residents. The empirical evidence is the reverse. Hawkes, Rose, and Phillips drew a nationally representative sample of assisted living facilities.[25] Only 47% of those facilities had policies that admitted individuals who required assistance with transferring or persons with moderate cognitive impairment.

---

[24] Whether they serve about the same number of people per year could not be determined, due to lack of occupancy data for the ALFs.

[*] http://healthreform.dc.gov/DC/Health+Reform/Insurance+Coverage+Options/Current+Insurance+Options/Medicaid/Medicaid+Eligibility

[25] Hawkes, C., Rose, M., and Phillips, C.D. 1999. *A National Study of Assisted Living for the Frail Elderly. Results of a National Survey of Facilities.* U.S. Department of Health and Human Services.

Nearly three-quarters of the facilities said they would not retain a resident who required more than two weeks of nursing care.

Table 10
Count of Florida ALFs and ALF Beds, By County

County	ALFs	Beds	Percent of Medicaid Beds[26]	County	ALFs	Beds	Percent of Medicaid Beds	GRAND TOTAL Beds
Alachua	10	607	10	Lake	36	1,402	24	
Baker	0			Lee	36	2,355	27	
Bay	9	427	46	Leon	11	717	2	
Bradford	2	42	100	Levy	1	65	100	
Brevard	88	2,376	21	Liberty	2	47	100	
Broward	308	8,681	33	Madison	6	81	85	
Calhoun	1	23	100	Manatee	38	1,827	25	
Charlotte	17	1,026	18	Marion	33	1,582	25	
Citrus	22	918	41	Martin	11	587	2	
Clay	10	335	9	Monroe	3	38	84	
Collier	22	1,713	11	Nassau	4	226	56	
Columbia	7	418	48	Okaloosa	11	550	26	
Dade	1,004	10,663	77	Okeechobee	2	69	0	
Desoto	5	115	62	Orange	92	2,120	33	
Dixie	1	25	100	Osceola	16	400	55	
Duval	78	2,631	35	Palm Beach	126	5,299	21	
Escambia	22	1,323	44	Pasco	52	2,395	60	
Flagler	23	347	2	Pinellas	217	8,203	37	
Franklin	1	30	0	Polk	37	2,131	42	
Gadsden	3	92	100	Putnam	10	173	100	
Gilchrist	0			Santa Rosa	7	480	55	
Glades	0			Sarasota	67	3,691	15	
Gulf	2	49	43	Seminole	45	2,172	29	
Hamilton	2	27	100	St. Johns	13	503	22	
Hardee	6	137	84	St. Lucie	54	1,124	35	
Hendry	1	30	0	Sumter	4	156	10	
Hernando	26	1,129	23	Suwannee	2	60	100	
Highlands	12	888	44	Taylor	0			
Hillsborough	180	5,705	37	Union	0			
Holmes	2	86	100	Volusia	90	3,239	25	
Indian River	21	887	34	Wakulla	0			
Jackson	2	88	86	Walton	5	202	21	
Jefferson	1	33	100	Washington	8	160	83	
Lafayette	2	78	100	**Total ALFs**	**2,938**			
								82,983

Source: *http://www.floridahealthfinder.gov/facilitylocator/FacilitySearch.aspx*

[26] Moore, Delehanty, Stivers, Mitchell, and Polivka. 2011. *Medicaid Assisted Living in Florid*. Issue Paper from the Claude Pepper Data Center at Florida State University.

Participant Share of Cost

Under the Florida Medicaid state plan, Medicaid pays the difference between the nursing home's approved rate and the individual's ability to pay. Aside from a small amount for personal items (*e.g.*, toiletries, stamps), any other income is to be paid by the resident to the nursing home. This is often referred to as *patient responsibility*. The continuum of long-term care is broader than nursing home services and assisted living. Medicaid participants who receive HCBS waiver services in their home do not bear the same "patient responsibility."

On the surface, this may appear simple to handle. The State of Florida could impose participant share of cost for assisted living or nursing home services even with a managed LTC model. The issue will be the collection of personal responsibility. Will the MCO plans be responsible for determining the amount of personal responsibility and collecting it? Or, will it be the responsibility of the service providers?

It is important to realize that personal responsibility is not a one-time determination. It is an ongoing determination. Individuals can lose income sources and/or receive new income sources, or their income might simply change.

Medicaid participants have limited financial resources. Among the aged, Medicaid recipients will typically be limited in their income sources to Social Security payments. Most likely, a Medicaid recipient will be at the low end of Social Security payments (currently, somewhere around $700 per month.) It is doubtful many ALFs would find such a sum acceptable as payment for room and board.

Monitoring of Care

As Grabowski and his colleagues note, monitoring of care can be difficult for nursing home residents and especially true for nursing home residents with dementia.[27] A casual reading of *Florida Administrative* Code, Rule 59G-4.180 Intermediate Care Services, might conclude that even the most basic ALF could provide care consistent with the definitions for Intermediate Care I/II.

A critical difference between care in a nursing home and in assisted living is the availability of 24-hour monitoring and care in nursing facilities. This is, in fact, a requirement for Intermediate Care I /II in a nursing home setting.

> *(e) To qualify for placement in a nursing facility, the applicant or recipient must require intermediate care services including 24 hour observation and care and the constant availability of medical and nursing treatment and care, but not to the degree of care and services provided in a hospital or that meets the criteria for skilled services.*

Florida assisted living facilities are not required to have someone on staff 24 hours a day who is awake unless the facility has more than 16 residents.

As Table 11 demonstrates, more than two-thirds of the Intermediate I/II residents in Florida nursing homes have moderate to severe cognitive impairment. Constant monitoring of residents with dementia

[27] Grabowski, D. and Mitchell, S. 2009. *Family Oversight and the Quality of Nursing Home Care for Residents with Advanced Dementia*. Medical Care. 47:5, pp. 568-74.

is even more critical, since residents with moderate or advanced dementia cannot monitor their own care.

Table 11
Demographic Information on Florida Nursing Home Residents for Calendar Year 2009
Long-Term Care Minimum Data Set Indicators

	Skilled Nursing	ICF I	ICF II
Cognitive Skills for Daily Decision-making			
Independent - decisions consistent/reasonable	19.3%	17.5%	12.2%
Modified Independence - some difficulty in new situations only	19.3%	20.7%	20.5%
Moderately Impaired - decisions poor; cues/supervision required	40.3%	42.9%	42.8%
Severely Impaired - never/rarely made decisions	21.0%	18.9%	24.5%
Activities of Daily Living Functional Rehabilitation Potential			
None of the below	42.2%	39.2%	41.0%
Resident or staff believe resident is capable of increased independence in at least some ADLs, resident is able to perform tasks/activity slowly, and/or there is a difference in ability from morning to evening	57.8%	60.8%	59.0%
Dementia - Alzheimer's Disease and/or dementia other than Alzheimer's Disease			
No	27.30%	25.50%	22.70%
Yes	72.70%	74.50%	77.30%
Mental Health - Anxiety Disorder, Depression, Manic Depression Bipolar Disease, and/or Schizophrenia			
No	16.40%	14.60%	13.20%
Yes	83.60%	85.40%	86.80%

Source: Office of Program Policy Analysis and Government Accountability, Presentation to the Florida Senate Subcommittee on Health and Human Services Appropriations. January 2011.

Elopement is more frequently reported for ALFs than for nursing homes. Table 12 summarizes the adverse incident data from AHCA's 2008 report to the Florida Legislature, Nursing Home and Assisted Living Facility: Adverse Incidents and Notices of Intent. This disparity of twice as many elopements reported by ALFs will likely widen as more Medicaid participants with moderate or severe dementia are diverted or transitioned into assisted living. As noted above, the total number of beds in the two types of facilities is about equal: "In Florida, there are approximately 675 nursing homes with a total capacity of 82,682 beds. There are approximately 2,929 assisted living facilities with a total capacity of 82,363 beds."

Table 12
Number of Incidents Reported in Florida for FY 2007-2008

Type of Incident	Nursing Homes	Assisted Living
Death	15	41
Brain/Spine	0	4
Disfigure	0	0
Fracture	456	451
Limit Function	7	0
No Consent	9	0
Transfer	883	1,096
Abuse/Neglect	789	168
Elope	289	429
Law Enforcement	350	405
TOTAL	2,798	2,594

Source: *Nursing Home and Assisted Living Facility: Adverse Incidents and Notices of Intent*, Florida Agency for Health Care Administration, Report to the Legislature, July 2008.

Quality of Care

The quality of care provided to nursing home residents has been a concern throughout the United States. With the Nursing Reform Act of 1987, Congress required CMS (formerly the Health Care Financing Administration, HCFA) to develop and mandate a standardized Resident Assessment Instrument. All nursing homes receiving any federal funds were required to use it and report the results as part of the Minimum Data Set (MDS).

Researchers at the University of Wisconsin – Madison used the MDS to create a set of MDS Quality Indicators.[28] Anyone with an Internet connection can view the results of nursing home inspections, including the number and nature of deficiencies as well as the MDS Quality Indicators for any nursing home via the Nursing Home Compare page on the Medicare.gov website. See Table 13 for national and selected state results.[29]

ALFs are not included under the Nursing Reform Act of 1987. Congress has not subsequently amended the Act to include assisted living. Resident assessment and quality monitoring is a state prerogative (one would also assume it to be a state responsibility).

[28] Zimmerman, David R. "Development of Quality Indicators for MDS" and "Constructing a Quality Monitoring System", Long-Term Care Minimum Data Set Demonstration Project Symposium, Durham, NC, March 19, 1992, sponsored by Office of Quality Management, Veterans Administration.

[29] Differences in the acuity of nursing home residents in the various states are available in confidential data sets maintained by CMS under the Minimum Data Set (now MDS 3.0). Confidential data would require a data use agreement with (DUA) with CMS. Additional research may uncover issues that should be addressed before any major systemic change (*e.g.*, the conversion of Medicaid LTC from fee-for-service to managed care).

Table 13
Nursing Facility MDS Quality Measure Scores
Second Quarter 2010

Measure	National	Arizona	Florida	Massachusetts	Minnesota	Tennessee	Texas	Wisconsin
Behavior/Emotional Patterns								
Depression	14.5%	12.5%	9.7%	14.0%	23.3%	9.7%	12.9%	18.9%
Elimination/Incontinence								
Indwelling Catheter	4.9%	5.7%	4.8%	4.4%	5.8%	4.5%	4.5%	8.3%
Incontinence	51.2%	53.3%	53.3%	63.0%	53.9%	49.3%	46.9%	23.4%
Infection Control								
Urinary Tract Infections	8.8%	9.2%	10.6%	8.5%	6.5%	9.2%	9.0%	8.9%
Nutrition/Eating								
Weight Loss	7.7%	6.8%	8.4%	6.6%	7.3%	8.3%	6.3%	9.5%
Pain Management								
Moderate to Severe Pain	3.1%	4.7%	2.3%	1.7%	3.2%	1.9%	3.6%	8.1%
Physical Functioning								
ADL	14.2%	13.3%	12.3%	12.4%	14.2%	11.7%	18.1%	14.6%
Bedfast Residents	3.9%	4.2%	4.0%	2.0%	1.3%	6.2%	5.2%	2.3%
Quality of Life								
Physically Restrained	2.7%	1.4%	3.4%	3.0%	1.3%	4.8%	2.0%	1.1%
Skin Care								
High Risk Pressure Ulcers	10.8%	9.7%	11.8%	8.9%	6.7%	10.0%	12.1%	9.7%
Low Risk Pressure Ulcers	1.8%	1.6%	2.1%	1.4%	1.5%	1.1%	1.6%	2.1%
Post-Acute Care								
Delirium	1.2%	1.0%	0.8%	1.2%	1.2%	1.0%	1.4%	3.5%
Pain	18.6%	26.9%	16.6%	17.7%	23.2%	12.8%	13.9%	25.7%
Pressure Ulcer	12.6%	10.9%	14.7%	12.2%	8.6%	12.9%	11.5%	12.2%

Source: Nursing Home Compare (http://www.medicare.gov/NHCompare), Center for Medicare and Medicaid Services.

The State of Florida does not use a standardized resident assessment tool for assisted living, nor is there any systematic collection of quality indicators from ALFs. Even the inspection of ALFs is done less frequently than for nursing homes. If a facility does not have a track record of deficiencies and citations, inspection occurs every two years.

Grabowski et al.[30] note that nursing home residents with dementia typically receive less adequate pain control and suffer from greater neglect. Given the lower staffing in the typical ALF relative to the typical nursing home, staffing standards may need to be changed to prevent a greater prevalence of these problems as more Intermediate I/II nursing home residents (with or without dementia) transition to assisted living.

Given the vulnerability of the population transitioning from nursing home to assisted living, regulators need to ensure that MCOs do not compromise quality as a consequence of their efforts to reduce costs.

[30] Grabowski, D. and Mitchell, S. 2009. *Family Oversight and the Quality of Nursing Home Care for Residents with Advanced Dementia*. Medical Care. 47:5, pp. 568-74.

They need to be certain that requisite care is received when it is needed.[31] It is difficult to foresee how this can be done in the absence of rigorous monitoring of quality indicators.

The need for systematic information goes beyond quality indicators. Assisted living is one step on the continuum of long-term care. Third-party evaluations that include tracking transitions across the different settings are essential if the State of Florida intends to move more rapidly in the direction of managed long-term care.[32]

Staffing

The major reason residents leave assisted living and enter a nursing home is because they require more care. Hawkes *et al.*[33] found that it is the absence of nursing services that precipitates most transitions to a nursing home. Stated differently, they found that the presence of a registered nurse in an ALF significantly reduced the likelihood of individuals moving from assisted living to a nursing home. The nominal availability of nursing services on an "on-call" basis might not be sufficient. Stone and Reinhard note, assisted living has the potential to substitute for nursing home services for some medically-involved residents, if ALFs provide some of the nursing services expected in a nursing home.[34]

The survey of assisted living facilities by Hawkes and his colleagues indicate that staffing will pose a severe challenge if assisted living is expected to care for a large influx of nursing home residents.[35] Nationwide, 92% of the surveyed facilities provided medications reminders. Of the facilities surveyed, 88% provided central medication storage or assistance with medications; 79% had care or monitoring by a licensed practical nurse. Only 40% employed a full-time registered nurse.

