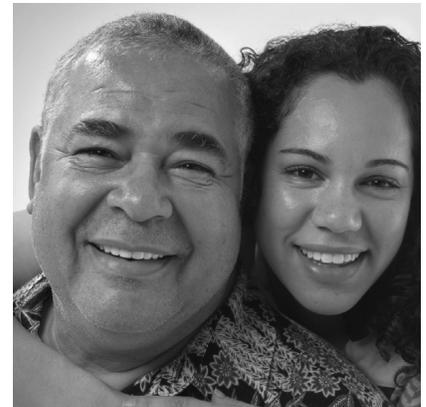




Profiles of State Innovation: Roadmap for Managing Long-Term Supports and Services

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The **Center for Health Care Strategies** is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs that better serve Medicaid beneficiaries.

For more information, visit www.chcs.org.

Foreword

The Affordable Care Act of 2010 presents national policymakers and state leadership across the country with the opportunity to improve quality outcomes for low-income adults receiving long-term supports and services (LTSS). Even prior to its passage, a number of states had developed successful long-term care models, particularly in the home- and community-based service area. The SCAN Foundation wanted to create an opportunity for all states not only to learn about these various model programs, but also to provide a specific roadmap for states interested in implementing similar programs. Key issues include what concrete steps state officials need to consider within their own state as well as how to best interface with the Centers for Medicare & Medicaid Services to implement these options.

To this end, the Center for Health Care Strategies (CHCS) has developed three *Profiles of State Innovation* roadmaps to help states explore and understand emerging options, best practices, and proven models of success in three areas: (1) rebalancing LTSS care options to support home- and community-based services; (2) the development and implementation of a managed LTSS program; and (3) integrating care for adults who are dually eligible for Medicaid and Medicare.

The mission of The SCAN Foundation is to advance the development of a sustainable continuum of quality care for seniors. The *Profiles of State Innovation* roadmaps outline ways to achieve a more balanced, integrated, and efficient LTSS system. The information included in each roadmap has the potential to ensure that older adults and people with disabilities can age with dignity, choice, and independence while remaining in their homes or in the environment they prefer.

We thank all of those who have contributed to this series, especially the state and program innovators profiled, and members of the project's National Advisory Group, who gave so generously of their time and expertise. We also acknowledge the dedication and hard work of the CHCS staff: Stephen A. Somers, Alice Lind, Lindsay Barnette, Suzanne Gore, and Lorie Martin.

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Top Ten Mileposts for Reaching Effective Managed Long-Term Supports and Services Delivery

This roadmap outlines best practices to help states reach the following critical mileposts in developing effective models for managed long-term supports and services.

1. Communicate a clear vision for managed long-term supports and services (LTSS) to promote program goals.
2. Engage stakeholders to achieve buy-in and foster smooth program implementation.
3. Use a uniform assessment tool to ensure consistent access to necessary LTSS.
4. Structure benefits to appropriately incentivize the right care in the right setting at the right time.
5. Include attendant care and/or paid family caregivers in the benefit package.
6. Ensure that program design addresses the varied needs of beneficiaries.
7. Recognize that moving from a 1915(c) waiver to risk-based managed care is a fundamental shift in how the state and managed care organizations think about LTSS financing and plan accordingly.
8. Develop financial incentives to influence behavior and achieve program goals.
9. Establish robust contractor oversight and monitoring requirements.
10. Recognize that performance measurement is not possible without LTSS-focused measures.

Introduction

The passage of the Affordable Care Act (ACA) left a fair amount of unfinished business in the U.S. health system in the long-term supports and services arena. It may be some time before Congress takes on major legislation on long-term care, but there is little doubt that demographics and economics will compel policymakers to consider more dramatic changes in how the nation organizes, finances, and delivers long-term supports and services (LTSS). In the meantime, with the exception of the Community Living Assistance Services and Support (CLASS) Act and some more modest features of ACA, the onus for rethinking publicly financed LTSS delivery will reside at the state level, particularly in Medicaid, which finances more than 40 percent of LTSS in America.¹

Fortunately a good number of states have made genuinely innovative and robust investments in this arena over the past several decades. These efforts can be grouped into three areas:

- Rebalancing LTSS to provide more home- and community-based services (HCBS) options as well as nursing facility alternatives;
- Developing and implementing a managed long-term supports and services (MLTS) program; and
- Integrating care for adults who are dually eligible for Medicare and Medicaid.

