

MEDICAID MANAGED LONG-TERM CARE

Background

In 2003, nearly 28 million of 40.5 million Medicaid beneficiaries (69 percent), received some or all of their services through risk-based managed care organizations, including commercial and Medicaid-only health plans (State Health Facts, 2005). Almost all of the Medicaid beneficiaries that receive services through managed care organizations are in the overall Medicaid acute care program. In contrast, nearly all seniors and people with disabilities who receive Medicaid-funded long-term care continue to receive it through traditional fee-for-service programs.

In the mid-1990s, when Medicaid managed care was growing rapidly for children and parents, many states considered including long-term care populations in Medicaid managed care in the hopes of containing costs as well as the possibility of improving outcomes through better coordination. Only a handful of states implemented the idea. Strong state revenues in the late 1990s reduced the urgency for state Medicaid programs to make changes, and a backlash against managed care (fueled in part by the substantial retrenchment of Medicare managed care plans that followed passage of the Balanced Budget Act of 1997) left seniors and advocates wary.

Meanwhile, states have organized care for people needing long-term care services within the fee-for-service system. Examples of these models of care include: 1) disease

management programs that seek to manage and improve care for certain individuals with chronic diseases; 2) Medicaid home and community-based waiver programs where care managers coordinate home and community-based services (HCBS) and the programs ensure that, on average, the services cost no more than nursing home services; and 3) consumer directed care where people can control their own care through programs such as Cash and Counseling.

In 2005, as federal and state budget pressures challenge Medicaid programs, a number of states now are taking a second look at risk-based Medicaid managed long-term care (MMLTC). MMLTC is defined here as an arrangement in which the state Medicaid program makes a single contractor responsible for a range of long-term care services and pays the contractor a set monthly fee, called capitation, regardless of the amount of care delivered.

The financial risk assumed by the contractor is one of the features that distinguishes MMLTC from the fee-for-service programs such as the HCBS waiver programs. In MMLTC, if care averaged across all members costs more to deliver than capitated payment amounts, the MMLTC contractor loses money; if it costs less, the contractor makes money. By contrast, in current HCBS waiver programs, a long-term care provider typically receives reimbursement for units of service (e.g., hours

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The views expressed in this policy brief are solely those of the authors.

Exhibit 1. Definition of Medicaid Managed Long-Term Care

Medicaid Managed Long-Term Care: A contractual agreement between a Medicaid agency and a contractor (health maintenance organization, community services agency, provider organization or other entity) under the terms of which the contractor accepts financial risk through a capitated payment for providing long-term care benefits to Medicaid beneficiaries.

- *Care coordination.* The contractor coordinates care and sometimes provides long-term care services directly, although usually through subcontracts with traditional providers.
- *Financial risk.* The degree of financial risk varies by program. In some programs, the contractor assumes financial risk for the entire range of long-term care services, including home care, adult day care, residential care, and nursing home care. In other programs, contractors are only partially at risk; the contractor's financial liability is limited in some way, usually by capping the amount of nursing home care for which it is responsible at 90 or 180 days.

of personal assistance) up to a maximum authorized in a plan of care, and care managers are paid either a per person management fee or a percentage of the value of the care plan.

Another important feature of MMLTC is that the contractor is typically responsible for a broad range of long-term care services. By contrast, a fee-for-service provider typically provides a single type of service, such as home care, adult day care, or residential care, and is responsible only for what happens in that specific setting of care. While some fee-for-service providers—particularly HCBS waiver providers—offer care coordination, MMLTC contractors are financially accountable for, and coordinate across, a greater range of services.

Purpose

This issue brief is focused on risk-based MMLTC. The purpose is to explore the history and current status of MMLTC; the emerging evidence of its impact on access, quality, and cost; the likelihood of program expansion in the future; and key issues for policymakers.

This brief centers around Medicaid-financed long-term care, although the discussion includes Medicare, since most Medicaid long-term care beneficiaries are eligible for both programs. Some MMLTC programs have focused solely on Medicaid-funded services,

while others have partnered with the federal Centers for Medicare and Medicaid Services (CMS) to combine Medicaid services with Medicare-funded acute care services for dually eligible beneficiaries. This brief addresses both Medicaid-only and Medicaid-Medicare programs, focusing on programs that enroll older persons. The brief does not address programs targeted primarily to persons with developmental disabilities or severe and persistent mental illness, such as managed behavioral health or disability support programs.

Consumers: Risks and Benefits

Risk-based managed care payments provide an incentive to contractors to manage services and costs closely, and contractors use a variety of methods to do so. For example, managed care organizations typically limit the number of providers members can see. Providers generally must meet certain qualifications and must accept a price that may be less than fee-for-service rates. The incentives of risk-based payments create concern among some consumers that they will not be able to get the care they need, that they will have less choice than they would like, and that contractors will violate their privacy by collecting information about the services they use. Some beneficiaries worry, for example, that MMLTC will limit their ability to direct their own services or that they will be denied access to specialists.

However, some consumers also have been attracted to the advantages of MMLTC relative to traditional fee-for-service programs. Consumers who use many different kinds of services (as long-term care beneficiaries often do) may find the care coordination helpful, and MMLTC programs typically require less consumer cost sharing than their fee-for-service counterparts. Generally, as an incentive to enroll in voluntary programs, MMLTC programs also can offer enhanced benefits, such as better coverage of prescription drugs and greater emphasis on HCBS. Most MMLTC programs are voluntary, but in a few geographic areas, MMLTC is mandatory for consumers who need Medicaid-funded long-term care.