Consumer Education

Medicaid participants (and their families) need more information about assisted living than is currently available. The Agency for Health Care Administration (AHCA)[36] and Department of Elder Affairs (DOEA)[37] do offer a number of helpful consumer-oriented publications that discuss the potential and limits of assisted living. What is lacking, however, is user-friendly information on staffing and quality indicators for assisted living. Providing consumers with this information will allow quality to improve as LTC providers compete for participants.

---

[31] Stone, R. and Reinhard, S. 2007. The Place of Assisted Living in Long-Term Care and Related Systems. Gerontologist. 47(Special Issue III), pp. 23-32.

[32] *ibid*.

[33] Hawkes, C., Rose, M., and Phillips, C.D. 1999*. A National Study of Assisted Living for the Frail Elderly. Results of a National Survey of Facilities.* U.S. Department of Health and Human Services.

[34] Stone, R. and Reinhard, S. 2007. The Place of Assisted Living in Long-Term Care and Related Systems. Gerontologist. 47(Special Issue III), pp. 23-32.

[35] Hawkes, C., Rose, M., and Phillips, C.D. 1999*. Op cit.*

[36] http://www.floridahealthfinder.gov/reports-guides/reports-guides.aspx

[37] http://elderaffairs.state.fl.us/english/CRG/TC.html

Managed Long-Term Care

One impetus for managed long-term care is the potential promise for reducing the escalating costs of long-term care. While managed care, in theory, can reduce the escalating trend in Medicaid budgets for LTC services, cost-savings are not guaranteed. A recent study from Duggan and Hayford examined whether or not shifting from fee-for service to managed care would decrease Medicaid expenditures.[38] Using data from each state, the findings suggest that the shift did not reduce Medicaid spending in the typical state. However, the expenditure effect varied significantly depending on the amount of reimbursement from the Medicaid Single State Agency. Specifically, higher reimbursement rates relative to commercial reimbursements reduced Medicaid spending. The opposite effect was true in states with lower provider reimbursement rates.

Managed long-term care also poses potential risks for a frail and vulnerable Medicaid population. Given the potential to impact tens of thousands of individuals and billions of dollars annually, a more comprehensive shift to managed long-term care requires careful study of risks that might be involved.

Florida has taken several steps designed to help the state create a more balanced LTC system through the expansion of HCBS waiver programs.[39] Florida Medicaid currently operates 12 HCBS waivers, each developed to meet the needs of a particular population. No other state has more HCBS waivers. Since the State of Florida does not provide a personal care benefit as a Medicaid state plan service, access to HCBS services for adult Medicaid participants must occur through one of the Florida Medicaid HCBS waivers.

In addition to Medicaid HCBS waivers, the State of Florida also supports additional programs through funding from Florida funds. Aging HCBS supports funded by Florida include ten programs supervised by Florida Department of Elder Affairs. The State of Florida will continue to be challenged to adequately fund its current array of state-funded programs, especially as its population ages and service demands continue to increase.

The State of Florida, like most states, faces continuing pressures to control the growth of public spending. For individuals who qualify for Medicaid participation, the use of Medicaid HCBS waivers allows the State of Florida to leverage additional federal dollars to serve more individuals and to provide a broader array of HCBS.

From the perspective of the State of Florida, the primary objective to be achieved by adopting statewide managed LTC is to contain costs by reimbursing MCOs a predictable and set amount per enrollee. Since HCBS alternatives are generally less expensive than care in a nursing home, the MCOs have a strong

[38] Duggan, M. & Hayford, T. (2011). *Has the Shift to Managed Care Reduced Medicaid Expeditures? Evidence from State and Local-Level Mandates.* Unpublished paper from the National Bureau of Economic Research. http://www.nber.org/papers/w17236.

[39] Florida Department of Elder Affairs (2009). *Florida's State Profile Tool.*

financial incentive to divert or delay long-term nursing home stays. Tables 14-20 illustrate the MCD LTC expenditures for FY 2009 for each state reviewed in this paper[40].

Table 14
Certain Medicaid Long-Term Care Expenditures FY 2009 for Arizona

Arizona	FY 2009 Expenditures	Percent Change from FY 2008-09	FY 2009 Expenditures Per State Resident
Service			
Nursing Home Services	$33,119,468	-1.0	$5.02
ICF-MR Total	$0	0.0	$0
ICF-MR Public	$0	0.0	$0
ICF-MR Private	$0	0.0	$0
Personal Care	$7,919,299	-5.7	$1.20
HCBS Waivers Total	$0	0.0	$0
HCBS Waivers DD	$0	0.0	$0
HCBS Waivers A/D	$0	0.0	$0
HCBS 1115	$0	0.0	$0
Home Health	$1,113,883	37.4	$0.17
Total Home Care	$9,033,182	-1.9	$1.37
Inpatient Hospital Care	$260,403,601	11.3	$39.48
Inpatient Dispro Share	$133,125,418	53.2	$20.18
Inpatient Mental Health	$1,443,268	-8.4	$0.22
Mental Health Dispro Share	$28,474,900	0.0	$4.32
Medicaid Managed Care Premiums	$5,822,789,535	13.3	$882.81
Prescribed Drugs	$7,068,186	8.5	$1.07
Total Long Term Care	$42,152,650	-1.2	$6.39
Targeted Case Management	$0	0.0	$0
PACE	$0	0.0	$0
Total Medicaid HCBS	$6,346,643,390	105.5	$962.23

Note: Care is required in the interpretation of this table because of apparent underreporting of information, especially by the State of Arizona.

[40] Eiken, S., Sredl, K., Burwell, B. & Gold, L. (2010). *Medicaid Long Term Care Expenditures FY 2009.* Thomson Reuters.

Table 15
Certain Medicaid Long-Term Care Expenditures FY 2009 for Florida

Florida	FY 2009 Expenditures	Percent Change from FY 2008-09	FY 2009 Expenditures Per State Resident
Service			
Nursing Home Services	$2,402,791,045	-0.4	$129.61
ICF-MR Total	$328,017,908	-3.2	$18.00
ICF-MR Public	$121,200,481	-18.3	$6.54
ICF-MR Private	$206,817,427	8.7	$11.16
Personal Care	$40,992,889	10.5	$2.21
HCBS Waivers Total	$1,258,490,776	-6.1	$67.89
HCBS Waivers DD	$858,537,287	-5.7	$46.31
HCBS Waivers A/D	$408,754,219	12.7	$22.05
HCBS 1115	$37,082,367	112.3	$2.00
Home Health	$165,515,352	-4.1	$8.93
Total Home Care	$1,507,068,472	-4.0	$81.30
Inpatient Hospital Care	$3,065,925,875	-0.2	$165.39
Inpatient Dispro Share	$234,896,769	4.8	$12.67
Inpatient Mental Health	$14,415,216	52.0	$0.78
Mental Health Dispro Share	$112,437,431	4.8	$6.07
Medicaid Managed Care Premiums	$2,527,416,961	5.9	$136.34
Prescribed Drugs	$1,066,079,757	1.0	$57.51
Total Long Term Care	$4,237,877,425	-1.9	$228.61
Targeted Case Management	$102,830,026	21.0	$5.55
PACE	$4,987,088	82.0	$0.27
Total Medicaid HCBS	$18,702,134,771	271.8	$1,009.19

Table 16
Certain Medicaid Long-Term Care Expenditures FY 2009 for Massachusetts

Massachusetts	FY 2009 Expenditures	Percent Change from FY 2008-09	FY 2009 Expenditures Per State Resident
Service			
Nursing Home Services	$1,616,521,340	-0.2	$245.17
ICF-MR Total	$265,098,972	12.9	$40
ICF-MR Public	$265,098,972	12.9	$40.21
ICF-MR Private	$0	-100.0	$0
Personal Care	$639,285,871	18.6	$96.96
HCBS Waivers Total	$908,959,456	31.7	$137.86
HCBS Waivers DD	$825,522,555	30.0	$125.20
HCBS Waivers A/D	$76,873,964	52.7	$11.66
HCBS 1115	$0	0.0	$0
Home Health	$102,054,809	18.0	$15.48
Total Home Care	$1,739,056,166	24.8	$263.75
Inpatient Hospital Care	$1,504,677,709	10.1	$228.20
Inpatient Dispro Share	$0	0.0	$0
Inpatient Mental Health	$144,913,316	227.9	$21.98
Mental Health Dispro Share	$0	0.0	$0
Medicaid Managed Care Premiums	$2,493,474,697	8.9	$378.17
Prescribed Drugs	$473,597,931	-2.3	$71.83
Total Long Term Care	$3,620,676,478	11.5	$549.12
Targeted Case Management	$104,011,249	-36.6	$15.77
PACE	$88,756,030	15.2	$13.46
Total Medicaid HCBS	$14,868,579,515	336.1	$2,254.82

Table 17
Certain Medicaid Long-Term Care Expenditures FY 2009 for Minnesota

Minnesota	FY 2009 Expenditures	Percent Change from FY 2008-09	FY 2009 Expenditures Per State Resident
Service			
Nursing Home Services	$835,049,290	1.2	$158.57
ICF-MR Total	$176,405,610	-1.1	$34
ICF-MR Public	$10,383,499	-19.8	$1.97
ICF-MR Private	$166,022,111	0.4	$31.53
Personal Care	$409,853,665	10.5	$77.83
HCBS Waivers Total	$1,674,010,243	4.5	$317.88
HCBS Waivers DD	$939,910,486	0.6	$178.48
HCBS Waivers A/D	$640,558,759	10.7	$121.64
HCBS 1115	$0	0.0	$0
Home Health	$80,487,894	-4.1	$15.28
Total Home Care	$2,164,351,802	5.3	$410.99
Inpatient Hospital Care	$400,007,129	-1.7	$75.96
Inpatient Dispro Share	$127,316,022	-3.0	$24.18
Inpatient Mental Health	$53,639,400	-18.8	$10.19
Mental Health Dispro Share	$82,060	-0.8	$0.02
Medicaid Managed Care Premiums	$2,459,112,892	16.0	$466.96
Prescribed Drugs	$247,745,232	-0.1	$47.04
Total Long Term Care	$3,175,806,702	3.8	$603.05
Targeted Case Management	$158,885,564	6.3	$30.17
PACE	$0	0.0	$0
Total Medicaid HCBS	$13,719,628,360	9.9	$2,605.74

Table 18
Certain Medicaid Long-Term Care Expenditures FY 2009 for Tennessee

Tennessee	FY 2009 Expenditures	Percent Change from FY 2008-09	FY 2009 Expenditures Per State Resident
Service			
Nursing Home Services	$975,022,948	-6.3	$154.86
ICF-MR Total	$267,567,506	11.0	$43.00
ICF-MR Public	$183,009,961	21.3	$29.07
ICF-MR Private	$84,557,545	-6.2	$13.43
Personal Care	$0	0.0	$0
HCBS Waivers Total	$663,092,694	5.7	$105.32
HCBS Waivers DD	$579,465,066	-1.0	$92.03
HCBS Waivers A/D	$83,627,628	97.7	$13.28
HCBS 1115	$0	0.0	$0
Home Health	$0	0.0	$0
Total Home Care	$674,182,772	6.3	$107.08
Inpatient Hospital Care	$477,213,388	10.1	$75.79
Inpatient Dispro Share	$115,929,115	-51.0	$18.41
Inpatient Mental Health	$1,214,388	-93.8	$0.19
Mental Health Dispro Share	$349,231	100.0	$0.06
Medicaid Managed Care Premiums	$3,254,570,120	16.6	$516.91
Prescribed Drugs	$736,177,911	4.0	$116.92
Total Long Term Care	$1,916,773,226	0.0	$304.43
Targeted Case Management	$209,905,299	35.7	$33.34
PACE	$11,090,078	54.4	$1.76
Total Medicaid HCBS	$10,233,748,876	204.5	$1,625.88

Table 19
Certain Medicaid Long-Term Care Expenditures FY 2009 for Texas

Texas	FY 2009 Expenditures	Percent Change from FY 2008-09	FY 2009 Expenditures Per State Resident
Service			
Nursing Home Services	$2,151,950,372	11.0	$86.83
ICF-MR Total	$898,706,862	-5.8	$36.00
ICF-MR Public	$600,053,463	-7.8	$24.21
ICF-MR Private	$298,653,399	-1.5	$12.05
Personal Care	$531,132,044	17.5	$21.43
HCBS Waivers Total	$1,385,393,697	10.8	$55.90
HCBS Waivers DD	$788,701,467	10.7	$31.83
HCBS Waivers A/D	$527,517,051	7.8	$21.29
HCBS 1115	$0	0.0	$0
Home Health	$272,651,021	15.4	$11.00
Total Home Care	$2,584,970,257	12.3	$104.31
Inpatient Hospital Care	$3,587,751,843	-1.6	$144.77
Inpatient Dispro Share	$1,323,033,759	10.3	$53.39
Inpatient Mental Health	$23,932,285	-1.7	$0.97
Mental Health Dispro Share	$292,457,483	1.7	$11.80
Medicaid Managed Care Premiums	$4,399,624,489	14.2	$177.53
Prescribed Drugs	$2,133,122,165	8.4	$86.07
Total Long Term Care	$5,635,627,491	8.5	$227.41
Targeted Case Management	$31,253,050	-86.2	$1.26
PACE	$29,944,220	0.7	$1.21
Total Medicaid HCBS	$27,496,476,418	24.7	$1,108.05

Table 20
Certain Medicaid Long-Term Care Expenditures FY 2009 for Wisconsin

Wisconsin	FY 2009 Expenditures	Percent Change from FY 2008-09	FY 2009 Expenditures Per State Resident
Service			
Nursing Home Services	$1,098,776,448	48.5	$194.31
ICF-MR Total	$283,288,787	631.3	$50.00
ICF-MR Public	$250,463,071	3466.4	$44.29
ICF-MR Private	$32,825,716	3.5	$5.80
Personal Care	$179,328,014	-8.8	$31.71
HCBS Waivers Total	$637,868,275	-2.2	$112.80
HCBS Waivers DD	$453,026,121	-3.7	$80.11
HCBS Waivers A/D	$150,002,921	0.6	$26.53
HCBS 1115	$0	0.0	$0
Home Health	$56,007,081	0.4	$9.90
Total Home Care	$873,203,370	-3.5	$154.42
Inpatient Hospital Care	$576,890,012	134.8	$102.02
Inpatient Dispro Share	$14,661,409	-90.3	$2.59
Inpatient Mental Health	$30,161,950	15.9	$5.33
Mental Health Dispro Share	$3,945,475	-6.9	$0.70
Medicaid Managed Care Premiums	$1,941,550,244	96.5	$343.35
Prescribed Drugs	$545,253,396	14.3	$96.42
Total Long Term Care	$2,255,268,605	34.0	$398.83
Targeted Case Management	$56,511,035	40.1	$9.99
PACE	$0	0.0	$0
Total Medicaid HCBS	$9,439,031,930	4,370.9	$1,669.10

Description of Managed Long-term Care Systems by State

Arizona

The Arizona Health Care Cost Containment System (AHCCCS) offers individuals long-term care services, such as nursing home or in-home care.[41] These services are provided through the Arizona Long Term Care System (ALTCS). The ALTCS is a federally-funded Medicaid program. Individuals are referred to AHCCCS for ALTCS eligibility determination.