Through support from The SCAN Foundation, the Center for Health Care Strategies (CHCS) conducted an environmental scan to identify state best practices in each of these three critical areas. The resulting *Profiles of State Innovation* series culls lessons from state LTSS pioneers to create roadmaps for other states to follow as they develop new or improved systems of LTSS.

For this report, CHCS, with assistance from an advisory group of state staff and other experts,² identified five innovative states — Arizona, Hawaii, Tennessee, Texas, and Wisconsin — with expertise in managed care approaches for individuals with long-term care needs (see sidebar for selection criteria). The lessons herein were gathered through interviews and in-depth site visits with these pioneering states. CHCS also drew from its extensive work with additional states in pursuing MLTS programs and integrating care for duals. While the featured states each have different approaches to managing the full spectrum of long-term care needs, they are joined by the common vision of providing higher quality and more cost-effective long-term supports and services.

IN BRIEF

Medicaid pays for more than 40 percent of the nation's long-term supports and services (LTSS) costs. Although costs for LTSS represent almost one-third of all Medicaid spending, these services are often disconnected and financially misaligned. Overhauling the delivery of long-term care offers significant opportunities for states to improve health care quality, control costs, and enhance the quality of life for millions of Americans. Health reform legislation extends new funding options for states to achieve a more equitable balance between institutional and home- and community-based care.

This roadmap culls from state best practices across the country to outline key elements for managing LTSS that provide high-quality, consumer-focused, and cost-effective care.

¹ Kaiser Commission on Medicaid and the Uninsured estimate based on CMS National Health Accounts data, 2008.

² See appendix for list of advisory group members.

State Environment

Today, 94 percent of Medicaid beneficiaries needing LTSS receive their care through the fragmented fee-for-service (FFS) system.³ LTSS costs continue to account for greater proportions of Medicaid spending and the nation's aging population is generating increasing need for services. This is motivating many states to look for ways to offer consumers broader access to home- and community-based options, while at the same time better managing overall long-term care spending. Thus, more states are interested in pursuing managed care approaches for these types of services.

Interviews with the states indicated that they sought to implement an MLTS program to:

- Build upon existing managed care experience and/or infrastructure, as in Arizona and Tennessee;
- Use managed care organizations to decrease and/or end waiting lists for home- and community-based waiver services, as in Hawaii, Texas and Wisconsin;
- Provide a more flexible set of benefits and more choice than typically found in Medicaid FFS, particularly for community-based care;
- Achieve a more cost-effective long-term supports and services system;
- Strengthen the quality of care; and/or
- Take an important step toward fully integrating the delivery and financing of the full range of acute and long-term supports and services for those needing long-term care.

Prevailing wisdom tells us that if “you’ve seen one Medicaid program, you’ve seen one Medicaid program.” There is no aspect of the program wherein this is more true than in the design of MLTS programs. These programs vary dramatically from one state to the next in terms of target populations, covered benefits, enrollment options, and contracting. The decisions states make in the design of MLTS programs are dependent on their individual histories and context, including existing infrastructure (both in terms of managed care as well as LTSS) and the political support for and stakeholder concerns about managed

State Selection Criteria

To identify state innovators, CHCS and the advisory group members referenced several information sources on state progress in improving LTSS systems, including the Kaiser Family Foundation's and Thomson Reuters' reports on waiver expenditures, and an AARP report that breaks out LTSS expenditures by eligibility category.⁴

General criteria:

1. State's system for assessment, determination of need, and case management of LTSS is independent of providers.
2. State collects and analyzes data for performance measurement, and mines data to track utilization and program impacts on costs.
3. Consumers and other stakeholders are engaged in program design and quality monitoring.
4. State is committed to continuous quality improvement of its LTSS towards statewide system that supports multiple populations.
5. State has formal and informal bridges across medical/LTSS systems.

Criteria for managed LTSS states:

1. State has regulatory and/or legislative support for non-FFS approach to LTSS.
2. State engages consumers in program implementation.
3. State relies on cross-agency integration to blend financing and delivery systems.
4. State has commitment to evaluate along multiple dimensions.
5. The managed care system in the state is replicable.

³ P. Saucier. “Overview of Medicaid Managed Long-Term Care.” Presented at the National Health Policy Forum on Medicaid Managed Long-Term Care, April 25, 2008.