Rationale for MMLTC

State policymakers are primarily interested in MMLTC because Medicaid-funded long-term care services are growing rapidly, and this growth will accelerate in the future. MMLTC is attractive because state officials can achieve budget stability over time through capitation. By paying a single, fixed fee per enrollee, states limit their financial risk, passing part or all of it on to contractors. Also, states may hold one entity accountable for both controlling service use and providing quality care. That kind of focused accountability is impossible in the traditional fee-for-service system, in which the state pays several different providers for their respective components of care but has no single entity to hold accountable for consumer or system outcomes.

With MMLTC, states shift financial risk to the MMLTC contractor, though recent litigation in Arizona makes it clear that states remain accountable for meeting basic Medicaid service standards even if they have contracted that responsibility to an MMLTC contractor. (*Ball v. Biedess*, No. CIV 00-0067-TUC-EHC)

State officials also are interested in learning if MMLTC can address some of the major challenges that their long-term care systems face, including lack of accountability for outcomes when care is provided across multiple settings, avoidable hospital

admissions, unnecessary use of nursing home care, and medication mismanagement resulting from multiple parallel systems of care.

Many policymakers hope that MMLTC will address these problems. However, except for Arizona, which has operated a statewide MMLTC program for more than 15 years, states have little experience with large-scale MMLTC.

Growth of MMLTC

Today, state-specific MMLTC programs exist in Arizona, Florida, Minnesota, Massachusetts, New York, Texas, and Wisconsin. Programs for All-inclusive Care for the Elderly (PACE) operate in 18 states. Estimated national enrollment in 2004 in MMLTC programs—including state-specific programs and PACE programs—was still relatively small at just under 70,000 members (Saucier, Burwell, and Gerst, 2005; see exhibit 2).

MMLTC appears poised for growth in the near future. In the next two years, California, Hawaii, Maryland, and Washington hope to enter the market; more significantly, a number of existing programs (for example, those in Texas, Florida, and Minnesota) have proposed expansions that could add significant numbers of people to MMLTC programs by the end of the decade.

The Texas Health and Human Services Commission has proposed expanding the STAR+PLUS program in seven new metro-centered service areas (San Antonio, Dallas, El Paso, Lubbock, Corpus Christi, Fort Worth, and Austin). If this expansion occurs, an estimated 40,000 new long-term care users would be enrolled; however, the proposal is controversial and was vigorously debated in the Texas legislature in 2005. At issue was the likely loss of Medicaid dollars to certain hospitals that qualify for special revenue in the Medicaid fee-for-service program through federal upper payment limit (UPL) provisions. The hospitals would no longer be eligible for UPL payments from the state if hospital services were included in a capitation to an

MMLTC contractor. The Legislature has excluded the Dallas area from STAR+PLUS expansion because of the UPL issue, and consideration is being given to excluding hospital payments from MMLTC capitation in other areas.

In 2004, the Florida legislature authorized its Diversion Program to increase enrollment to another 3,000 individuals with a potential expansion to 25 total counties. The Diversion Program is voluntary, but Florida’s traditional fee-for-service alternatives were flat-funded during the same period, making managed care the only alternative to a waiting list in the short term. By March 2005, the new slots had been filled, and program enrollment had grown to approximately 6,000 in this MMLTC program.

In addition, by December 2005, the Florida Agency for Health Care Administration, in partnership with the Department of Elderly Affairs, will create an integrated, capitated delivery system for Medicaid recipients who are 60 years of age or older initially on a pilot basis in two areas of the state.

Minnesota plans to add a long-term care benefit to its mandatory Medicaid managed care Prepaid Medical Assistance Program (PMAP). The specifications for PMAP are similar to those of the Minnesota Senior Health Options (MSHO) program, except that PMAP will not attempt to integrate Medicare. Minnesota is also considering expansion of the MSHO program into additional counties.

The Massachusetts Senior Care Options (SCO) program began enrolling members in 2004; with nearly statewide coverage, it has the potential to become a fairly large program. By March 2005, it had enrolled 980 members. Though voluntary, the program may prove attractive because SCO members are not currently subject to copayments, which were recently established in the state’s traditional program.

In September 2004, Wisconsin won a \$5.5 million grant from CMS to undertake comprehensive reform of its long-term care system. The state intends to use the award in

part to design a statewide expansion of MMLTC.

Also in 2004, the Maryland legislature enacted a law calling for the development of two MMLTC pilot programs for dually eligible beneficiaries. Washington State is developing two new programs that include MMLTC, and San Diego County, California is planning an initiative based on the Massachusetts SCO model. Early in 2005, Hawaii submitted a federal waiver application to enroll older persons and persons with disabilities in managed care plans that would be responsible for all Medicaid services, including long-term care.

Exhibit 2. Estimated Enrollment in Medicaid Managed Long-Term Care Programs, 2004	
MMLTC Program	Enrollment
Arizona Long Term Care System (ALTCS)	23,427
Texas STAR+PLUS	10,671
New York Managed Long-Term Care (MLTC)	7,078 ^a
PACE and “Pre-PACE” ^b	8,419
Wisconsin Family Care	6,998
Minnesota Senior Health Options (MSHO)	3,910
Florida Frail Elder Option Program	3,070
Florida Diversion Program	2,800
Wisconsin Partnership Program	1,644
Massachusetts Senior Care Options (SCO)	100
Total	68,117

Source: Saucier, Burwell, and Gerst, 2005.

^aThis number has been reduced by 2,000 to avoid double-counting of New York PACE sites, which are included in the national PACE totals, next row down. New York State includes PACE and non-PACE programs under its managed long-term care initiative.

^bPre-PACE is an informal designation given to sites that are preparing to become PACE sites but are not yet operating under full dual capitation of Medicaid and Medicare.