This program is *mandatory* except for Native Americans. It is intended for individuals who are age 65 or older, blind or have a disability (at any age) and need ongoing services at a nursing facility. ALTCS-eligible members can receive both acute medical services and home and community-based services (HCBS). Once an individual has been determined eligible for ALTCS services he or she must choose a health plan that is covered in the zip code area, and a primary care doctor that works with that health plan. The member will then be given a program contractor and assigned to a case manager. Program contractors work like a Health Maintenance Organization (HMO), and provide the same quality services; however,

[41] http://www.azahcccs.gov/applicants/categories/nursinghome.aspx

each may work with different nursing homes, assisted living facilities, specialists, doctors, dentists, and hospitals. The case manager will meet with the enrollee and the family to coordinate the enrollees' care. The AHCCCS received the Medicaid 1115 medical waiver and the Medicaid state plan to operate the ALTCS program.

Massachusetts

Senior Care Options (SCO) is a joint venture between MassHealth and Medicare, which provides a complete package of health care and social support services for low-income seniors aged 65 and older.[42] SCO is a comprehensive health plan that includes all of the services reimbursable under Medicare and MassHealth through any of the four senior care organizations (Commonwealth Care Alliance, Evercare, NaviCare-HMO, Senior Whole Health) and their network of providers. Seniors have the option of enrolling in any of the organizations. The program is available to people with or without Medicare. Dual eligible members who enroll in a SCO must continue to pay their Medicare premiums.

Members enrolled in SCO have 24-hour access to care. SCO offer seniors coordinated care services, in which a team of health professionals develops a plan of total care addressing the specific needs of each member. The team includes a primary care physician (PCP) who is affiliated with the senior care organization along with a team of nurses, specialists, and a geriatric support services coordinator. They work with the member (and family members or caregivers, if applicable) to develop a plan of care. The coordination of care, specialized geriatric services, and respite care for families and caregivers, provides an important advantage for members over traditional fee-for-service care.

Enrollment in this managed care program is *voluntary* and open to MassHealth Standard members who meet the following criteria:

- aged 65 or older
- live at home (independently or with support services) or in a long-term-care facility (member cannot be an inpatient at a chronic or rehabilitation hospital or reside in an intermediate care facility for mentally retarded)
- are not subject to a six-month deductible period under MassHealth regulations at 130 CMR 520.028
- are not diagnosed with end-stage renal disease
- reside in a geographic area serviced by a SCO organization

After enrollment in SCO, MassHealth only covers services provided by the individuals' senior care organization and its network of providers, except in an emergency. There are no Medicaid waivers, only the Medicaid state plan.

[42] http://www.mass.gov/?pageID=eohhs2terminal&L=5&L0=Home&L1=Provider&L2=Insurance+%28including+MassHealth%29&L3=MassHealth&L4=Senior+Care+Options&sid=Eeohhs2&b=terminalcontent&f=masshealth_provider_sco_overview&csid=Eeohhs2
http://www.massresources.org/senior-care-options.html

Minnesota

Minnesota has two managed care programs available to its residents: Minnesota Senior Health Options and Minnesota Senior Care Plus.

The Minnesota Senior Health Options (MSHO) was implemented in 1997 by the Minnesota Department of Human Services (DHS).[43] It was designed to provide more consistent access to primary, acute and long term care services, with the key feature being the care coordinator (a nurse, nurse practitioner, or social worker) who is the participants' contact person for helping to navigate the health care system and in getting the appropriate services needed.

The MSHO demonstration has generated much national attention from researchers, providers, health plans, policymakers, and officials from other states and countries due to its unique financing arrangements. The Robert Wood Johnson Foundation, the State of Minnesota, and the federal Centers for Medicaid & Medicare Services (CMS) have provided financial support for development and administration of the program. MSHO operates under a Medicare payment demonstration waiver granted by the CMS in 1995, and extended in October 2001. DHS received the Medicaid 1915(b) waiver and 1915(c) waiver to operate the MSHO program. The program is currently administered by the Minnesota DHS and nine health maintenance organizations: Blue Plan, First Plan Blue, HealthPartners, Itasca Medical Care, Medica, Metropolitan Health Plan, PrimeWest Health System, South Country Health Alliance and UCare Minnesota.

MSHO is a *voluntary* managed health care program that combines Medicare and Medicaid services for people who meet one or more of the following criteria:

- eligible for Medical Assistance (Medicaid) and enrolled in both Medicare Parts A and B
- eligible for only Medical Assistance (MA)
- age 65 or older
- live in one of the counties where at least one health plan offers MSHO

The following people are *excluded* from participation in the program:

- People who have Medicare but are not eligible for MA
- People who have MA and Medicare, but only Part A or Part B (not both)
- People eligible for the Refugee Assistance Program
- Residents of regional treatment centers (RTCs), unless the MCO approves the placement
- People who are Qualified Medicare Beneficiaries (QMB), but not eligible for MA
- People who are Service Limited Medicare Beneficiaries (SLMB), but not eligible for MA
- People who have Medicare coverage through United Mine Workers
- People with medical spend-downs who are not currently enrolled in MSHO

[43] http://hcopub.dhs.state.mn.us/28_10_10_10.htm
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_006271#P54_3658

During its first six years of operation, MSHO has been successful in the following:

- Attracting highly qualified health plans and providers
- Stimulating the development and growth of geriatric care systems
- Providing a single point of accountability for evaluating health outcomes
- Providing more seamless access to primary acute and long-term care services through additional care coordination and geriatric provider delivery systems
- Preventing nursing home placements
- Increasing access to community services for underserved populations
- Integrating Medicare and Medicaid managed care requirements
- Attracting higher than projected enrollment
- Achieving equal or higher enrollee satisfaction

Managed care enrollees who are age 65 or older who do not choose to enroll in MSHO are enrolled in Minnesota Senior Care Plus (MSC+).[44]

MSC+ began operating in 25 counties in 2005 and was phased in statewide. It is the managed care product for MA enrollees who live in managed care counties, are not part of an excluded group, and do not choose to enroll in MSHO. The program is part of a waiver from the CMS. The purpose of the waiver is to phase in greater coordination of standard MA benefits (sometimes referred to as "state plan services") with other MA benefits such as Elderly Waiver (EW) services and nursing facility care. It pays for medical services for low-income people in Minnesota who are age 65 or older. This includes coverage for physician services, hospital stays, rehabilitation services, preventive care, and prescription drugs. An enrollee of MSC+ may also be eligible for Elderly Waiver services, HCBS, and case management. To qualify for MSC+, you must meet income and other eligibility requirements.

For MSC +, in addition to MA state plan services, the MCO is also responsible for authorization and payment of EW services, and is liable for up to 180 days of nursing home care. MSC +enrollees who are not eligible for EW services are enrolled in a different MSC+ product from those who are EW-eligible. DHS received the Medicaid 1915(b) waiver and 1915(c) waiver to operate the MSC+ program.

Tennessee

TennCare is the State of Tennessee's Medicaid program that operates under the Section 1115 waiver from the CMS.[45] The program is one of the oldest Medicaid managed care programs in the country, which began in 1994. The Bureau of TennCare within the Tennessee Department of Finance and Administration is the state agency charged with responsibility for administering the TennCare program,

[44] http://www.ucare.org/healthplans/mhcp/mscplus/Pages/default.aspx
http://hcopub.dhs.state.mn.us/28_10_10_15.htm
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_143880

[45] http://www.tn.gov/tenncare/news-about.html
http://www.tn.gov/tenncare/CHOICES/whoqualifies.html

and is responsible for payment of Medicare premiums, deductibles, and/or coinsurance for certain low-income Medicare beneficiaries.

TennCare is 100 percent Managed Care, which means everyone receives health services that are coordinated through a MCO. TennCare uses a "Medical Home" model in which all enrollees are matched with a primary care physician from the MCO as a way to provide patient-centered care at each step. The primary care provider from the MCO is responsible for the enrollee's coordination of care. Services are offered through MCOs in each region of the state. Enrollees can choose one of the MCOs (AmeriChoice, AmeriGroup, BlueCare) serving the area in which they live. In addition to the MCOs, there is a Pharmacy Benefits Manager for coverage of prescription drugs.

In 2010, the state implemented the TennCare CHOICES in Long-Term Care Program which brought long-term care services for persons who are elderly and disabled into the managed care program. To qualify for CHOICES an individual must need the level of care provided in a nursing home, and qualify for Medicaid long-term care. There are two groups of people in CHOICES: Group 1 and Group 2**.** CHOICES Group 1 is for people who receive nursing home care**.** CHOICES Group 2 is for certain people who receive home care instead of nursing home care. It's only for adults 65 years of age and older, or adults 21 years of age and older who have physical disabilities.

Texas

Texas Senate Concurrent Resolution 55 (74th Legislative Session) instructed the Texas Health and Human Services Commission (HHSC) to create a cost-neutral model that incorporated acute and long-term services and support for Medicaid recipients over age 65 and those with disabilities.[46] STAR+PLUS was developed as a Medicaid managed care program that provides health care, acute and long-term services and support through a managed care system. The main feature of STAR+PLUS is service coordination. Medicaid clients, their family members, and providers work together to coordinate health, long-term and other community support services.

Participants of STAR+PLUS choose a health plan (HMO) from those available in their county, and receive Medicaid services through that plan. It includes a continuum of care with a range of options and flexibility to meet individual needs.

Enrollment in STAR+PLUS is *required* for Medicaid recipients who live in a STAR+PLUS service area and fit one or more of the following criteria:

- People who have a physical or mental disability and qualify for Supplemental Security Income (SSI) benefits or for Medicaid due to low income.
- People who qualify for Community-Based Alternatives (CBA) 1915(c) waiver services.
- People age 21 or older who can receive Medicaid because they are in a Social Security Exclusion program and meet financial criteria for 1915(c) waiver services.
- People ages 21 or older who are receiving SSI.

[46] http://www.hhsc.state.tx.us/starplus/Overview.htm

The following people are *not eligible* to participate in the STAR+PLUS program:

- Residents of nursing facilities.
- STAR+PLUS members who have been in a nursing facility for more than 120 days.
- Clients of Medicaid 1915(c) waiver services, other than Community-Based Alternative services.
- Residents of Intermediate Care Facilities for the Mentally Retarded (ICF-MR).
- Clients not eligible for full Medicaid benefits, such as Frail Elderly program members, Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries, Qualified Disabled Working Individuals and undocumented aliens.
- People not eligible for Medicaid.

STAR+PLUS members who are not eligible for both Medicare and Medicaid are required to choose a health plan and a primary care provider. These members receive all of their services from their STAR+PLUS health plan.

STAR+PLUS does not change how dual eligible members receive Medicare services. Dual eligible members only choose a STAR+PLUS health plan but not a primary care provider because they receive acute care from their Medicare providers. The STAR+PLUS health plan only provides Medicaid long-term services and support to the dual eligible members. HHSC received the Medicaid 1915(b) waiver and 1915(c) waiver to operate the STAR+PLUS program. Overall, the program increases the number and types of providers available to Medicaid clients.

Wisconsin

Wisconsin has two managed care programs available to its residents: Family Care Partnership Program, and Family Care.

The Family Care Partnership Program (FCPP) is an integrated health and long term care program for frail elderly and people with disabilities.[47] The goals are: Improve quality of health care and service delivery while containing costs; reduce fragmentation and inefficiency in the existing health care delivery system; and increase the ability of people to live in the community and participate in decisions regarding their own health care. A key element of the program is team-based care management. With this, the participant, his or her physician, and a team of nurses and social workers develop a care plan together. The interdisciplinary team coordinates the delivery of all acute and long-term support services.

The Wisconsin Department of Health Services is the State Medicaid Agency. This department contracts with MCOs to implement the FCPP; and, the MCOs, in turn, subcontract with hospitals, clinics, HMOs and other providers to ensure a comprehensive network of acute and long-term care. Combining the benefits of the Medicaid/Medicare systems into one program through an 1115/222 dual waiver helps to avoid fragmentation and duplication of services.

Participation in the FCPP is *voluntary*. Participants in the program must be Medicaid-eligible and meet nursing home level of care criteria. Under this arrangement, qualified MCOs have a contract with the Wisconsin Department of Health Services and a Medicare contract with the federal CMS. MCOs receive

[47] http://www.dhs.wisconsin.gov/wipartnership/BasicInfo.htm

monthly capitation payments for each member and pay for all member services with the funds received from the capitation payments. MCOs are responsible for the care of each individual regardless of what agency provides the services or where the services are provided, i.e., whether the participant is at home, in the hospital, or in a nursing home.

Individuals enrolled in the program are offered a choice of care, setting, and the manner in which service is delivered. Participants are also able to choose their primary care physician within very broad parameters.

Family Care is a comprehensive and flexible long-term care service system, which attempts to promote people's autonomy and quality of life, while realizing the need for interdependence and support.[48] It was designed to provide cost-effective, comprehensive and flexible long-term care for people with physical disabilities, developmental disabilities and frail elders. Family Care builds on the ideology of respect and consumer choice in the Home and Community-Based Waiver programs, and makes those services an entitlement.

The program is *voluntary* and serves both Medicaid and Medicare eligible older adults. Individuals who need long-term care services can select where they live while receiving those services, and have timely access to both community-based and institutional services.