⁴ B. Burwell, et al. “Medicaid Long-Term Care Expenditures in FY 2008.” Thomson Reuters, December 1, 2009 (available at <http://www.hcbs.org/moreInfo.php/doc/2793>); T. Ng, C. Harrington, M. O'Malley-Watts. “Medicaid Home and Community-Based Service Programs: Data Update.” Kaiser Commission on Medicaid and the Uninsured, November 2008 (available at http://www.kff.org/medicaid/upload/7720_02.pdf); and E. Kassner, et al. “A Balancing Act: State Long-Term Care Reform.” AARP Public Policy Institute, July 2008 (available at http://assets.aarp.org/rgcenter/il/2008_10_Itc.pdf).

care. While Figure 1 (see pages 8-9) provides detailed information on the key characteristics of the MLTS programs found in the states interviewed, there are a few distinctions worth highlighting:

- While most states have a broad inclusion policy (all adults age 65 and over as well as people with physical disabilities are eligible to enroll), some states (Arizona and Tennessee) have chosen to focus on those at risk for or at the nursing home level of care. Wisconsin includes people with developmental disabilities in its program in addition to other eligibility categories. Hawaii includes all age groups, which means that medically fragile children are served under the MLTS program as well as frail elderly.
- Contractors in Arizona, Hawaii, and Tennessee are responsible for providing the full-range of Medicaid acute and long-term supports and services to the population being served, while Wisconsin's program includes Medicaid long-term supports and services only. While Texas includes both acute and LTSS, its STAR+PLUS program does have some notable carve-outs including hospital and nursing facility care.
- Arizona, Hawaii, Tennessee, and Texas have elected to make their MLTS programs mandatory for eligible beneficiaries while Wisconsin's Family Care program is voluntary.
- Hawaii, Tennessee, and Texas have chosen to include large, national managed care organizations among their contractors, while Wisconsin uses "public" managed care organizations (MCO), composed of consortia of counties, as well as private plans. Arizona has more of a hybrid approach, contracting with a mix of large, national plans as well as local, home-grown or county-based MCOs.
- The majority of states have created an MLTS program that is separate from the managed care program providing acute care to the broader Medicaid population. Tennessee is the exception — it chose not to have a separate procurement for MLTS contractors and instead chose to amend contracts with their existing MCOs to bring LTSS into the mix.

Three of the five states interviewed have been operating their respective MLTS programs for more than 10 years. As a result, these states are focused primarily on expanding or improving upon the existing program infrastructure. For example, the Arizona Long Term Care System (ALTCS) program was established in 1989. Texas is in the midst of expanding its STAR+PLUS program into the Dallas/Fort Worth area, which will bring the total of those with LTSS needs in managed care to approximately 45 percent. Similarly, Wisconsin is in the process of expanding Family Care statewide. As of summer 2010 the program, which began as a five-county pilot, was operating in 55 of the state's 72 counties. Hawaii and Tennessee are relative newcomers; Hawaii implemented its program statewide in 2009, and Tennessee completed implementation of its CHOICES program in August 2010.

Figure 1: State Managed Long-Term Supports and Services Program Dashboard

	Arizona Long Term Care Services	Hawaii QExA	Tennessee CHOICES	Texas STAR+PLUS	Wisconsin Family Care
Implementation Date	1989	2008	2010	1998	2000
Medicaid Authority	1115	1115	1115	1915 (b)/(c)	1915 (b)/(c)
Eligibility	Medicaid aged (65+), blind and disabled beneficiaries who need a nursing home level of care. Includes dual eligibles.	Medicaid aged and disabled beneficiaries of all ages, including those on spend-down.	Three target groups: (1) Medicaid beneficiaries receive care in nursing facilities (NF); (2) Medicaid beneficiaries age 65+ and adults age 21+ with physical disabilities who need a nursing home level of care; (3) Medicaid beneficiaries age 65+ and adults age 21+ with physical disabilities “at risk” of institutionalization.	Medicaid beneficiaries who receive SSI and/or qualify for certain waiver services. Includes dual eligibles.	Medicaid beneficiaries with long-term care needs, including frail elders, people with physical disabilities, and people with developmental disabilities.
Enrollment	Mandatory	Mandatory	Mandatory	Mandatory	Voluntary
Beneficiaries Served	49,501	41,500	Almost 30,000	155,000	30,013
Geography	Statewide	Statewide	Statewide	Limited geographic areas	Limited geographic areas (in process of expanding statewide)
Covered Benefits	Medicaid acute, behavioral health, and LTSS (including HCBS and NF).	Medicaid acute medical and behavioral health, LTSS (including HCBS and NF).	Medicaid acute, behavioral health, and LTSS (including HCBS and NF).	Medicaid acute, limited behavioral health, and home- and community-based services.	Medicaid LTSS (including HCBS and NF).
Integration with Medicare for Dual Eligibles	Contractors are not currently required to be special needs plans (SNPs) but many are, allowing for integration of care for beneficiaries who chose to receive both sets of services from single plan.	Contractors are not currently required to be SNPs.	Contractors are not currently required to be SNPs.	Contractors in the STAR+PLUS expansion area (Dallas/Ft. Worth) will be required to be SNPs in order to fully integrate care for dual enrollees. Contracts in other areas of the state are not currently required to be SNPs but many areas, allowing for some integration.	Wisconsin has a separate program (Family Care Partnership) that uses SNPs and provides fully integrated acute, primary and long-term Medicaid/ Medicare services for dual eligibles.