Note: The estimates in the table include older people and people with physical disabilities but not those with developmental disabilities or mental illnesses.

Exhibit 3. Major Types of Managed Long-Term Care

1. Medicaid Long-Term Care Only	2. All Medicaid	3. Medicaid-Medicare	Contractor at risk for
HCBS Nursing Home	HCBS Nursing Home ^a	HCBS Nursing Home ^a	Medicaid Long-Term Care
	Medicaid Primary Medicaid Acute Medicaid Rx	Medicaid Primary Medicaid Acute Medicaid Rx	Medicaid Primary and Acute Care
		Medicare Acute Medicare Rx ^b	Medicare

HCBS = home and community-based services

^aContractor liability for nursing home benefits varies. ^bMedicare Part D Rx benefit begins January 2006.

MMLTC Models and Their Evolution

Three general types of MMLTC have emerged in terms of the scope of risk that is included in capitated payments to contractors (exhibit 3). In Type 1, contractors are at risk only for Medicaid long-term care services, including home and community-based and nursing home services. In Type 2, the managed care plans are responsible for long-term care plus all or most additional Medicaid-covered services, including primary care, acute care, and prescription drugs (though prescription drugs are excluded in at least one program). Type 3 is the most comprehensive, including both Medicaid and Medicare services. Type 3 programs are designed to address the fact that 90 percent or more of older persons with Medicaid also have Medicare coverage.

One might assume that MMLTC has evolved from the least to the most comprehensive type, but no clear pattern has emerged. Exhibit 4 on the following page shows the major MMLTC programs by date of inception and type.

First implemented in 1983, San Francisco’s On Lok program pioneered the most comprehensive Type 3 model of full risk for the provision of all Medicare and Medicaid services to frail older persons. On Lok later became the model for the Program for All-inclusive Care for the Elderly (PACE). PACE was an early promoter of placing organizations at financial risk for all primary, acute, and long-term services to enhance accountability and increase flexibility in the

allocation of resources. Like the fee-for-service HCBS waiver programs that were rapidly developing around them, PACE sites enrolled only persons whose long-term care needs were significant enough to qualify them for nursing home care but could be met appropriately in community settings.

In 1987, Florida launched a Type 2 model with its Frail Elder Option Program in Dade County, an initiative that also focused exclusively on persons who met nursing home functional eligibility levels. The Frail Elder Option capitated its contractor for Medicaid services only (including all long-term care); for people with both Medicare and Medicaid coverage, the Medicare part remained fee-for-service. Two years later, in 1989, the Arizona Long Term Care System (ALTCS) was launched, using a similar Type 2 model (Medicaid only for persons with nursing-home-level needs), but it greatly exceeded the scale of previous programs by making enrollment mandatory. ALTCS was the first—and remains the only—MMLTC program to cover an entire state.

By the early 1990s, managed care had become the dominant mode of health financing and delivery in private sector markets, and states were enrolling substantial numbers of children and parents in Medicaid managed care plans for primary and acute care. Hoping to extend managed care to long-term care users, more than a dozen states, including Colorado, Delaware, Florida, Minnesota, New York,

Exhibit 4. Characteristics of Major Managed Long-Term Care Programs

	Program for All-inclusive Care for the Elderly (PACE)	Florida Frail Elder Option Program	Arizona Long Term Care System (ALTCS)	Wisconsin Partnership Program	Minnesota Senior Health Options (MSHO)	New York Managed Long-Term Care (MLTC)	Texas STAR+ PLUS	Florida Diversion	Wisconsin Family Care	Massachusetts Senior Care Options (SCO)
Inception Date and Type	1983 Type 3	1987 Type 2	1989 Type 2	1995 Type 2/3 ^a	1997 Type 3	1997 Type 1	1998 Type 2	1998 Type 2	2000 Type 1	2004 Type 3
Eligibility <i>Older persons</i> <i>Under age 55 with disability</i> <i>Level of LTC need</i>	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
	No	Yes	Yes	Yes	No	Yes	Yes	No	Yes	No
	NF eligible	NF eligible	NF eligible	NF eligible	Any or no LTC needs	NF eligible	Any or no LTC needs	NF eligible	Any LTC needs	Any or no LTC needs
Medicaid Enrollment Choice	Voluntary	Voluntary	Mandatory	Voluntary	Voluntary	Voluntary	Mandatory	Voluntary	Mandatory ^b	Voluntary
Area Covered	40 mostly urban sites in 18 states	2 urban counties in Southeast Florida	Statewide (urban and rural)	6 counties (urban and rural)	7 urban and 3 rural counties	Multiple counties (rural and urban, but mostly urban)	1 urban county; additional urban expansion proposed	25 urban and contiguous counties	5 counties (urban and rural)	Nearly statewide (urban and rural)

Source: Saucier, Burwell and Gerst, 2005

NF = Nursing Facility

^a Wisconsin Partnership began operating in 1995 as a partially capitated Medicaid model (Type 2). In 1999, it received the federal waivers required to become a fully capitated Medicaid-Medicare program (Type 3).

^b In order to receive HCBS waiver services in Family Care counties, persons must enroll in Family Care. State plan services, including nursing home care, personal care, and home health care, are available through the traditional fee-for-service Medicaid program.

Oregon, Texas, Virginia, Washington, and the six New England states, undertook formal planning for MMLTC initiatives. Most were supported by The Robert Wood Johnson Foundation, which had earlier supported the PACE replication and development of the Minnesota initiative. In 1996, the Foundation created the Medicare/Medicaid Integration Program (MMIP) at the University of Maryland Center on Aging, an \$8 million grant program that served as a national focal point for program development activities.