Individuals must meet both financial and functional eligibility tests to receive LTC services through Family Care.

Financially eligible:

- Financially eligible for Medical Assistance, or
- Needs LTC services that cost more than the income and assets available to them (after certain deductions and allowances), or
- People with too much income and assets to be eligible for public subsidy can pay for their own services and buy case management, service coordination and provider oversight from the care management organization (CMO)

Functionally eligible:

- Is either over age 65, or over age 18 and has a physical or developmental disability, and
- Has a condition expected to last at least 90 days or result in death within a year, and
- Needs assistance at:
    - The Comprehensive Level – requires ongoing care, assistance or supervision, or
    - The Intermediate Level – is at risk of losing independence or functional capacity unless he or she receives assistance from others

[48] http://www.dhs.wisconsin.gov/LTCare/
For a description of the key differences between the Wisconsin Family Care Program and the Family Care Partnership Program, go to http://www.dhs.wisconsin.gov/LTCare/Generalinfo/differences.htm

This program improves the cost-effective coordination of long-term care services by creating a single benefit with a large number of health and long-term care services, which otherwise would be offered through separate programs. Enrollees of a MCO have access to various health services offered by Medicaid, along with the long-term care services in the Home and Community-Based Waivers and the state-funded Community Options Program. MCOs receive a payment each month per member to manage and provide care for their members. MCOs are responsible for continuous improvements in the quality of care of their members and services received.

Individuals enrolled in a CMO have funding for services available in all living arrangements. In addition, they can help design their own care plan by choosing from available services, select providers even outside the CMO network for intimate care, decide to manage and control their own service and will be supported to do so, and choose to work without ending up with less income or losing access to services.

Critical Considerations

Combination with Medicare and Other Medicaid Services

Medicaid managed long-term care can be combined with other Medicaid services and even operates alongside Medicare services. The Star+Plus program in Texas has integrated Medicaid managed LTC with primary, acute, and behavioral health services. Under this arrangement, dual eligibles receive acute care services through their Medicare doctor. The ALTCS integrates Medicaid acute and LTC services under a single blended rate. Massachusetts uses the SCO program, which combines their entire Medicaid benefit with Medicare managed care for dual eligibles. Tennessee recently introduced TennCare Choices, a Medicaid managed LTC system that incorporates primary, acute, behavioral health, HCBS, and institutional care. Minnesota provides two options. The first choice, MSHO, combines Medicare and Medicaid services by integrating primary, acute, and long-term care services. Managed care enrollees who do not choose to enroll in the first option are enrolled in MSC+, which includes coverage for physician services, hospital stays, rehabilitation services, preventive care, and prescription drugs. Wisconsin also has two options, both of which serve Medicaid and Medicare eligible elders that incorporate primary, acute, HCBS, and institutional care.

Mandatory v. Voluntary Enrollment

In a report to the Governor of New Jersey in 2009, the New Jersey Department of Health and Senior Services reported that “States that have made managed long-term care voluntary for Medicaid beneficiaries generally see most of their LTC users stay in the fee-for-service system.” LTC costs are more predictable when plans can encourage enrollment from Medicaid participants with “favorable” risks. If MCOs can select a case-mix favoring low-cost participants (or induce high cost participants to disenroll), then managed LTC could be more expensive than fee-for-service.

Mandatory enrollment is complicated for dual eligibles: while they can be mandated into Medicaid managed care, they cannot be mandated to enroll into Medicare Advantage plans. Thus, integration of care is challenging. States are attempting to address this by mandating enrollment of dual eligibles into MCOs that are Medicaid managed care plans and also Medicare Advantage plans. While the enrollee can

choose another Medicare arrangement, many will stay enrolled because it is easier to receive all services from a single provider.

Regulators will need to ensure that MCO contracts are prescriptive in the scope of provider networks or require plans to admit “any willing provider” to participate. Consumer choice can be severely limited if MCOs use a small lists of participating physicians and other service providers.

Covered Services

States have considerable flexibility when determining which LTC services are accessible through a managed care model. In Arizona, members of the ALTCS are provided with the following services from the AHCCCS, which is Arizona's Medicaid agency: doctor's visits, immunizations (shots), prescriptions (not covered if you have Medicare), lab and X-rays, specialist care, hospital services, transportation to doctor, emergency care, pregnancy care, podiatry services, surgery services, physical exams, behavioral health, family planning services, dialysis, and annual well women exams. In addition to those services, people who qualify for ALTCS can receive services such as: nursing facility, Hospice, attendant care, assisted living facility, adult day care, health services, home health services (such as nursing services, home health aide, and therapy), home delivered meals, and case management.

The SCO program in Massachusetts currently provides seniors with the option of enrolling in one of five senior care organizations. Members can contact the SCO or individual plans to learn more about which plan is best for them. The selected organization will assist with completing a SCO enrollment form and selecting a primary care physician from the available network. Covered services vary by plan.

In the Minnesota MSHO program the member can choose from 8 health plans or stay with their current health plan if it offers the MSHO program. In addition to the standard Medicare and MA benefits (sometimes referred to as “state plan services”), the MCO also provides the following services for eligible enrollees: Elderly waiver services, 180 days of nursing facility services (Note: If an MA enrollee resides in a nursing facility on the effective date of enrollment in MSHO, the nursing facility per diem is not a covered service through the MCO. If a person covered by MA enrolls in MSHO while living in the community and later enters a nursing facility, the MCO is responsible for payment of the nursing facility services for 180 days), and Medicare services (including Part D).

The Minnesota MCS+ program includes coverage for physician services, hospital stays, rehabilitation services, preventive care, and prescription drugs. Members may also be eligible for Elderly Waiver services, home and community-based services, and case management.

In Tennessee, TennCare services include: medical, behavioral and long-term care, which are covered by "at risk" MCOs in each region of the state. Those individuals enrolled in CHOICES receive home care services such as, personal care visits, attendant care, homemaker services, home-delivered meals, personal emergency response system, adult day care, in-home and in-respite patient care, assistive technology, minor home modifications, pest control, and community-based residential alternatives.

Medicaid recipients in Texas have 30 days after receiving the enrollment packet to select a STAR+PLUS health plan. If no health plan is selected, HHSC chooses a health plan and primary care provider for them. Dual eligible members can decide which STAR+PLUS health plan they want, but do not choose a

primary care provider because they receive acute care from their Medicare providers. The program combines traditional health care (such as doctor visits) and long-term services and support, such as providing help in your home with daily activities, home modifications, respite care (short-term supervision) and personal assistance. Long-term services and supports provided by the health plans include Day Activity and Health Services (DAHS), Personal Assistance Services (PAS) and home delivered meals. Additional services include adaptive aids, adult foster care home services, adult day care services, assisted living, emergency response services, medical supplies, minor home modifications, nursing services, respite care (short-term supervision), and therapies (occupational, physical and speech-language). In addition to all of the traditional services listed, the health plans offer "value-added" services as incentives for Medicaid recipients to join their plan – services that are above and beyond those that are required. Some value-added services are offered by all of the HMOs, while others may vary from plan to plan.

The FCPP in Wisconsin integrates health and long-term support services, and includes HCBS, physician services, and all medical care. Services are delivered in the participant's home or a setting of his or her choice. Members of Family Care receive the following services: long-term care that has traditionally been part of the Medicaid Waiver programs or the Community Options Program (adult day care, home modifications, home delivered meals and supportive home care), health care services (home health, skilled nursing, mental health services, and occupational, physical and speech therapy), help members communicate with their physicians and manage their treatments and medications, daily living skills training, day treatment, pre-vocational services and supported employment, transportation and personal care. The MCO, however, is not restricted to providing only the specific services listed in the Family Care benefit package. The care management team and the member may decide that other services, treatments or supports are needed to achieve his or her goals, and the MCO would then authorize those services in the member's care plan.

The State of Florida has recently had marked success transitioning individuals from nursing homes into assisted living (or back to private residences with HCBS waiver services).

When designing managed LTC programs, states must guard against inappropriate service substitution that is contrary to the intent of a program. Mitchell *et al*., for example, noted that it appeared that short-term hospital inpatient stays were being used by some Florida Nursing Home Diversion Plans in lieu of respite care.[49] Since dual eligibility is an enrollment requirement for Nursing Home Diversion, the MCOs could shift most of the cost for a hospital inpatient stay of short duration to Medicare. For respite care, the MCO would have to bear the entire cost.

Regulatory Standards

MCOs can reduce costs through the reduction of the use of unnecessary/inappropriate services, by negotiating advantageous terms in the enrollment of participating service providers; and, by working directly with consumers through effective case management programs.

[49] 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, 483- 494.

Effective regulatory standards will be required in order to hold MCOs accountable for adequate levels of service, quality of care received, and appealing MCO plan decisions.

Rigorous third-party evaluations are critical for the State of Florida to make informed decisions about the performance of managed LTC. The evaluations should include access to appropriate services, quality assurance performance, quality of life, and participant satisfaction in addition to cost-effectiveness.

Network adequacy is a critical consideration at two levels. Under statewide mandatory enrollment, the State of Florida will need to ensure that an adequate network of MCO providers is available throughout the state. At the level of the individual MCOs, the State will need to establish standards that ensure that the MCOs continuously offer an adequate network of providers. The availability of local service providers is probably the most important factor for many participants in Medicaid LTC. Under voluntary enrollment, the nature of the provider network is another way in which MCOs can "game the system" and encourage "unfavorable risks" to disenroll. For example, participants can be offered nursing home care in less desirable facilities and told that if they disenroll and opt for fee-for-service, they can instead choose from more "desirable" facilities.

A closely related consideration is the question of whether MCOs should be required to accept the services of "any willing provider" or whether they can impose additional requirements upon LTC care providers beyond those under existing licensure standards.

Utilization management requires constant monitoring and evaluation. One way for MCOs to reduce costs is to deny access or make necessary and appropriate care otherwise less available. Managed LTC offers care to a vulnerable population and, consequently, the State would have a heightened responsibility to ensure timely access to appropriate care. A strong monitoring system will be required to ensure that MCO plans provide appropriate access and levels of appropriate care.

A transparent and user-friendly process for appeals and grievances is necessary. The appeals process should include a fair hearing process with state regulators. It is also important to recognize that the LTC population has a high incidence of cognitive impairment. The grievance and appeals process should include assistance for participants with cognitive impairments.

Comparative information relating to quality indicators, inspection citations and deficiencies, staffing, and the like are accessible through resources like the Nursing Home Compare website from CMS. Comparable information in Florida is either not available or less than user friendly when it comes to comparing ALFs. The Agency for Health Care Administration is not currently authorized to require the collection of comparable measures from assisted living facilities relating to quality indicators and staffing ratios. Such information would be essential for regulators to ensure that the provider network offered by the MCO plans for ALFs is adequate and appropriate.

Type of Ownership

There is a range of MCOs among the states that offer Medicaid managed LTC. Minnesota, for example, requires that MCOs be not-for-profit. In Arizona, there are traditional, for-profit HMOs, not-for-profit HMOs, and county government-run providers. The MCOs in Wisconsin are not-for-profit. Massachusetts has a mix of for-profit and not-for-profit plans. Florida has three decades of experience building a

community-based long-term care infrastructure through its private, not-for-profit aging network agencies and the Area Agencies on Aging. That experience and the current infrastructure should be considered when addressing issues related to type of ownership.

Capitation Rates

The rate setting process is another area where there is wide variation among the various states. Some states use multiple cells to better assign risk and reduce costs. Others have adopted a single cell or a blended rate. The capitation rate setting for Florida's Nursing Home Diversion waiver has undergone several changes. Currently, the consulting actuary recommends plan-specific rates that vary by county for the plans. Those recommendations are then used to inform the negotiating process between the MCOs and state regulators.

Both Arizona and Wisconsin place restrictions on profit and administrative expense. Both have a minimum Medical Cost Ratio (MCR) of 85%. This requires that a minimum of 85% of all funds received from Medicaid be applied to the care of participants. Maximums are also applied for administrative expense and profit of 7-8%.

Program Growth

Of the six states examined in this paper, three of them provide coverage statewide: Arizona, Minnesota, and Tennessee. Arizona's ALTCS began with Maricopa and Pima counties. A few years later, coverage was extended to Yavapai, Pinal, and Cochise counties. Each MCO served one county. Today, there are eight more providers, with four in Maricopa County.

The original plans and plans added during early expansion of ALTCS were former county-based, not-for-profit MCOs. Requirements of 85% MCR and maximum profit and administrative expense of 7-8% have not prevented ALTCS from adding commercial, for-profit plans and extending ALTCS to state-wide coverage.

Regulators in Arizona were quick to note that expansion of ALTCS into rural counties was critical to meeting the program's goals. Commercial MCOs would be reluctant to establish the necessary infrastructure in rural counties. To ensure coverage for ALTCS extended to rural areas of Arizona, regulators have required MCOs that serve urban counties also serve rural counties. For example, Bridgeway Health Solutions is a for-profit MCO that serves Maricopa County. The plan also includes residents from adjoining Yuma and La Paz counties. Evercare Select is another for-profit MCO serving Maricopa County. That plan also serves Mohave, Coconino, Navajo, and Apache counties.

Massachusetts provides services throughout the state except for certain locations in the Berkshires and Cape Cod. They hope to make the option available to those areas in the near future. The Massachusetts State Office of Rural Health (SORH) builds partnerships with a vast statewide network of providers, healthcare organizations, community groups, and local officials across the state to address a variety of health needs and build better systems of organized care in rural Massachusetts communities. SORH funding is provided by a base grant from the Federal Office of Rural Health Policy at Health Resources

and Services Administration (HRSA) with substantial additional matching and in-kind funds from the Massachusetts Department of Public Health. [50]

Between the two programs in Wisconsin, all but 14 counties are covered. Developing the necessary infrastructure in the more rural and remote areas of Wisconsin has proved to be challenge. Texas has the least amount of coverage, which includes 29 mostly urban counties. They are currently expanding to 42 counties; however, most of the rural areas are still excluded.