	Arizona Long Term Care Services	Hawaii QExA	Tennessee CHOICES	Texas STAR+PLUS	Wisconsin Family Care
Care Management Overview/ Innovations	<p>Require MCOs to use the following case manager/ beneficiary ratios:</p> <ul style="list-style-type: none"> ▪ 1:48 in home; ▪ 1:60 in assisted living; and ▪ 1:120 in NF <p>In-home visits are required every 90 days.</p>	<p>Mandatory ratios of case manager to beneficiary based on eligibility status. In-person visits are required.</p>	<p>State requires that care management be vested within the MCOs. In-home visits are required quarterly with monthly contacts. Focus on managing transitions—inpatient admissions must be reported to MCOs in order to trigger immediate discharge planning.</p>	<p>State requires MCO service coordinators to be able to authorize services, including waiver services and adult family home. States does not mandate a case manager to client ratio, but has an expectation that the case manager will be able to meet the client’s needs, working with community resources.</p>	<p>Each beneficiary is assigned both a care manager and a registered nurse. In-home visits are required every 90 days. Care planning and service decisions are decided by beneficiary and care team. RNs are required to coordinate with acute care providers as well.</p>
Performance Measurement Overview	<p>23 acute care HEDIS measures. Also measure annual initiation of HCBS.</p>	<p>HEDIS, CAHPS measures.</p>	<p>HEDIS, CAHPS and select 1915(c) CMS performance measures regarding applicable waiver assurances.</p>	<p>State tracks quality of care, process measures, complaints and appeals; annual surveys conducted on access and satisfaction.</p>	<p>MCOs required to report on several quality indicators including continuity of care, vaccinations, and dental visits. State also measures personal experience outcomes through state-specific tool.</p>
Contractors	<p>Contractors at risk for all covered benefits. Includes large, national managed care organizations (MCOs) as well as local, public (county-based) plans.</p>	<p>Contractors at risk for all covered benefits. Includes large, national MCOs but HI-focus.</p>	<p>Contractors at risk for all covered benefits. Include large, national MCOs and plans with national affiliations.</p>	<p>Contractors at risk for everything except inpatient and NF care. Include large, national MCOs.</p>	<p>Contractors at risk for all covered LTSS services. Include primarily local and/or public (county-based) plans.</p>

	Arizona Long Term Care Services	Hawaii QExA	Tennessee CHOICES	Texas STAR+PLUS	Wisconsin Family Care
Rate Structure Overview	Blended capitation rate based on experience of health plan enrollees. Historically rate cells are defined by contract type. In FY 2007, separate capitation rates for (1) Dual; (2) Non-Dual; (3) Acute Care only; and (4) Prior Period Coverage, were developed.	Moving to blended capitation rates.	Blended capitation rate with built in assumptions regarding expected utilization (e.g., mix of HCBS/NF use) and level of care provided. Two rates: (1) Duals and (2) Non-duals.	LTSS portion of capitation rate is based on HCBS waiver experience. Rate cells include: (1) Other Community Care Medicaid Only; (2) Other Community Care Medicaid/ Medicare; (3) Community-Based Alternatives Medicaid Only; (4) Community-Based Alternatives Medicaid/Medicare	Capitation rates built for individual beneficiaries based on functional status and level of care needed in prior year. Rate development starts with base rates for NF level of care and non-NF level of care.
Evaluation	Yes, McCall 1996 and 1997. ⁵	Yes; Health Services Advisory Group is the EQRO.	Planned components include EQRO annual reports and NCOA Accreditation Survey reports.	Institute for Child Health Policy (external quality review organization) annual report. ⁶	Yes, APS Healthcare 2003. ⁷