Despite substantial interest in every region of the country, planning and authorization proved to be challenging. Advocates and consumers expressed concern that choice would be diminished and care unfairly rationed. Providers opposed efforts in many areas, fearing that contractors would not subcontract with them, or would demand deep price discounts in a program already thought to be underfunded. Implementation of the federal Balanced Budget Act (BBA) of 1997 had resulted in serious disruption of the Medicare managed care market and contributed to a general backlash against managed care in the late 1990s among consumers whose plans had pulled out of their areas and among providers who had been left with unpaid bills. Additional challenges included a shortage of willing MMLTC contractors in many states, dual eligibility for Medicare and Medicaid (which complicated program design), and legal authority for MMLTC programs (which was largely uncharted), resulting in protracted negotiations between initiating states and CMS.

Only a handful of states achieved implementation in the 1990s. In 1995, Wisconsin launched its Partnership Program, a PACE-like initiative that departed from the model by adding younger persons with physical disabilities to the target group (PACE participants must be at least age 55); allowing physicians in independent practice to participate; and allowing members to decide whether or not they would attend adult day centers. In 1997, after five years of development, Minnesota Senior Health Options (MSHO, a Type 3 model) was

launched, making Minnesota the first state to implement a fully integrated model that combined Medicare and Medicaid benefits, including the full range of long-term care services, for the entire spectrum of older people, from well to frail.

However, the former Health Care Financing Administration (HCFA, now CMS) signaled that it was not anxious to approve many more comprehensive state experiments. State MMLTC programs were largely untested, and HCFA was hearing concerns from advocates and interest groups. HCFA, states, and the federal Office of Management and Budget also had significant disagreements about whether MMLTC programs would be budget-neutral. Some observers believe that, because of the high proportion of dually eligible beneficiaries, HCFA also had policy concerns about ceding Medicare authority to states, and diminishing Medicare's freedom of choice in the process. Instead, it supported making the voluntary PACE program a mainstream option by advocating permanent legislative authority for PACE in the BBA of 1997.

Several states put MMLTC on the back burner, deciding that the potential benefits were not worth the effort required to overcome HCFA's reluctance, difficult consumer concerns regarding choice, access, and quality, provider concerns about being displaced, and complex program design issues.

Other states proceeded with less complex models that required less intensive planning and could be implemented without §1115 demonstration waivers. For example, New York, which already had substantial PACE experience by the late 1990s, added the first Type 1 Medicaid long-term-care-only program to the mix in 1997, in part to create less risky options for long-term care providers who wanted to get into the business but lacked substantial experience managing acute care risk. In 1998, Texas implemented a Type 2 model called STAR+PLUS in Harris County (Houston and the surrounding area), becoming the second state to implement a mandatory MMLTC program and the second largest enroller of long-term care users, after Arizona.

Also in 1998, Florida created its voluntary Type 2 Diversion Program in four counties, adding a second MMLTC initiative to its Frail Elder Option.

In 2000, when the Wisconsin Department of Health and Family Services held out the fully capitated Type 3 Partnership Program as a potential model for statewide comprehensive redesign of the long-term care system, consumers and advocates feared loss of choice and access and mobilized against the initiative. Responding to the outcry, Wisconsin instead piloted the Family Care Program, a Type 1 MMLTC model that puts participating counties (in which many traditional providers are central) at financial risk for long-term care while allowing the traditional aging services network to retain its historical role at the center of the delivery system.

Some wondered whether comprehensive Type 3 MMLTC with private sector contractors was an idea whose time had come and gone. But then, the Massachusetts Senior Care Options (SCO) program emerged in 2003 after almost eight years of development. Massachusetts and CMS issued a joint procurement, and three contractors were selected. Enrollment in the voluntary Type 3 Medicaid-Medicare program began in early 2004.

Experience to Date

Before the late 1990s, few studies had been completed to assess whether beneficiaries experienced better or worse health and social outcomes under MMLTC models; whether utilization patterns changed; and whether MMLTC models were cost-effective relative to fee-for-service systems. Recently, a number of new studies have been completed, and although the evidence remains inconclusive, some important patterns are emerging.

Access: MMLTC reduces use of emergency rooms, hospitals, and nursing homes

One fairly clear outcome is that MMLTC, like private sector managed care, reduces the use of higher cost services, including emergency rooms, hospitals, and nursing homes.

In their evaluation for CMS of the Minnesota Senior Health Options program, Kane and Homyak (2003a) found that MSHO members in nursing homes had fewer hospital admissions and days, fewer preventable hospital admissions, and fewer emergency room visits and preventable emergency room visits than control group members. Differences were not as great for community MSHO members, but they did experience shorter hospital length of stay and fewer preventable emergency room visits than control group members.

In their evaluation of PACE, Chatterji and colleagues (1998) found decreased inpatient hospital admissions and days and decreased nursing home days. Both MSHO and PACE are Type 3 Medicaid-Medicare programs.

Similar findings emerge from evaluations of Medicaid-only programs. An independent assessment of the Wisconsin Family Care program found that hospital length of stay decreased significantly following enrollment in Family Care, though no change occurred in inpatient hospital admission rates (APS Healthcare, Inc., 2003). In a focused study of Texas STAR+PLUS Supplemental Security Income (SSI) beneficiaries who received adult day health or personal assistance services, Aydede (2003) found that STAR+PLUS members had shorter hospital lengths of stay, fewer emergency room visits, and much lower health care costs overall than a comparison group of SSI beneficiaries who were not enrolled in a managed care plan.