Provider Rates

MCOs generally negotiate rates with service providers, such as nursing homes. This is typically done on a contract-by-contract basis between each plan and each service provider. Some states have a requirement in their Medicaid managed LTC program that the existing Medicaid fee-for-service rates serve as a floor for rates paid by MCOs to service providers. Doing so compels the MCO to contain costs by effective management of care rather than by reducing the rates offered to service providers or opting for less desirable providers of residential or institutional care.

Coordination of Benefits

Nearly all aged and disabled adults requiring Medicaid long-term care services are also active Medicare participants. Coordinating care benefits between Medicare and Medicaid will be an important challenge for any comprehensive managed LTC system. Federal guidelines for integrating Medicaid and Medicare benefits are very prescriptive. Managed care organizations should be fully aware of relevant CMS requirements.[51]

Care Management

The MCOs in Arizona and Wisconsin stressed the critical role of care managers. They tended to prefer the title "Care Manager" rather than "Case Manager." This was more than a superficial distinction. In Wisconsin, the MCOs are even called collectively "Care Management Organizations (CMOs)."

"Case management" is viewed by Arizona and Wisconsin programs as a depersonalizing holdover from more traditional health care models (*i.e.,* HMOs). What the key informants were suggesting is the critical role of care managers. Care management requires more "face-to-face" interaction between care managers and Medicaid participants in managed LTC. Care managers play a powerful role in assuring that participant needs are being met. Both states emphasize "member-centered" care management relying on an integrated team of care professionals.

Mercy Care Plan is an especially instructive case study. Mercy Care Plan started as an Arizona not-for-profit MCO. It has subsequently come under management by Aetna. The care management team at Mercy Care Plan noted that the level of care management required in a long-term managed care model has been a culture shift for Aetna executive management. The amount of care management required to meet the needs of participants has been major point of disagreement, with Aetna executive

[50] For a complete list of activities, visit their website http://www.mass.gov/dph/ruralhealth

[51] One example of a set of such requirements, related to Special Needs Plans, can be found at: http://www.cms.gov/SpecialNeedsPlans/Downloads/SNPs_How_To_Document_111710.pdf

management skeptical of the level of care management required for managed LTC. The ratio of care managers to participants is carefully monitored by Arizona regulators to ensure that access and quality are not threatened by inadequate care management. The mandated levels require more care management than is typical with HMOs handling acute medical care and chronic diseases like diabetes and asthma.

MCOs in Arizona and Wisconsin uniformly stressed the role of care management in achieving cost-effectiveness through managing care rather than simply rationing care or paying providers less than fee-for-service rates. In Arizona, for example, care managers can override the nursing home determination that a resident is receiving skilled nursing services or primarily just custodial care. That distinction results in a different payment rate for the nursing home. The nursing home can challenge the care manager determinations by asking the MCO for a second opinion.

The MCOs in both states also stressed the critical role of the care managers in assuring that participants receive appropriate care of high quality. Care managers are required to have telephone contact with each participant at a minimum of once each month and face-to-face visits at a minimum of every ninety days. As a consequence, the care managers are "in and out" of the facilities on a frequent basis. When they visit, they note in their records staffing ratios and other QI/QM issues that the MCO will need to address with the providers. Several Arizona and Wisconsin MCOs noted that these on-site reports from the care managers were critical components in their decisions to drop providers from their networks.

Summary

The managed care programs examined in this paper vary by state, but there are some common characteristics among them. The main purpose of these programs is to avert or postpone nursing home placement by promoting autonomy and providing cost-effective, comprehensive care for the aging adult population and people with disabilities. For all of the programs this includes, but is not limited to, home and community based services along with health and medical services (primary and acute). All programs, except for Texas, also include institutional care.

The programs are federally funded in some way by the Centers for Medicare and Medicaid Services (CMS). All managed care plans involve an arrangement between the insurer and a selected network of health care providers. The enrollee must choose a health plan and a primary care physician from the list provided.

A key component of the comprehensive arrangement in all the programs is the coordination of care, in which a team of health professionals develops a plan of total care addressing the specific needs of each member. The team can include a primary care physician who is affiliated with the organization along with a team of nurses, specialists, and a care manager. They work together with the member (and family members or caregivers, if applicable) to develop a plan of care. This coordination of care helps reduce costs and increases the quality of care for enrollees by ensuring appropriate services and preventative care. Without coordination of care, the services would be available through separate programs, which can lead to inefficient services and higher costs.

Although there are similarities among the various types of managed care programs, different characteristics can also be found. Arizona, MCS+ in Minnesota, Tennessee, and Texas all have mandatory enrollment for their programs. Massachusetts, MSHO in Minnesota, and Wisconsin have voluntary enrollment.

Some of the services are provided through the Medicaid state plans, and others have Medicaid waivers. Minnesota, Texas, and Wisconsin have the 1915(b)(c) Medicaid waiver. Tennessee uses the 1115 Medicaid waiver. Massachusetts has the Medicaid state plan, and Arizona has both the 1115 Medicaid waiver and the Medicaid state plan.

Eligibility for enrollment varies between the different programs. Massachusetts and Minnesota allow for participants to be dually eligible for Medicare and Medicaid regardless of level of care needs. Wisconsin also accepts dually eligible participants; however, they must meet the nursing home level of care requirements. In Arizona, Tennessee, and Texas only adults 65 and older on Medicaid and physically and developmentally disabled adults who meet nursing home level of requirements are eligible.

These programs are not available to everyone in some states. Only Arizona, Minnesota, and Tennessee provide the programs statewide. Massachusetts, Texas, and Wisconsin only cover select counties, most of which are urban. Services offered also vary by each program. The most common services include physician services, hospital stays, rehab service, preventative care, home services, and prescription drugs. A summary of the programs by state is provided in table 21 below.

Table 21
Summary of State Programs

	Arizona	Florida	Massachusetts	Minnesota		Tennessee	Texas	Wisconsin	
	Long-term Care System (ALTCS)	Nursing Home Diversion Program	Senior Care Options (SCO)	Senior Health Options (MSHO)	Senior Care Plus (MSC+)	TennCare CHOICES	STAR+PLUS	Family Care Partnership Program (FCPP)	Family Care
Implementation Date	1989	1998	2004	1997	2005	2010	1998	1999	2000
Mandatory or Voluntary Enrollment	Mandatory (except for Native Americans)	Voluntary	Voluntary	Voluntary	Mandatory for individuals not enrolled in MSHO	Mandatory	Mandatory	Voluntary	Voluntary
Geographic Coverage	Statewide	Available in 46 counties	Available throughout the state except for certain locations in the Berkshires and Cape Cod	Statewide	Statewide	Statewide	29 mostly urban counties, expanding to 42 counties	Available in 19 counties	Available in 57 counties
Waiver Authority	1115	1915(a)(c)	MCD State Plan	1915(b)(c)	1915(b)(c)	1115	1915(b)(c)	1115/222 dual waiver	1915(b)(c)
Eligibility	MCD eligible age 65 or older, blind or have a disability (at any age) and need ongoing services at a nursing facility level of care	MCD and MCR (Part A and B) Dually eligible, age 65+, must meet nursing facility level of care criteria	MCD and MCR Dually eligible, age 65+, regardless of level of care needs	MCD and MCR Dually eligible, age 65+, regardless of level of care needs	MCD eligible, age 65+, regardless of level of care needs	MCD eligible, age 65+, who meet nursing home level of requirements	MCD eligible, age 65+, who meet nursing home level of requirements and receives SSI	MCD eligible or MCD and MCR Dually eligible, age 65+, who meet nursing home level of care criteria	Must have LTC service needs, be an older adult or an adult with a disability, live in a Family Care county, and meet financial eligibility requirements. MCD-eligible individuals automatically meet the financial eligibility criteria

Table 21 (cont.)

	Arizona	Florida	Massachusetts	Minnesota		Tennessee	Texas	Wisconsin	
	Long-term Care System (ALTCS)	Nursing Home Diversion Program	Senior Care Options (SCO)	Senior Health Options (MSHO)	Senior Care Plus (MSC+)	TennCare CHOICES	STAR+PLUS	Family Care Partnership Program (FCPP)	Family Care
Health Plans	Bridgeway Health Solution, Cochise Health Systems, Evercare Select, LTC DD DES, Mercy Care Plan, Pima Health System, Pinal/Gila, SCAN, Yavapai County	American Eldercare, AMERIGROUP Florida, Evercare/United HealthCare, Florida Comfort Choice/Humana, Forever Home/Little Havana, Hope Choices, Neighborly Care Network, Project Independence, Simply Healthcare, Tango/Sunshine State, United Home Care, Universal Health Care, Urban Jacksonville, Vista Health Plan, WorldNet Services, YourCare Brevard	Commonwealth Care Alliance, Evercare, NaviCare-HMO, Senior Whole Health	Blue Plus, HealthPartners, Itasca Medical Care, Medica, Metropolitan Health Plan, PrimeWest Health System, South Country Health Alliance, UCare Minnesota	Blue Plus, HealthPartners, Itasca Medical Care, Medica, Metropolitan Health Plan, PrimeWest Health System, South Country Health Alliance, UCare Minnesota	AmeriChoice, AmeriGroup, BlueCare	AMERIGROUP Community Care, Molina Healthcare of Texas, Superior HealthPlan, Evercare	Care Wisconsin First Inc, Community Care Inc, Community Health Partnership, iCare	Care Wisconsin First Inc, Community Care of Central Wisconsin, Community Care Inc, Community Health Partnership, Lakeland Care District, Milwaukee County Department of Family Care, Northern Bridges, Southwest Family Care Alliance, Western Wisconsin Cares
Covered Medicaid Services	Acute, Behavioral, HCBS, Institutional Care	Acute, LTC community services, Nursing facility services	Acute, Behavioral, HCBS, Institutional Care, Integrated with Medicare SNP	Acute, Behavioral, HCBS, Institutional Care up to 180 days, Integrated with Medicare SNP including MCR Part D Prescription Drug Coverage	Acute, Behavioral, HCBS, Institutional Care up to 180 days	Acute, Behavioral, HCBS, Institutional Care	Acute, Behavioral, HCBS, Limited Institutional Care	Acute, Behavioral, HCBS, Institutional Care, Prescription Medications, Integrated with Medicare SNP	Certain MCD state plan services such as home health and personal care, HCBS, Institutional care

Evaluation of Managed Long-term Care Programs by State

This section provides the results from different studies on the various managed LTC programs from each state discussed in this paper.[52]

Arizona

AHCCCS and ALTCS Performance Measure for Initiation of HSCB Services [53]

AHCCCS requires that services for HCBS members are initiated within 30 days of enrollment. This includes a personal visit and thorough assessment of service needs by a case manager. The measurement is taken to verify Contractor compliance with performance standards, as well as to analyze rates of initiation of services for HCBS members. It specifically focuses on the health-related services that allow ALTCS members to remain in their homes as long as possible. AHCCCS reports the findings of the MCOs annually.

For this period (2009-2010), the Minimum Performance Standard (MPS) that Contractors must achieve for this measure is 92 percent. A corrective action plan must be developed by Contractors who do not meet the MPS. These plans must be approved by AHCCCS.

The results show 97.1 percent of members received services within 30 days of enrollment, which did not represent a statistically significant difference from the previous rate of 96.0 percent. There was no significant difference in rates of initiation of services between rural and urban counties, or by members' race or ethnicity. Rates by Contractor ranged from 88.2 percent to 100 percent. Six of eight Contractors exceeded the minimum standard and three achieved the AHCCCS goal. At the end of the evaluation period, 64.3 percent of the 27,547 elderly and physically disabled individuals who were enrolled in ALTCS resided in home and community-based settings.

External Quality Review Annual Report[54]

State Medicaid agencies are required to have an annual external independent review of the quality, timeliness, and access to, services covered under each MCO and prepaid inpatient health plan (PIHP) contracts. The Health Services Advisory Group, Inc. (HSAG) prepared the annual report for AHCCCS. The results include a description of HSAG's findings including Contractor compliance with federal and State standards, improving performance, and conducting valid and effective AHCCCS-required Performance Improvement Projects (PIPs). AHCCCS reviewed the ALTCS EPD Contractors' performance and DES/DDD's performance on a variety of standards.

[52] The CHOICES program in Tennessee was implemented in 2010. The researchers did not find any studies on the program during the time of review.

[53] Betlach, T. (2011). *Arizona Long-Term Care System Performance Measure: Initiation of Home and Community Based Services for Elderly and Physically Disabled Members.* Prepared by the Division of Health Care Management.

[54] Arizona Health Care Cost Containment System (2011). *External Quality Review Annual Report for ALTCS EPD and DES/DDD Contractors.* Prepared by Health Service Advisory Group: Phoenix, Arizona.

The compliance categories include: General Administration, Delivery Systems, Grievance Systems, Case Management, Medical Management, Quality Management, Maternal and Child Health and Early and Periodic Screening Diagnosis and Treatment (EPSDT), Third Party Liability, Claims Information System, Encounters, Reinsurance, and Member Information. The eight ALTCS EPD Contractors were in full compliance for 83 percent of the 895 reviewed standards. The Grievance Systems category scored the highest (98%) for the standards of full compliance, and the Encounters and the Reinsurance categories showed the lowest percentage (13 % and 68%, respectively). The remaining categories scored above 70 percent compliant for their associated standards. All of the categories received at least three corrective action plans (CAPs). The largest percentages of CAPs relative to the number of standards in a category was in the Encounters category (88%) followed by Reinsurance (33%), Delivery Systems (29%) and Medical Management (26%). The Grievance Systems had the lowest percentage of CAPs (2 %). Overall, the Delivery Systems, Medical Management, and Reinsurance categories showed the largest proportional opportunities for improvement, with 39 percent of all CAPs.

The performance measures include: Initiation of HCBS, Comprehensive Diabetes Care (HbA1c Testing, Lipid Screening, Retinal Exams), and EPSDT Participation rate. All performance measures except for EPSDT Participation rate increased by a statistically significant amount and met the AHCCCS MPS for all Contractors combined. Contractors were required to submit more CAPs in CY 2010 than in the previous measurement period, primarily due to four additional CAPs for EPSDT Participation. The number of CAPs for the Comprehensive Diabetes Care measures declined from the previous measurement period by one.