⁵ N. McCall and J. Korb. "Utilization of Services in Arizona's Capitated Medicaid Program for Long-Term Care Beneficiaries." *Health Care Financing Review* 19 (2): 119-34, 1997. McCall, N., C.W.Wrightson, J. Korb, M. Crane, W.Weissert, and J.Wilkin. *Evaluation of Arizona's Health Care Cost Containment System Demonstration*. San Francisco: Laguna Research Associates, 1996.

⁶ Texas External Quality Review Annual Report Fiscal Year 2006 for Medicaid Managed Care and Children's Health Insurance Program. Prepared by Texas External Quality Review Organization Institute for Child Health Policy, University of Florida. January 2008. Available at: http://www.google.com/url?sa=t&source=web&cd=2&sqi=2&ved=0CBsQFjAB&url=http%3A%2F%2Fwww.hhsc.state.tx.us%2Freports%2F2006_External_Quality_Review_Annual_Report.pdf&rct=j&q=Texas%20Star%20Plus%20ICHP&ei=a4zITMqpJYOGlAestrIz1Cw&usg=AFQjCNF-0pxvto5dRIE_fc_MbWOiDLwulw

⁷ APS Healthcare, Inc. 2003. *Family Care Independent Assessment: An Evaluation of Access, Quality and Cost Effectiveness for Calendar Year 2002*. Available at <http://www.dhfs.state.wi.us/>

Implementation Mileposts

Based on the experiences of Arizona, Hawaii, Tennessee, Texas, and Wisconsin, CHCS identified 10 critical mileposts that states interested in pursuing MLTS approaches should strive for in the development and implementation of their programs.

1. Structure MLTS program around a vision/goal that addresses the needs of the state/community and communicate that vision to the broader stakeholder community.

Health Reform Intersections: The ACA, in §2406, expresses Congressional intent to expand the provision of home- and community-based long-term supports and services. States where legislatures have expressed similar visions have greatly benefited from the transparency and stakeholder involvement that passing such legislation required.

Each of the states interviewed began its respective program with a similar purpose — to provide Medicaid beneficiaries with additional options for receiving care in their homes and communities. Each state then tailored that goal around the specific concerns of the state and its stakeholder community. For Wisconsin and Texas, the emphasis was on ending waiting lists for waiver services, while Tennessee and Arizona focused on providing consumers with additional choices and diverting and/or transitioning consumers from institutional settings to home and community settings where appropriate. It is critically important to start the program design and planning process with a clear idea of where the state wants to go in terms of overall program outcomes. In Hawaii, the goal of increasing HCBS use by 5% was established early in the program design of QExA (see sidebar for additional details). Having a clear vision to guide MLTS program development provided additional clarity to state staff as well as the stakeholder community at large.

States have communicated the identified vision or overarching program goals in various ways. Tennessee and Wisconsin each pursued legislation for the implementation/expansion of MLTS programs. In both states, legislative authority was not required to advance the development and implementation of an MLTS program. However, each state felt that the process of getting legislative approval was an important opportunity to ensure that the state's vision for MLTS was communicated and understood in a very public way. This transparent process helped build buy-in and support for the program from policymakers and stakeholders alike.

Transparency was also critical for success in Hawaii. Two months prior to the go-live date, the legislature expressed concern about implementation of QExA, and state staff began frequent informational briefings with legislators that lasted through the implementation period. One key product of this intensive communication was a QExA Dashboard that allows key indicators to be shared regularly with stakeholders.

By establishing a statutory basis for the MLTS program, Wisconsin was able to codify key program features, such as entitlement and duties of the health plans and the state, which helped protect the integrity of the program design over time. Likewise, Tennessee embedded a series of guiding principles for LTSS in its authorizing statute, including “a global budget for all long-term care services for persons who are elderly or who have physical disabilities that allows funding to follow the person into the most appropriate and cost-effective long-term care setting of their choice, resulting in a more equitable balance between the proportion of Medicaid long-term care expenditures for institutional, i.e., nursing facility, services and expenditures for home and community-based services and supports” and a mandate for the state to rebalance the overall allocation of funding for Medicaid-reimbursed long-term care services by expanding access to and utilization of cost-effective home and community-based alternatives to institutional care for Medicaid-eligible individuals.