Evidence also shows that MMLTC increases access to HCBS. The Arizona Long Term Care System has progressively increased the use of HCBS over time. For example, from 1998 to 2002, the percentage of ALTCS members being served in their own homes or in alternative residential settings increased from 41.1 percent to 63.3 percent (Arizona Health Care Cost Containment System, Arizona Department of Economic Security, and Arizona Department of Health Services, 2002). The independent assessment of Wisconsin Family Care found that waiting lists for long-term care services in Family

Care counties were eliminated, while waiting lists in comparison counties continued to increase (APS Healthcare, Inc., 2003). The study does not describe the specific dynamics of the waiting list, but the finding is consistent with evidence elsewhere that MMLTC reduces the use of hospital and nursing home care by substituting HCBS. Kane et al. (2003b) found that homemaker services, home-delivered meals, and outpatient rehabilitation all increased for Minnesota Senior Health Options community members relative to control groups.

Cost: Findings regarding savings are inconclusive

Studies on the cost-effectiveness of MMLTC programs are mixed and inconclusive. Utilization studies support the theory that relatively expensive hospital and nursing home services are reduced and replaced with more community-based services, but aggregate savings are elusive.

- *Arizona*. In the first evaluation of ALTCS, McCall and colleagues (1992) found overall savings of 6 percent and 13 percent respectively in 1990 and 1991, but nearly all the savings were related to members with developmental disabilities, and the study was limited by its use of people in a different state (New Mexico) for the comparison group. Weissert and colleagues (1997) took a different approach later in the life of ALTCS, developing a complex model that estimated the nursing home savings resulting from the expansion of HCBS in the program. By subtracting the cost of expanded HCBS from the money saved by diverting ALTCS members from nursing homes, Weissert and colleagues concluded that about \$4.6 million had been saved.
- *Texas*. A Lewin Group analysis (2004) conducted for the Texas Health and Human Services Commission *projected* substantial STAR+PLUS savings if the program were expanded to 51 metropolitan counties. Greater savings (8.6 percent) were projected for SSI beneficiaries under 65 years of age than

for older people (5 percent). A large percentage of savings were projected from reductions in inpatient and emergency room use.

- *Wisconsin*. In the Family Care program, APS Healthcare, Inc. (2003) found savings in four of five Family Care counties (\$113 per member per month less than fee-for-service comparison counties), but overall state savings disappeared when the fifth Family Care county—Milwaukee—was included in the analysis. The study did not explain why Milwaukee results were different from those for the other counties.

The studies described above analyzed Type 1 and 2 Medicaid-only MLTC programs and examined only Medicaid costs. Studies that include both Medicaid and Medicare costs are no more conclusive, however. Kane and Homyak (2003a) found that Minnesota Senior Health Options Medicare capitation payments were higher than Medicare fee-for-service payments among comparison group members, but state officials have pointed out that the study was conducted in the post-BBA period. The BBA effectively decoupled Medicare managed care rates from fee-for-service spending, allowing capitated payments to rise above average fee-for-service expenditures.

White, Abel, and Kidder (2000) compared PACE capitation rates to projected costs in the absence of PACE in the study areas and found that the Medicare capitation was considerably lower than projected fee-for-service costs, the Medicaid capitation was considerably higher, and combined payments to PACE were slightly higher than projected combined fee-for-service costs would have been. However, the cost analysis was limited to the first year of enrollment and does not capture the higher acute and long-term care costs typically incurred by PACE as members develop increasing needs. PACE officials also argue that Medicaid fee-for-service comparison costs may be artificially suppressed by unmet needs in the community. And officials have expressed concern that not all of a state's HCBS costs were included in the costs for the

PACE comparison group because of the way fee-for-service Medicaid claims are categorized. A new cost evaluation of PACE is under way.

Although cost savings have been difficult to demonstrate with certainty, state officials value the increased predictability of spending under MMLTC. Unlike fee-for-service, in which the state spending depends on the use of services, MMLTC budgets are based on a set payment per beneficiary.

Quality: Recent reports neutral to favorable

In recent years, a few independent evaluations have been conducted for CMS, which have shown modest to positive benefits for MMLTC consumers. In a CMS-sponsored evaluation, Kane et al. (2003b) found few significant differences between Minnesota Senior Health Options members and control group members in their evaluation of MSHO. Community MSHO members did become less likely to report moderate to severe pain over time than control group members, but comparative measures of functioning (ADL and IADL scores) over time showed no significant differences. Functioning of MSHO members in nursing homes (ADL scores) was not significantly different from functioning of nursing home comparison group members. The authors concluded that, in general, MSHO resulted in modest benefit for enrollees compared with control groups.

A CMS-sponsored evaluation of PACE outcomes (Chatterji et al., 1998) was very positive, finding improved quality of life, satisfaction, and functional status. The study also found that PACE enrollees lived longer and spent more days in the community than members of a comparison group.

In addition, states commission consumer surveys and other studies in response to federal requirements or as part of their quality management programs. Consumer satisfaction levels, based on consumer and family surveys, have been high for most MMLTC programs. ALTCS, MSHO, and the New York MLTC programs all report high overall levels of satisfaction (Arizona Health Care Cost

Containment System, 2002; Minnesota Health Data Institute, 2002; New York State Department of Health, 2003). Satisfaction levels for Texas STAR+PLUS have not been as high as they have been for programs in other states; nonetheless, they have been higher than other Texas mandatory managed care programs that do not include long-term care or care coordination (Texas Department of Health, 2000; Texas Department of Human Services, 2001).