All nine health plans improved during the first re-measurement of the Advance Directives PIP, and six plans had statistically significant improvements. All Contractors are encouraged to increase the use of advance directives by ALTCS members. Doing so should show continued improvement in the scores of the next evaluation and demonstrate sustained gains for the PIP. Overall, results from the compliance review and rates for AHCCCS-selected performance measures and PIPs demonstrated some significant and substantive improvement, while highlighting other existing or new opportunities to improve performance.

ALTCS Satisfaction Survey[55]

This report describes the findings from a survey in 2008 concerning satisfaction with care and services provided by the Arizona Long-Term Care System for the Elderly and Physically Disabled (the ALTCS-EPD program). The survey examined consumer satisfaction with facilities, facility staff and caregivers, home caregivers, personal doctors and nurse practitioners, case managers, transportation for medical services, and program contractors.

The overall results were favorable. The facilities (ALF and nursing) were rated as very good or excellent by 75 percent of the respondents. ALFs were evaluated more favorably than nursing facilities for cleanliness, availability of food and water, availability of help with bathroom/bedpan, and whether the

[55] Arizona Health Care Cost Containment System (2009). *Arizona Long-Term Care System Satisfaction Survey Report of Findings.* Prepared by Synovate Public Sector and Healthcare Services Research Group: Falls Church, VA.

facility administration is responsive. Organization of enough activities for residents was rated better in the nursing facilities.

Facility staff and caregivers were perceived as respectful and kind when providing physical assistance. Improvements can be made in two areas: decision making, and reducing language barriers between facility staff and residents. With respect to the home caregivers, 83 percent rated their home caregivers as very good or excellent. There were positive results concerning personal doctors and nurse practitioners, with 81 percent of the population feeling that their personal doctor or nurse practitioner was very good or excellent. Similarly, 82 percent of the respondents rated their care manager as very good or excellent. On average the case managers visited the members once every 3 months.

Eighty-two percent of the population did not have a problem getting transportation for medical services in the last 6 months. Overall, 77 percent of the population regarded their program contractor as very good or excellent. The most important factor in determining overall satisfaction with a program contractor appears to be access to information, with 21 percent having a problem getting information from their program contractor in the last 6 months.

Massachusetts

Managing the Care of Dual Eligible Beneficiaries[56]

Interviews were conducted with state agency officials, health plan representatives, providers, and consumer counselors in 2010. The evaluation section on Massachusetts discusses the lessons learned and barriers to expansion.

Lessons Learned: The findings from an examination of coordinated care suggest that with a comprehensive Medicare-Medicaid benefit package and separate capitated payments from Medicare and Medicaid, the SCO plans have the time and resources they need to develop and sharpen their care coordination programs. The plans can target their efforts to meet the varying care needs of the different types of members, and to address both their social and medical needs. However, some areas have been challenging, and other states considering programs for duals should take the following into consideration:

Relationships with ASAPs and GSSCs: The SCO plans have been required to contract with ASAPs and their GSSCs for care coordination and social service support. Therefore, in order for the coordination to be successful there needs to be an emphasis on the value of increased communication between and among care managers, nurses, and beneficiaries as a result of SCO.

Transitions into and out of hospitals: The SCO plans find it difficult to work with hospitals in reducing avoidable admissions and readmissions. The fundamental problem is that hospitals presently do not have adequate incentives to focus resources or attention on activities that would reduce admissions.

[56] Verdier, J., Au, M., & Gillooly, J. (2001). *Managing the Care of Dual Eligible Beneficiaries: A Review of Selected State Programs and Special Needs Plans.* Prepared by Mathmatica Policy Research, Inc. for the Medicare Payment Advisory Commission: Washington D.C.

Reducing avoidable hospitalizations for nursing facility residents: Nursing facilities have considerable financial incentives to hospitalize dual-eligible residents who need more intensive care than nursing facilities provide. One SCO plan has a well-developed model, which uses their own nurse practitioners to work with facilities and physicians to reduce hospitalizations. Since SCO plans are fully at risk for all hospital services for their members, they can fund extra payments to nursing facilities out of savings from prevented hospitalizations.

In terms of measurement data, Massachusetts and Medicare do not currently require the SCO SNPs to submit encounter data on the services they provide. Some SCO plan representatives suggested that better measures be developed to reflect the complexity of serving frail elderly duals, such as hospital and nursing facility transitions, hospital readmissions, "treatment in place" in nursing facilities, behavioral health, social service assessments, use of HCBS, and hospice care. Further, Medicaid and Medicare should address the challenges in administering surveys such as HEDIS and HOS to persons with cultural and language differences and chronic medical and behavioral health conditions.

Barriers to Expansion: Voluntary and Passive Enrollment is the first barrier. Approximately 11 percent of dual eligibles are enrolled in SCO, and increases in enrollment for all four plans have been slow and incremental. Without larger enrollment numbers, it is difficult to demonstrate the benefits of managed care. Identifying and marketing to potential enrollees on an individual basis is very costly and resource-intensive, and the state does not have the resources to assist the SCO plans with outreach and marketing. Part of the problem of increasing enrollment is attributed to CMS Medicare Advantage marketing guidelines that make marketing to individual dual eligibles resource-intensive and frequently confusing to enrollees, particularly those who do not speak English or have low levels of education. In addition, even though the state has reasonably good contact information for dual-eligible beneficiaries, the SCO plan representatives have received relatively little outreach and marketing assistance from them. Many dual eligibles in Massachusetts are not enrolled in managed care simply because they are unaware of their options.

Nursing Facility support for SCO: Nursing facilities in Massachusetts have normally supported the SCO program; however, some representatives expressed concerns related primarily to Medicare skilled nursing facility lengths of stay. One respondent stated, "Length of stay with SCO is half of the length of fee-for-service…SCOs move them out faster" (p. 31).

CMS Marketing Restrictions: There tends to be beneficiary confusion, which often leads to unintended disenrollment. Also, CMS rules prevent providers from guiding patients to enroll in particular plans if the providers receive any financial gain from doing so. This makes some providers uncertain about what they can and cannot do.

Medicare Advantage Member Communication Requirements: Medicare requires the use of a generic model Explanation of Coverage (EOC), which contains language that does not apply to all of the members. It is also a requirement to discuss certain features as if they apply to the members, when all members are eligible due to the nature of the program.

Inconsistent and Conflicting Medicaid and Medicare Requirements: The SCO representatives explained that the dual regulatory oversight by both the state and CMS produces many challenges. For instance, CMS requirements for contracting and enrollment timelines, eligibility, enrollment and disenrollment, grievances, and monitoring and reporting are often inconsistent.

Senior Care Options Evaluation: Report of Individual Interviews [57]

This report (phase 2) evaluated the health care experience of nursing home certifiable enrollees in the Senior Care Options (SCO) program by using data gathered from focus groups and individual interviews. The findings from the 82 interviews show that, in general, the SCO members were satisfied with the program, the services received, and the workers who provided the services. Specific aspects that respondents particularly liked were free medications and the helpful personnel. The majority of respondents (64) said they were receiving the services needed; however, these reports may be limited by the degree to which members are aware of what services are available, and how to request such services.

Improvements could be made in clarifying SCO contact points, decreasing language barriers, and providing some services that members identified as still needed, such as such as an electric wheelchair, walker or support socks, or transportation. Some respondents did not know who to contact at the SCO if they had a question or concern about their services. Also, a few respondents indicated they did not know that they had access to the SCO anytime, including nights and weekends. There were some problems with language barriers between the member and worker. Other complaints included wait time at doctor's offices, low pay for personal care attendants, lack of choice in medical providers, difficulty contacting the program, and feeling that the program was overly intrusive. Future research that focuses on family caregiver experiences and other non-English speaking members would be useful.

Minnesota

Enrollment Figures October 2011[58]

Minnesota Senior Health Option (MSHO) - 36,762

Minnesota Senior Care Plus (MSC+) -Duals (enrollees with both Part A and B, Part A only, Part B only) 9,930; Non-Duals 1,919

Home Care Reimbursement Methodologies [59]

Minnesota law requires an independent analysis of home health service reimbursement methods to members of MSHO, along with recommendations from Minnesota's Quality Improvement Organization

[57] Little, F., McManus, R., Centerbar, D., Curry, L., Gruman, C., Robison, J., Flanders, D., Smith, C., & Bochenko, F. (2007). *Senior Care Options Evaluation Phase 2: Member Experience Report of Individual Interviews.* Prepared by Center for Health Policy and Research in collaboration with Center on Aging, University of Connecticut Health Center.

[58] http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_141529

[59] Minnesota Department of Human Services (2008). *Home Care Reimbursement Methodologies.* Prepared by Stratis Health.

(QIO). The study population included Medicare certified home health agencies only. Home health care providers expressed concerns about reimbursement for Medicare skilled services. Respondents reported various issues and opportunities about home health reimbursement. These issues include the following: communication between home health stakeholders, access to home health services, reimbursement methods, billing and coding processes, home health technology, and quality improvement.

Recommendations are as follows: MCO staff should make efforts to build relationships with home health agencies as a way to improve effectiveness. Minnesota Department of Health should conduct comprehensive analysis of access to home health services in order to see where services are lacking and why. Home health agencies state that reimbursement rates are inadequate to cover the cost of services. A thorough cost analysis study should be conducted, along with other research to better understand the relationship between reimbursement methods and health outcomes of members receiving home health services. Billing and coding and receiving timely reimbursement for services are concerns of the home health agencies. MCOs and home health agencies should collaborate to implement standardized processes for billing and reimbursement. Increase in the use of technology could benefit members and assist home health agencies. MCOs and home health agencies should work together and find ways to finically support home health pilot projects. Conduct surveys to promote improvement in the quality of care.

A Study of Care Coordination and Case Management in Minnesota's Publicly-Funded Managed Health Care Programs for Seniors [60]

The purpose of this study was to examine the care coordination and case management currently in use by the nine managed care organizations (MCOs) that contract with MSC, MSC+ and MSHO, to determine the impact of statewide expansion and which models of care coordination should be considered in the future. The MCOs have implemented care coordination in various ways within the parameters decided by the State.

The results conclude that there are different ways that care coordination can be provided to members that are effective in providing the appropriate services needed. This freedom has allowed for consistency with their organizational culture, while maintaining the objectives of providing care across the continuum, supporting the goal of aging in place, and allowing for consumer choice. The relationship between the coordinator and member is the key to effective care coordination. The better the care coordinator knows the member, the more successful they can be in making accurate judgments for care; and in turn, the member is educated and has the means and knowledge about when it is appropriate to contact their care coordinator. In general, members spoke very favorably about their care coordinator and their positive impact it has on the members' lives.

More specific conclusions are discussed according to the members, care coordinators, providers, and MCOs.

[60] Johnson, A., Ripley, J., Nwoke, S., Malone, J., Morishita, L., Paone, D., (2007). *A Study of Care Coordination and Case Management in Minnesota's Publicly-Funded Managed Health Care Programs for Senior.*

Members: Members reported an overall satisfaction rate of 89%. MSHO Community non-EW members sometimes refuse a home visit for assessment. Causes include: busy seniors who are not home and suspicion about the reason for the requested home visit. Some care coordinators are in need of translator and assistance with cultural understanding. Members reported multiple phone calls from various people offering services, leaves them uncertain about the importance of each call. The care coordination models place little emphasis on caregiver support and coordination. On occasion members disenrolled from a MCO unintentionally due to misunderstood or incomplete information. When this happens, some members had to change providers, which lead to a loss of access to their care coordinator, primary care physician, or specialist. At time of enrollment there are many different unmet needs depending on the member.

Care Coordinators: Care coordinator accomplishments include socialization, coordinate services, assistance with transitions, and helping members better manage their own health. Balancing of care coordination focus depends on the members needs. Care coordinator backgrounds include social workers, registered nurses, physician assistants, nurse practitioners, public health nurses, or physicians as defined in Minnesota Statutes, section 256B.0625, subd.19c. Care coordinators are better able to identify any issues through home visits and building relationships with the members. Current case loads exceed those established as goals by MCO administrators. Members in ALFs and nursing homes have duplication in care coordinator functions in terms of requirement for assessment, care planning and care management of their residents. Need to explore methods of "dosing" Care Coordinator time and effort in order to make efficient use of resources, particularly with higher caseloads. More efforts are needed for specific activities/needs such as socialization, medication coordination, transitions, safety devices, building relationships.

Providers: Few care coordinators meet with or have real time conversations with physicians. They mostly inform the physician office about member issues but communication is typically one-way. There are problems navigating the billing processes established by the MCOs. Providers report that MCOs offer varying interpretations of benefits for Medicaid, EW and MSHO programs. Standards and guidelines must be clarified in terms of services needed, for how long, who provides the services and how they coordinate with other services such as adult day care.

MCOs: MCOs feel they must maintain good relationships with counties, because they feel that the counties control enrollment. Different care coordination models best serve certain geographical areas. There is a need to develop care coordination programs that are sensitive to the needs of diverse ethnic populations being served by MCOs. Care coordinators ability should be utilized to inform Primary Care Physicians (PCPs) of the member's mental health, social and medical needs.

The Quality of Care Under a Managed-Care Program for Dual-Eligibles [61]

This comparative study examined the differences in the quality of care provided by the MSHO and two control groups who receive fee-for-service Medicare and Medicaid managed care. One group (called Control–In) was drawn from individuals who lived in the same geographic area but who opted not to

[61] Kane, R., Homyak, P., Bershadsky, B., Lum, T., Flood, S., & Zhang, H. (2005). "The Quality of Care Under a Managed-Care Program for Dual Eligibles. *The Gerontologist*. 45(4):496-504.

enroll in MSHO. A second group (called Control–Out) consisted of eligible persons living in urban areas where MSHO was not available.

The study extends the findings from previous studies by investigating a mix of processes and outcome measures, such as utilization of resources, mortality, and nursing home admissions. Specifically, for the community group they examined mortality, nursing home admission rate, and preventable hospitalizations and emergency room visits. For nursing home residents they looked at mortality, preventable hospitalization and emergency room rates, and quality indicators.

The findings show that there were no differences in mortality rates for either group. The MSHO was favored with the community residents when a difference in quality was found. There was some decline in nursing home admission rates for short stays but no difference for stays 90 days or longer. They experienced fewer preventable hospital and ER admissions compared to the Control–In group but not compared to the Control–Out group.

The quality impact was, to some extent, more evident among nursing home residents. Although there were no differences in mortality rates, there were fewer preventable hospital admissions compared to the Control–In group and fewer ER visits compared to both control groups.