Key Issues for Policymakers

MMLTC has been slow to develop, in part because it involves complex policy choices and intense stakeholder engagement. Policymakers must choose from a potpourri of options. These options include mandatory versus voluntary enrollment; fee-for-service versus capitated benefits; program eligibility (e.g., the broad long-term care Medicaid population versus only those who are eligible for nursing facilities); the geographic area served (statewide versus regional); payment rates; quality assurances; and legal authority from the federal government (Section 1115 versus Section 1915 waivers or no waiver at all). A brief discussion of these issues follows.

Enrollment: Mandatory or voluntary?

Most MMLTC programs are voluntary—Medicaid beneficiaries may choose between MMLTC and a traditional fee-for-service system—but mandatory programs have the highest enrollment. Only ALTCS and STAR+PLUS have mandatory enrollment for all community-based long-term care services. Wisconsin's Family Care program is mandatory for persons seeking HCBS waiver services in Family Care counties, but State Medicaid plan services, including nursing home, personal care, and home health, are also available through the traditional fee-for-service Medicaid program.

If a state wants to bring an MMLTC program to scale quickly or be able to guarantee a large number of members and revenue to prospective contractors, mandatory enrollment is attractive. Rate-setting for mandatory programs is easier, and there is less concern

about contractors “cherry picking” healthier, low-cost members. However, Medicare enrollment must be voluntary under federal law, so states that desire Medicare and Medicaid integration must create voluntary programs.

Consumers typically prefer voluntary enrollment. Consumers may have established relationships with long-term care providers and fear that mandatory programs with selective provider networks will disrupt those relationships. Also, consumers are wary of underservice and are fearful that they will be locked into a mandatory system and unable to obtain services, and that quality will diminish.

Long-term care providers generally prefer to contract directly with the state Medicaid office rather than with private contractors.

Capitated benefits: What benefits should be included in the capitation? Should contractors be at risk only for long-term care, Medicaid long-term care, and acute care, or for the comprehensive range of Medicaid and Medicare benefits?

Having a comprehensive set of benefits in the capitation payment reduces or even eliminates opportunities for cost shifting; provides better coordination of care across more services with perhaps fewer errors; and allows for budget stability over a larger part of the Medicaid budget. On the other hand, the more services that are included in the capitation rate, the more tightly these services will be managed, potentially leading to a loss of choice and access for consumers.

Many states have avoided Type 3 Medicaid-Medicare models because of the challenges states have had negotiating Medicare agreements with CMS and the federal Office of Management and Budget. States have argued that because dually eligible beneficiaries (those who have both Medicaid and Medicare coverage) usually have needs greater than those of Medicare-only beneficiaries, the usual rate paid to Medicare managed care plans is not adequate for Medicaid-Medicare programs. But getting a different Medicare payment from CMS

requires a §222 waiver, and applications are scrutinized for cost neutrality. (Section 222 waivers allow CMS to authorize special Medicare payment demonstration programs, but they must be cost neutral.) This issue may diminish as CMS continues to phase in a risk adjustment system for Medicare payments, assuming it adequately captures the costs of dually eligible beneficiaries.

Target group: Who is eligible for an MMLTC program?

Program designers must decide (1) whether to limit enrollment to older people (as in Massachusetts SCO, Florida Diversion, Minnesota SHO, and PACE) or to include both older and younger groups (as in Florida’s Frail Elder Option, ALTCS, Wisconsin’s Family Care, New York’s MLTC, and STAR+PLUS), and (2) whether to target only persons who already need a nursing home level of care or persons with a broad range of needs.

From the inception of PACE through 1996, all MMLTC programs targeted high-need beneficiaries who would otherwise qualify for nursing home care. Minnesota SHO pioneered a new approach in 1997, preferring to serve all older persons, regardless of their need for long-term care services. Since then, three other programs—STAR+PLUS, Wisconsin Family Care, and Massachusetts SCO—have included persons with any level of long-term care need. In these programs, contractors have an opportunity to provide services that may prevent or delay the need for long-term care among their healthier members.

Contractors: What capacity is needed, and will it be available?

Program designers must also decide what type of organization is preferred as a contractor and which ones are likely to bid. Market and political dynamics, as well as state insurance laws, influence this decision.

To serve members well, contractors should have experience managing a range of long-term care services, as well as the capacity and experience to bear financial risk. Long-term care experience tends to reside in small

community-based organizations that lack the capital to bear risk. The capacity to bear risk tends to reside in HMOs and other large organizations that meet insurance regulations but are inexperienced with long-term care.

To date, the majority of contractors have been nonprofit community-based organizations limited to local markets such as community hospitals, home health agencies, and disability services organizations.

There is low interest among mainstream HMOs. This is not surprising, given HMOs' relative lack of experience with long-term care and the volatility of the public managed care market.

States have been left to work largely with nonprofit and government organizations that often have substantial experience in long-term care but little or no risk management experience or capital to meet the solvency standards applied to the insurance industry.

Many states are struggling with the appropriate balance between allowing traditional long-term care providers (including county-based agencies) to be risk-bearing contractors, perhaps by relaxing insurance requirements and protecting consumers against financial failure of the organizations. For example, counties have been given special status in Arizona and Wisconsin, and Florida has waived certain insurance requirements for licensed long-term care providers that want to be contractors.

Geographic area: Are rural areas viable?

With the exception of Arizona, no programs operate statewide. Most are limited to urban and suburban counties. The two programs with the greatest rural presence—Wisconsin's Family Care and Arizona's ALTCS—use county governments as contractors.

Payment methods: How should states pay managed care plans for MMLTC?

Many state officials who oversee MMLTC programs report that they have not yet fully refined their payment systems. Texas has had concerns that plans within STAR+PLUS might experience adverse or favorable

selection relative to one another and has tried two risk adjustment systems to address the problem. Florida reduced Diversion Program rates after determining that favorable selection resulted in overpayment, and it has notified contractors that more reductions could come in the future. New York believes that more study is needed to determine whether its MMLTC programs are cost-effective.

Clearly, payment is a challenging area, but state administrators believe that rates can be fine-tuned as better technology is developed. As long as utilization patterns move from higher cost to lower cost services (as they appear to be doing in most studies), the actual costs of delivering care are probably declining. The challenge becomes one of appropriate pricing to allow states and the managed care plans to share savings.

Quality: How should the quality of MMLTC be measured?

States must ensure three major quality components for any risk-based Medicaid managed care program:

- States must articulate a quality management strategy that includes a method for detecting individual consumer problems, taking action in response to problems, and making system-level quality improvements;
- States must ensure that their risk contractors have internal quality improvement programs that meet requirements established by the state. The state's requirements would, among other things, specify the data that contractors must submit to the state. For example, some MMLTC programs require plans to collect and submit Medicare HEDIS (Health plan Employer Data and Information Set) measures; and
- Under the BBA of 1997, states must contract with an external quality review organization (EQRO) to perform independent reviews of program quality.

States have considerable discretion in how they meet the three major components of

quality measurement. Exhibit 5 lists some of the quality improvement activities that have been undertaken in MMLTC programs.

Exhibit 5. Examples of MMLTC Quality Improvement Activities

- Consumer and provider satisfaction surveys
- Health Outcomes Survey (HOS)
- EQRO focus study on care coordination
- HEDIS performance measures
- Enrollee records reviews
- Contractor best practice collaborative
- Protocols and tools for care coordinators
- Utilization review
- Provider credentialing
- Reviews of clinical outcomes
- Program evaluation

Legal authority: What are the options for state program planners?

Since there was initially very little experience applying managed care to long-term care, CMS took a cautious stance. Also, early applications for waivers for MMLTC were unprecedented in many ways, requiring CMS to clarify its own legal authority to grant what states were requesting. Exhibit 6 shows how states and CMS have moved from more complex demonstration waivers to more mainstream statutory authority. Early on, with no experience to guide it in this area, HCFA (now CMS) considered MMLTC proposals under Section 1115, the authority that allows the secretary of health and human services to approve Medicaid demonstration programs as long as they are budget-neutral relative to the traditional program. Section 1115 waivers are notoriously difficult and time-consuming to obtain, discouraging many states from applying.

Recently, CMS and the states have established more innovative ways to use existing statutory authorities at Section 1915 (a), (b), and (c), greatly streamlining the Medicaid approval process.

States that want special Medicare payments as part of a Medicare-Medicaid integrated model still face protracted negotiations with CMS, but a new option is emerging. The Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 increased Medicare managed care rates, a move that has resulted in the reentry of private sector plans and renewed growth of the Medicare managed care market. Specifically, the MMA offers Medicare Advantage plans a new opportunity to create special needs plans. Medicare Advantage rules require that plans be open to all Medicare beneficiaries; however, special needs plans may be marketed exclusively to enrollees with special needs, including those who live in nursing homes, are eligible for Medicare and Medicaid, or have certain chronic or disabling conditions. This new vehicle allows states to combine Medicaid and Medicare benefits for long-term care populations without the extensive use of waivers. Because this option is new, it is still uncertain whether states will contract with specialized plans under the MMA or whether Medicare risk adjustments will be adequate for dually eligible enrollees with Medicare and Medicaid coverage, thus making §222 Medicare waivers unnecessary.

Exhibit 6. Evolution of Legal Authority for MMLTC

1980s: Early initiatives require §1115 Medicaid waivers and §222 Medicare payment waivers.	1983	On Lok receives §1115 Medicaid and §222 Medicare waivers.
	1987	Florida Frail Elder Option begins under a §1115 Medicaid waiver.
	1989	ALTCS receives a §1115 Medicaid waiver.
1990s: Two more §1115/§222 programs approved, but movement is toward less onerous §1915 waivers for Medicaid, and fewer states pursue Medicare payment waivers.	1990	Florida Frail Elder converts to §§1915 (a) and (c) in an early preview of waiver evolution.
	1995	Wisconsin Partnership begins operating without waivers as a partially capitated Medicaid prepaid health plan.
	1997	Minnesota Senior Health Options receives §1115 Medicaid and §222 Medicare waivers.
	1997	Balanced Budget Act of 1997 makes PACE an optional program with its own statutory authority under §§1894 and 1934 of the Social Security Act, enabling “waiverless” PACE sites.
	1997	New York launches MLTC plans under §§1915 (a) and (c).
	1998	Texas STAR+PLUS becomes the first state to use §§1915 (b) and (c) waivers to create a mandatory MMLTC program.
	1998	Florida adds its Diversion Program under §§1915 (a) and (c).
	1999	Wisconsin Partnership receives §1115 Medicaid and §222 Medicare waivers, allowing it to fully capitate both Medicaid and Medicare payments.
2000s: Continued emphasis on Medicaid §1915; exploration of future waiverless options.	2000	Minnesota converts MSHO from §1115 to §1915 (c) Medicaid waiver, retaining §222 Medicare waiver.
	2000	Wisconsin launches Family Care, using §§1915 (b) and (c) waivers.
	2004	Massachusetts SCO launched with no Medicaid waivers but with §222 Medicare waivers.
2005+: A waiverless future?	2005	Will states contract with specialized plans under the MMA? Will Medicare risk adjustment be adequate for dually eligible long-term care users, making §222 Medicare waivers unnecessary?