The major goal of MSHO focused on quality and coordination, which it appears to have succeeded to a modest degree. "In general, the quality-indicator results suggest that there were no impressive quality differences between the MSHO clients and those in the control groups" (p. 501). Therefore, the findings indicate that the cost of shifting the model of care from a mixture of fee-for-service and managed care to a merged managed-care approach cannot be readily justified by the improvements in quality observed.

Texas

STAR+PLUS Enrollee Survey Report [62]

The purpose of this report is to present demographic and health profiles of STAR+PLUS members, document involvement in healthy behaviors and health promotion activities, and assess their satisfaction with services. The results illustrate that, in general, the enrollees had positive views about having a personal doctor, continuity of care, access to medication, and care coordination. The program rated higher than the national average in five or more personal doctor visits and two or more visits to a specialist in the past six months.

More specific findings show considerable improvement from last year for several measures: access to special therapies (21%), frequency of delays while waiting for health plan approval (11%), flu shots received and access to special medical equipment (10%), access to urgent and routine care (7%), and enrollee satisfaction- getting needed care, getting care quickly, and customer service (5%).

[62] 2009. *STAR+PLUS Enrollee Survey Report.* Prepared by Institute for Child Health Policy at the University of Florida, and Texas External Quality Review Organization.

Particular measures that fell below average scores include the following: low health status scores, high overweight/obesity rates, difficulty finding personal doctors after enrolling in a health plan, enrollee satisfaction (getting needed care and customer service), frequency of delays while waiting for health plan approval, and frequency of entering the exam room within fifteen minutes of the appointment. For these measures, HHSC examined the reasons for less than satisfactory performance and plans to work with MCOs to address those factors in order to promote better performance in the future.

Care coordination is a key component of the external quality review. Twenty-three percent of respondents indicated having a care coordinator who helps arrange services such as doctor visits, transportation, or meals. Significant differences in having a care coordinator were found by health status. Thirty-nine percent of those rating their overall health as "excellent" had a care coordinator, compared with 25 percent rating their overall health as "poor." This could suggest that care coordination is not reaching those in most need as effectively as those in good health. Another possibility is that the presence of care coordination itself results in improvements in enrollee's self-rated health status.

Texas Medicaid Managed Care STAR+PLUS Quality of Care Measures[63]

This report provides an annual update of the quality of care provided to enrollees for 2007-08. In general, members reported many positive results. The specific areas that the program performed better than the state HHSC Performance Indicator Dashboard standards are as follows: Well-child visits in the 3rd-6th years of life, Diabetic Nephropathy Care, HbA1c Testing, LDL-C Screening, and follow-up within 7 days and 30 days after hospitalization for mental illness.

Some measures scored lower than the HHSC Performance Indicator Dashboard standard: Adolescent well-care visit, cervical cancer screening, and percent of emergency visits with a primary diagnosis of ambulatory care sensitive condition. Other findings show performance was less than the national HEDIS® average in the following areas: Adolescent well-care visit, cervical cancer screening, HbA1c Testing, follow up within 7 days after hospitalization for mental illness, and average cost of prescriptions per member per month and per year.

Admission rates considerably exceeded national estimates reported by the Agency for Healthcare Research and Quality (AHRQ). These differences may be explained by the fact that national rates are based on a general community population, while the majority of members from the STAR+PLUS program are chronically ill or disabled individuals. The adult inpatient admission rates for chronic obstructive pulmonary disease was 11 times greater, hypertension 57 times greater, CHF 7 times greater, bacterial pneumonia 6 times greater, angina without procedure 26 times greater, and uncontrolled diabetes 41 times greater.

[63] 2009. *Texas Medicaid Managed Care STAR+PLUS Quality of Care Measures.* Prepared by Institute for Child Health Policy at the University of Florida, and Texas External Quality Review Organization for Medicaid Managed Care and CHIP.

Wisconsin[64]

Family Care Financial Evaluation

The purpose of this study was twofold: 1) to assess the effectiveness of methods for determining capitation payments to MCOs while continuing to meet the department goals, requirements, and members' needs; 2) to evaluate the current and projected financial status of the MCOs based on existing financial statements of each MCO.

The findings from the first section suggest that the current methods are effective for tailoring capitations rates. However, possible weaknesses were observed. First, the capitation model and the functional status screen has the potential to underestimate the costs for members with the most severe functional impairments and overestimate the cost for those with low levels of limitations. Future studies should examine additional measures from assessments or supplemental data sources, which could improve the ability to match payments to risks. Suggested measures include: behavioral health diagnosis, information related to progression of condition, and additional care plan indicators, such as intensity of behavioral interventions (staffing needs required). Second, the linear cost model, which provides information on functional status information, may not efficiently account for cost-outliers, and is problematic for MCOs with a large amount of members with high costs associated with high-acuity of functional status impairment. Future studies should examine the exponential cost model with data from pilot or expansion counties with adequate experience.

Findings for the second section are as follows: In terms of financial status, there are two types of MCOs: 1) those on track to reach sufficient reserves to maintain solvency within three years, and 2) those that will not be able to achieve solvency. The latter is due to higher initial fee-for-service costs, higher administrative costs due to coordination of agencies across multiple counties, higher proportions of developmentally disabled members, and failure to implement the Family Care service and financial management model.

Suggested actions to improve the situation for MCOs in the latter group fall into two categories: funding policies and cost control policies.

> On the funding side, risk sharing arrangements between DHS and the MCOs may need to be extended beyond the 3-year limit currently in effect. Using the risk-sharing arrangements mentioned here, these actions would increase the program budget by as much as $40 million over two years (2.1% of total capitation payments) if all four of the MCOs suggested above encountered their worst case scenarios. However, DHS would have net positive recoveries of $3 million under the intermediate scenarios, and would recoup $23 million (1.2% of total capitation payments) if all MCOs with risk-sharing achieved their best-case scenario results. Phase-in payments might also be extended for MCOs with higher initial cost structures, large multi-county service areas, or higher proportions of members with developmental disabilities relative to the pilot counties (p. 54).

On the cost control side, some actions to achieve cost savings include: Reduction of administrative costs where warranted; provide technical training and monitoring to ensure that the Family Care service

[64] All of the studies for Wisconsin can be found at http://www.dhs.wisconsin.gov/LTCare/Reports/index.htm

delivery model is deployed effectively; share centralized or standardized infrastructure where feasible; and standardize provider fee schedules.

Legislative Audit Bureau Report: An Evaluation of Family Care

This study reviewed program expenditures and participation for the five-year period from 2005-2010, services provided to members and assessment tools, the method for setting capitation rates that control payments to the MCOs and paying provider claims, the financial solvency of the nine MCOs that currently participate in Family Care, and quality of care indicators.

Family care participants- The "functional screen" assessment tool is a web-based screening tool used to evaluate eligibility for services. The majority of the 28,885 individuals who received Family Care benefits in June 2010 were either developmentally or physically disabled and 96.8 percent qualified for comprehensive care. They found errors in functional eligibility determinations for less than 1 percent, and did not find patterns to suggest that MCOs were systematically decreasing participants' level of care in order to limit their own costs.

Expenditures- The program expanded and expenditures increased from $248.4 million in FY 2005-06 to $936.4 million in FY 2009-10. The needs of the members vary widely, as do the services they receive. In FY 2009-10, the developmentally disabled members were more likely to need assistance with IADLs tasks such as money and medication management, while the physically disabled and elderly were more likely to need assistance with mobility and ADLs such as laundry. MCOs' FY 2009-10 expenditures were for health and supportive services (55.7%), such as assistance with daily activities, care management and transportation. Residential service costs were 44.3 percent of total expenditures. The average monthly service costs during FY 2009-2010 ranged from $1,800 to $2,800 per participant for physically disabled or elderly members and from $2,900 to $4,600 for developmentally disabled members. The number of developmentally disabled participants with high-cost needs increased significantly. MCOs argue that the capitation payments they receive to fund care for the members are inadequate. Administrative expenditures for salaries, supplies and services, and rent and facilities costs more than tripled since 2005, totaling $53.2 million in 2010. Executive compensation varied considerably, but there were four cases of salaries that exceeded $200,000, excluding fringe benefits.

Financial solvency- MCOs are required to obtain an annual permit from OCI that demonstrates they are managing their finances appropriately and can ensure they are able to continue to pay providers for all members' services. As of December 2010, five MCOs owed a total of $4.6 million to their reserve funds, and four owed a total of $2.0 million to the solvency fund. DHS established corrective action plans to address certain management issues that were identified as contributing to the MCOs financial losses.

Quality of care indicators- DHS has the health care consulting firm MetaStar complete annual reviews of MCOs' compliance with federal regulations and contract requirements for program administration, and analyze a random sample of case files to evaluate whether MCOs' care planning practices appropriately addresses participants' needs. The findings in each annual compliance review from FY 2005-06 through FY 2009-10 illustrates that the MCOs fully met between 87.1 and 89.5 percent of all standards in each year reviewed. Care plans were generally completed and services were authorized in

a timely manner, and they only identified one case in which an MCO did not meet a standard in more than one annual compliance review.

Family Care Quarterly Financial Summary

The Family Care program will be a $1.15 billion program when annualized for the full 2011 calendar year. The following results were compared to the same time period in 2010. The program has seen a 20.9 percent growth in total capitation payments and over the first six months there has been a 19.1 percent increase in member months. Seven of the MCOs reported a surplus, compared to four in 2010. Intensive corrective action plans have been put into place for the MCOs that have significant deficits, and monitoring of the MCOs performance will continue to ensure that the operational and financial goals are met. The overall program is in a modestly positive position with a surplus of $10.3 million, compared to a $4.8 million gain.

The average capitation revenue increased by 1.6 percent on a per-member per-month (PMPM) basis. This increase reflects a slower enrollment growth and the policy action plans to slow increases in capitation. Member service costs tend to decrease over time to reflect the Family Care program model of being cost effective, member-centered, and focused on care planning; however, there was a 2.1 percent increase in the overall costs on a PMPM basis. This has resulted from additional expansion and transition of members from the waiver program to Family Care.

Care management costs decreased by 1.5 percent due to a change in accounting methods by one MCO to more accurately reflect administrative expenses included in care management. There was a 17.3 percent decrease in the cost to administer the program on a PMPM basis, resulting from fixed costs spread across a larger number of members, contracting for claims processing under a master contract, a pooled purchasing approach to administrative services, and through specific MCO initiatives to achieve efficiencies.

The working capital improved by $12.8 million and the requirement of the annual budgeted capitation increased .5 percent. Restricted reserves are fully funded by six of the nine MCOs. Recent developments show that the solvency fund is currently at 92 percent of full finding, with eight of the nine MCOs in full compliance with its capital requirement. The CY 2012 capitation rates were down 1.1 percent and have been provided to the MCOs.

Annual External Quality Review Report

This annual report submitted by MetaStar, Inc. provides an external quality review (EQR), which describes the ability to provide access to care, timeliness of services, and quality of the MCOs.

Access to care: MCOs are required to maintain a comprehensive network of providers and coordinate unpaid supports to meet members' personal needs. The results illustrate that access to care is the greatest area of strength for MCOs. The prominent areas of strength identified across MCOs include the following: accessing and addressing member risk, access to grievance systems, members rights to be free from restraints or seclusion, timely access to service providers, face-to-face contact between staff and member on a quarterly basis, first visit member checklist form, gathering information about

members' annual financial eligibility determination, exploring new tools to reduce communication barriers, negotiating contracts with disposable medical supply distributors, and reminders to members to notify MCO of any changes, such as status or condition.

The areas that had mixed results include: resource allocation decision method (RAD), and cost effectiveness in decision-making. Areas that had an opportunity for improvement include: compliance with provider contracting requirements, and compliance with provider background checks.

Timeliness: MCOs must establish provider networks that can provide timely and quality services to members. Care management teams are required to authorize, provide, arrange, and coordinate all services in a timely manner. The findings show that the area of strength identified across all MCOs was timeliness to appeals and grievances. Three of the measures have opportunities for improvement related to timeliness: notices of action, service authorization, and member-centered plans.

Quality of MCOs: Quality is determined from a member-centered point of view, in which they encourage members to participate in interviews/surveys, and are asked to join councils or committees that focuses on program improvement. A quality management program assesses the services provided by the MCO staff and sub-contracted providers in order to improve the overall quality of care. The notable areas of strength include: initial assessment process in care management, interdisciplinary team collaboration and support, and provider quality.

The areas that had mixed results include: member rights (respect, dignity, and privacy), and clinical practice guidelines. Areas that had an opportunity for improvement include: quality and comprehensiveness of member-centered plans, monitoring access to and quality of care, quality management program work plans, evaluating quality management programs, and utilization management.

<u>Member Satisfaction Survey</u>

Members of Family Care, Partnership and PACE were surveyed regarding their satisfaction with nine key features of the services they receive: satisfaction with team work, participation in decision making, recommend to a friend, team listens to concerns, receive help when needed, communication from team to help member understand, feels comfortable asking questions about care, comfortable with individuals who provide personal care, and happy with services received. The Quality Close to Home project workgroup developed the core questions of the survey. MCO and Department of Health Services (DHS) staff worked together to finalize the wording of the survey and the survey process.

There was a positive response from 60 percent or more of the respondents for every question. There was a notable increase in satisfaction levels from 2008 to 2009. This level was maintained in 2010, which was a challenge given the expansion and addition of several thousand members. In general, the MCOs with the highest level of satisfaction in 2009 had an increase in member's 2010 level of satisfaction and the MCOs with lower satisfaction levels in 2009 experienced decreased levels of satisfaction in 2010. The responses to the open-ended questions about what the members liked best and how the MCO could improve were mostly positive by approximately four to one.

Family Care Independent Assessment: An Evaluation of Access, Quality and Cost Effectiveness

The CMS requires that an independent assessment of the Family Care program be conducted as part of the waiver renewal request. The goal of this assessment was to illustrate the impact of the Family Care program on long-term care services. It focused specifically on access to services, quality of services and cost effectiveness. The results of this study are from 2003-2004.

The cost-effectiveness analysis compared the operation and costs of Medicaid funded services for members in the Family Care program to a group of similar individuals who received Medicaid funded services outside Family Care. Each part of the analysis supported the general conclusion of the assessment that Family Care reduced overall Medicaid and long-term care costs and provided more effective long-term care services than the fragmented existing waiver system.