Conclusion

In the past, policymakers have been cautious about moving toward MMLTC, in part because of the backlash against managed care following withdrawal of Medicare plans in the late 1990s, the complexity of design options, and the difficulty in getting federal approval. Also, resistance has come from some consumers and advocates—who worry about loss of choice and restricted access to care—and some providers concerned about a diminished role in the long-term care system.

Now, interest in MMLTC may rise again. A still limited but larger number of studies has emerged and provides evidence that a central goal of MMLTC, reducing hospital and nursing home care in favor of more community-based care, is realistic. With state and federal efforts to contain Medicaid costs and provide more community-based long-term care to growing numbers of people of all ages, pressure is building for alternatives to traditional fee-for-service, case managed or consumer-directed long-term care, which some view as unsustainable. Implementation of the MMA of 2003 has increased Medicare managed care rates and created new opportunities to serve dually eligible persons with Medicare and Medicaid coverage in special needs plans, expanding the pool of potential contractors for states. Despite inconclusive evidence of cost savings, these factors may result in a new wave of MMLTC planning and implementation in states.

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References

- APS Healthcare, Inc. 2003. "Family Care Independent Assessment: An Evaluation of Access, Quality and Cost-Effectiveness for Calendar Year 2002." Washington, DC: APS Healthcare, Inc.
- Arizona Health Care Cost Containment System, Arizona Department of Economic Security, and Arizona Department of Health Services. 2002. "Arizona's Community-Based Services and Settings Report, 3rd Biennial." Phoenix: State of Arizona.
- Arizona Health Care Cost Containment System. 2002. "Arizona Long Term Care System (ALTCS) Consumers Speak Out." Accessed 3/15/05 at www.ahcccs.state.az.us/Publications/Reports/ALTCSurveyProject/2002/WhatConsumersSay.pdf
- Aydede, Sema K. 2003. "The Impact of Care Coordination on the Provision of Health Care Services to Disabled and Chronically Ill Medicaid Enrollees (Texas Star+Plus Focus Study)." Gainesville: University of Florida, Institute for Child Health Policy.
- Chatterji, Pinka, Nancy R. Burstein, David Kidder, and Alan J. White. 1998. "The Impact of PACE on Participant Outcomes." Cambridge, MA: Abt Associates. Prepared under HCFA Contract No. 500-96-0003/T04.
- Kane, Robert L., and Patricia Homyak. 2003a. "Minnesota Senior Health Options Evaluation Focusing on Utilization, Cost and Quality of Care." Minneapolis: University of Minnesota School of Public Health, Division of Health Services Research and Policy. Final version (revised August 2003). Prepared under HCFA Contract No. 500-96-0008/TO3.
- Kane, Robert L., Patricia Homyak, Boris Bershady, Yat-Sang Lum, and Mir Said Siadat. 2003b. "Outcomes of Managed Care of Dually Eligible Older Persons." *Gerontologist*, v. 43, no. 2: 165-74.
- Lewin Group. 2004. "Actuarial Assessment of Medicaid Managed Care Expansion Options." Prepared for the Texas Health and Human

Services Commission. Amended version, January 21, 2004.

McCall, Nelda, Jodi Korb, Lynn Paringer, Donald Balaban, C. William Wrightson, John Wilkin, Alice Wade, and Margaret Watkins. 1992. "Evaluation of Arizona's Health Care Cost Containment System Demonstration, Second Outcome Report." San Francisco: Laguna Research Associates. Prepared under HCFA Contract No. 500-89-0067.

Minnesota Health Data Institute. 2002. "Minnesota Senior Health Options 2002 Consumer Assessment of Health Care: MSHO Nursing Home Population." St. Paul, MN. Accessed 2/20/05 at www.dhs.state.mn.us/HealthCare/pdf/Final-Report-Appendices.pdf

New York State Department of Health. 2003. "New York State Managed Long Term Care, Interim Report. Report to the Governor and Legislature." Albany, NY: New York State Department of Health.

Saucier, Paul, Brian Burwell, and Kerstin Gerst. 2005. "The Past, Present and Future of Managed Long Term Care." Submitted by Medstat and the University of Southern Maine to the U.S. Department of Health and Human Services, Office of Assistant Secretary for Planning and Evaluation.

State Health Facts. 2005. Henry H. Kaiser Family Foundation. Accessed 6/24/05 at www.statehealthfacts.kff.org/cgi-bin/healthfacts.cgi?action=compare&category=Medicaid+%26+SCHIP&subcategory=Medicaid+Managed+Care&topic=Enrollment+by+Plan+Type

Texas Department of Health. 2000. "Comparing Medicaid Managed Care Plans in Texas, 2000." Austin. Accessed 2/15/05 at www.hhsc.state.tx.us/medicaid/mc/about/reports/2000annrpts/2000consumersatsurvey/2000-09-15finalexecsummaryconsumersat.pdf

Texas Department of Human Services. 2001. "STAR+PLUS Dually Eligible Consumer Study Technical Report." Austin: Texas Department of Human Services.

Weissert, William G., Timothy Lesnick, Melissa Musliner, and Kathleen A. Foley. 1997. "Cost Savings from Home and Community-Based Services: Arizona's Capitated Medicaid Long-Term Care Program." *Journal of Health Politics, Policy and Law*, v. 22, no. 6: 1329-57.

White, Alan J., Yvonne Abel, and David Kidder. 2000. "A Comparison of the PACE Capitation Rates to Projected Costs in the First Year of Enrollment." Cambridge, MA: Abt Associates. Prepared under HCFA Contract No. 500-01-0027.