In order to determine whether and to what extent Wisconsin Family Care is cost-effective, four questions were examined. The first question asked, "What is the impact of Family Care on 2003-2004 Total Medicaid costs for its members?" The findings from the path analysis demonstrate that "Family Care has a significant direct effect on overall Medicaid and long-term care costs, reducing costs in both cases. In addition, Family Care indirectly reduces these costs by impacting institutionalizations, illness burden and functional status among members" (p. 91).

The results from the multivariate analysis on total Medicaid costs support the direct effect of Family Care on reducing these costs. In particular the findings show the following:

> After controlling for differences between individuals (e.g., gender, illness burden, functional status), and accounting for the existence of county-level differences, the multilevel analysis shows a significant difference of $452 PMPM between the non-Milwaukee Family Care counties and their comparison group counterparts. The Milwaukee County frail elderly also significantly outperformed their comparison group counterparts, reducing Medicaid costs by $274 PMPM (p.91).

The second question asked, "What are the differences between Family Care and the comparison group in terms of total long-term care costs at the beginning and at the end of the study period?" For all of the Family Care groups, except one, the average individual long-term care costs per month were lower than those of the comparison group. More specifically, care groups for which costs were significantly lower than those of their comparison group include the following: non-Milwaukee members, as a group ($517), non-Milwaukee frail elder members ($722), non-Milwaukee members with physical disabilities ($503), and Milwaukee County frail elder members ($565). The only Family Care group where average individual monthly costs did not show significant differences from the comparison group was individuals with developmental disabilities in the non-Milwaukee CMO counties.

The next question asked, "Where did Family Care members significantly differ from the comparison group on selected long-term care and primary and acute costs and utilization that contribute to cost-savings?" There are five areas that contributed to cost savings: nursing home costs; CBRF costs; cost

effect for home health care personal care and supportive home care; outpatient hospital costs; and inpatient hospital costs.

Nursing home costs were significantly less for all Family Care groups relative to the comparison group, except for those individuals in the Milwaukee County CMO without waiver participation before Family Care. The average individual monthly cost difference between Family Care and the comparison group was $1,967 at the end of the study period.

CBRF costs for the non-Milwaukee counties were also lower for Family Care than the comparison group. Although costs were increasing more rapidly for members in CBRFs, their actual average individual monthly costs remained less than their comparison group counterparts.

Costs for home health care increased at a slower rate than those in the control group. Personal care costs were also lower. "Specifically, the four non-Milwaukee CMO counties were $296 less than those for the comparison group; personal-care costs for individuals with developmental disabilities were $770 less; and personal-care costs for individuals with waiver experience before Family Care enrollment were $262 less" (p. 17). Average individual monthly supportive home care costs in the non-Milwaukee CMO counties for members with no waiver experience before Family Care enrollment were $624 lower than the comparison group.

Family Care members in the Milwaukee County elderly and non-Milwaukee County developmentally disability groups had lower average individual monthly outpatient hospital costs ($10 and $17) than the comparison groups ($12 and $29). Inpatient hospital costs decreased significantly in both the non-Milwaukee CMO counties ($65) and the Milwaukee County CMO ($18).

The final question asked, "Where did Family Care members significantly differ from the comparison group on selected long-term care and primary and acute costs and utilization that hinder cost-savings?" The non-Milwaukee County CMO members with physical disabilities and Milwaukee CMO individuals with waiver experience tend to cost significantly more than the comparison group.

Overall, the evaluation found that the program has produced noteworthy savings, increased consumer satisfaction, and has flexibility in managing resources. Findings such as these influenced the legislature in 2006 to extend the program throughout the state.[65]

Summary

Each state examined different aspects of their managed long-term care programs. The studies focused on issues, such as quality of care and performance measures, member satisfaction, external quality reviews of the MCOs, and financial evaluations. MCO quality reviews and member satisfaction surveys are the most common evaluations.

[65] Polivka, L., & Zayac, H., (2008). "The Aging Network and Managed Long-Term Care." *The Gerontologist*. 48(5):564-572.

In general, the findings from the quality reviews were positive. Most of the MCOs were in compliance with federal and state standards. Corrective action plans were implemented in each state for any non-compliance standards, which often led to improvements in performance by the MCOs.

The majority of members from the programs in each state were satisfied with the services provided by their MCO. Overall, members speak most favorably about their care coordinator. Improvements could be made in decreasing cultural and language barriers between the care manager and member and clarifying to their members which services they provide.

A major reason influencing the shift of Medicaid LTC services to HCBS through a statewide managed LTC program is because it is said to be a more cost-effective system. The type of study most lacking among the states (except for Wisconsin) is a cost analysis, and the results are inconsistent. Therefore, in order to learn more about the relative costs and outcomes of the programs, thorough cost analysis studies should be conducted. In addition, uniform data systems are critical to the development of any strong program monitoring initiative. The following section provides reasonable principles that should be taken into consideration if a Medicaid long-term care program is to be successfully put into place in Florida.

Implementation Mileposts

Based on the experiences of the six states reviewed and also derived from a broad reading of the available literature, we have identified twelve mileposts that we believe will be critical to a successful implementation of Medicaid managed long-term care in Florida.

Be realistic. *Have a clear vision of the overall Medicaid managed long-term care system with reasonable expectations for timelines related to program development and implementation.*

Medicaid managed LTC was initiated to provide Medicaid participants with a broader range of options for long-term care and to contain costs. Having a clearly identified vision of the managed LTC system and clearly articulated expectations regarding access, quality, and cost will help guide decision makers at all levels.

Identify funding shifts. *Understand that changing from a collection of §1915 waivers to a Medicaid managed long-term care system is a fundamental shift in how Florida long-term care providers, and managed care organizations think about funding and future financial plans.*

Florida does have experience with managed LTC waivers that it can leverage. State regulators have worked closely with an actuary firm to establish capitation rates. An encounter data system is in place. Florida managed LTC waivers do not penetrate statewide. Payment variations among provider groups in different parts of Florida may prove to be a significant challenge. Not only will MCOs face issues with developing a standardized set of rate bands for the various HCBS services, they will also face differing expectations between service providers for different LTC populations.

Identify capacity issues. *Have reasonable expectations about the future capacity to provide the full continuum of managed long-term care services statewide.*

Rural areas of Florida are still largely unserved or underserved by important components of the LTC continuum. This is true, especially for adult day health care and assisted living. Diverting participants from nursing home care or transitioning them from institutional to residential care begs the question, “Divert them where?” Locating qualified, willing providers in rural parts of Wisconsin has delayed statewide expansion of Wisconsin Family Care.

Expansion of Medicaid managed LTC statewide could threaten the financial viability of smaller plans operating in the current Medicaid managed LTC waivers. This could be especially true if Florida follows the precedent of Arizona ALTCS and places the MCOs at-risk for Medicaid acute care services as well as LTC services; smaller plans would probably not be able to accept the financial risk required.

Get it right, up front. *Take the time to design a system that can meet the varied needs of program participants.*

Hasty implementation and the need to revise goals, timelines, and policies while "on the move" were problems noted by all of the Wisconsin MCOs. Unrealistic expectations are a problem now faced by the Ohio Legislature, where the Ohio Governor has requested implementation of Medicaid managed LTC during a one month session. The LTC populations are among the most fragile and vulnerable Medicaid populations, which generates many important implementation details that require due deliberation if the goals of managed LTC are to be achieved without putting this population at excessive risk of inadequate care. Unintended adverse consequences during implementation and subsequent changes in policies and procedures will heighten both skepticism about and resistance to managed LTC.

Get buy-in. *Engage stakeholders throughout the planning process to foster smooth program implementation.*

It is critical that a wide range of stakeholders be engaged during development and continually consulted through implementation. This includes not only the MCOs but also professional associations and advocacy organizations. The MCOs in some states indicated that their communication and collaboration with state and local officials were spotty and superficial. Resistance to managed LTC is often initiated and sustained by professional associations, service providers and advocacy organizations, and should be included from the beginning in planning for the conversion to a managed LTC model.[66] It is especially important to include discussions with the Area Agencies on Aging (AAA) and AAA network service providers regarding their past and future roles in Medicaid LTC.

Successful implementation of a statewide managed LTC plan is also an important culture shift for the typical healthcare MCO. Managed LTC requires access to a different model of care management than is typically employed in non-LTC MCOs. Currently, only three national firms have extensive experience operating managed LTC plans: United Health Care, AmeriGroup, and Aetna/Schaller Anderson.[67]

Make it mandatory. *Voluntary participation risks inadequate enrollment and loss of financial viability of the program.*

In the voluntary enrollment model, participants have the choice to either participate in the managed LTC program or receive care in the fee-for-service system. Voluntary enrollment appeals to participants and to advocacy organizations because of concerns related to choice, provider access, and disruption of care. A voluntary enrollment model can make it difficult to attract high-quality MCOs. Voluntary enrollment makes it more difficult for MCOs to attract a "critical mass" of enrollees to ensure that their

[66] *Ibid.*

[67] *Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services*, Center for Health Care Strategies, Inc. (2010).

participation remains financially viable. It also makes it more difficult for MCOs to build needed infrastructure to support rebalancing from nursing home care to HCBS.

Voluntary enrollment is also less cost-effective. Plans are encouraged to spend money for advertising that could otherwise be spent on care services. From the perspective of the state policymakers, mandatory enrollment enhances budget predictability. On the other hand, however, consumers and advocates may think that voluntary enrollment is necessary.

As the Center for Health Care Strategies noted, "When deciding on an enrollment model, states face a challenging compromise – the approach that gathers the support of consumers and advocates may limit the interest of MCOs, thus reducing the benefits that a managed care system can provide to consumers (*e.g.*, enhanced benefits, care coordination) and states (*e.g.*, an accountable system, predictable costs)."[68]

Incentivize providers. *Structure benefits to ensure that participants receive the appropriate care in the appropriate setting at the appropriate time, and to ensure an adequate range of options for consumer freedom of choice, and the kind of MCO accountability that comes with the freedom of consumers to choose among multiple participants in the MCO market.*

Medicaid managed LTC can take many different forms. In all of the programs from the six states, there is considerable effort expended to coordinate acute and long-term care services.
Arizona encourages greater reliance on HCBS through its capitated rate structure. They use an HCBS-nursing facility mix to help set its rates. When plans provide HCBS to a greater number of participants than projected, they are rewarded through a reconciliation process at the end of the year.

Incentivize participants. *Structure benefits and include paid family caregivers.*

There is currently little or no capacity for assisted living in the more rural and remote parts of Florida. Building the necessary infrastructure for residential care will require innovative strategies and take time. Allowing family, neighbors, or friends to provide in-home care is a successful strategy in several states, including Florida, Arizona, Tennessee, and Wisconsin. Arizona discovered that their Spouse as Paid Caregiver option was a way to increase the available direct care workforce and to keep participants in the community and avoid nursing home placement. Florida has experience with this approach through its consumer-directed care models that include elders, adults with physical disabilities and persons with IDD.[69]

[68] *Enrollment Options for Medicaid Managed Care for People with Disabilities*, Center for Health Care Strategies, Inc. (2007).

[69] At least two demonstration studies, including an evaluation of the Florida Cash and counseling demonstration project, have found that abuse, neglect, and fraud occurred no more frequently in consumer-directed care than it does with agency-directed care. See Doty, P., Mahoney, K., & Sciega, M. (2010). *New State strategies to Meet Long Term Care Needs*. Health Affairs. 29(1):49-56.

In TennCare CHOICES the member can hire a family member, friend, neighbor or other acquaintances to provide care, but there are some limitations. CHOICES wants to support, but not replace care provided by family and friends.

Insist on accountability. *Establish robust contractor oversight and monitoring requirements beyond those required by managed care regulations with public disclosure of the findings being required.*

Continual, careful monitoring is required, especially when more impaired participants receive care in less formal settings. Close monitoring is also critical to ensure that consumers receive comparable benefits regardless of plan.

Ensure equitable access. *Keep the needs assessments and participant choice counseling independent from the program contractors.*

The Kaiser Commission on Medicaid and the Uninsured found "a pervasive lack" of relevant information from MCOs to plan participants about the enrollment process, how to seek and obtain care, and who is an available provider. Under both mandatory and voluntary enrollment, participants found it difficult to access care because they do not know which providers they can visit and how to make managed care serve their needs.[70]

The Affordable Care Act in section §10202 (Incentives for States to Offer Home and Community-Based Services as a Long-Term Care Alternative to Nursing Homes) authorizes incentive payments to qualifying states that are working to rebalance LTC. One requirement is that states must utilize a standardized assessment instrument to determine eligibility for HCBS and develop individual care plans. A second condition is that states must provide "conflict free" case management. Conflict free case management does not allow the provider agency, which stands to benefit from increased service utilization, to determine the level of services authorized under the care plan.

Ensure quality. *Use a uniform tool that includes a comprehensive set of long-term care measures to ensure consistent access to needed care and is conducted independently of the contractors and their providers.*

A uniform assessment tool is critical to the success of any managed care program. Independence from contractors and service providers in both the administration of the instrument and the subsequent analysis and service plan development help to ensure that participants are assessed objectively and receive appropriate care. The goal of a uniform assessment tool is to confirm that the services provided by the MCOs meet the needs of participants and are not driven instead by provider revenue interests.

Be transparent. *Provide consumers with user-friendly information so they can make meaningful choices among types of care, contractors and their care providers.*

[70] *Mandatory Medicaid Managed Care – Plan and Enrollee Perspectives on the Enrollment Process*, Kaiser Commission on Medicaid and the Uninsured (2000).

Lack of information undermines consumer choice. It also undermines competition.

If consumers are to be active participants in the planning and delivery of services, they must have easy access to relevant, user-friendly information. MCOs tend to send a large, bulky envelope of information that many participants find incomprehensible, overwhelming, and – as a result – frustrating. CMS provides limited details about QI/QM measures, staffing, citations, and the like for nursing homes. Access to this information assumes a level of computer literacy that many frail Medicaid participants do not possess. Access to information from the CMS Nursing Home Compare site is far from user-friendly. Information on other providers, such as assisted living or personal care services is even more limited.