Establishing a viable long-term vision for MLTS goes far beyond an initial buy-in campaign, however. States that have implemented successful MLTS approaches have done so by allowing the established vision to permeate the very fabric of the program, from concept to implementation and beyond. Wisconsin has worked very hard to ensure that its vision of providing cost-effective support to achieve consumer-identified outcomes was at the core of Family Care’s program design. Three of the most important aspects of the program — rate-setting, resource allocation, and performance measurement — have been designed with that goal in mind. Because the program is built on the premise of truly person-centered care, Wisconsin builds capitation rates on a *person-by-person* basis, factoring in individual needs and previous utilization. In addition, care planning is done using a resource allocation decision process that focuses on providing cost-effective services to meet the consumer’s desired outcomes. As a result, the consumer and his/her family or caregivers are at the center of the planning and decision-making process. In order to ensure that individual outcomes are being met, the state has developed a new tool — the Personal Experience Outcomes Integrated Interview and Evaluation System (PEONIES) — to evaluate outcomes from the member perspective.

Hawaii: Expanding Managed Care to Serve the Users of Long-Term Care

Hawaii created the QExA program to serve seniors 65 and older and beneficiaries of all ages with disabilities. With program implementation, most 1915c waivers were absorbed under a new 1115 demonstration waiver, so that most home- and community-based services could be delivered by a managed care delivery system. Services under QExA include service coordination, outreach, and enhanced quality of health care services. QExA established these goals for the program:

- Improve the health status of seniors and people with disabilities;
- Establish a “provider home” through the use of primary care providers;
- Empower beneficiaries by promoting independence and choice;
- Assure access to high-quality, cost-effective care that is provided, whenever possible, in the homes and/or communities of beneficiaries;
- Coordinate care, including primary, acute, behavioral health, and long-term supports and services; and
- Ensure that beneficiaries are able to receive needed care in their choice of settings.

Similarly, although Arizona already “rebalanced” its LTSS system through its ALTCS program, it remains committed to transitioning beneficiaries out of institutions whenever possible. Notwithstanding Arizona’s dramatic accomplishment of serving 70 percent of its seniors and population with disabilities in home and community settings (as opposed to nursing facilities), the state continues to pursue additional strategies to serve beneficiaries in the community. One recent program enhancement expanded the HCBS workforce by allowing spouses to serve as paid caregivers and establishing a self-directed attendant care program. As a result, the state has continued to see a 1-2 percent increase in people residing in home and community settings every year.

2. Engage stakeholders early and often to achieve buy-in and ensure smooth implementation and sustainability of program.

States that have successfully implemented MLTS have found it necessary to work with a variety of stakeholders both during the early stages of the design process and on a continuing basis thereafter. This is particularly true when a state faces significant opposition to managed care. Proactively addressing the concerns and/or needs of individual stakeholder groups can ease apprehension and support stakeholder buy-in.

Hawaii used multiple mechanisms for gathering stakeholder input. At the request of advocacy organizations representing consumers and family members, the agency implemented a QExA Advisory Committee including advocates for the developmental disabilities community, provider associations, state agencies, the medical school, family organizations, and faith-based organizations. The group met monthly for two years prior to and one year following program implementation. Focus groups were conducted with an array of consumers on different islands. QExA Roundtables were held quarterly to provide a forum for communication with providers and beneficiaries. An ombudsman program was also developed, resulting in a contract with the Family to Family Health Information Center that provides information, referrals, and assistance in navigating the QExA system.

Tennessee: A Framework to Support MLTS Program Implementation

Concerned about gaining buy-in from a wide variety of stakeholder groups, Tennessee spearheaded its efforts to transform LTSS by establishing a long-term vision for the program. In doing so, the state looked at the challenges with its current fragmented long-term care system that provided consumers with limited choices and/or decision-making opportunities and resulted in the inefficient use of the state’s limited resources. To restructure the LTSS system, the state sought to improve access to the system as a whole, while providing increased service options particularly at the community level.

With the public support of Governor Bredesen, the state initiated stakeholder meetings to solicit input on what the restructured LTSS system should look like. The state met with key advocacy and provider groups, establishing close partnerships to help guide the best approach for improving access and community choices. Based on stakeholder recommendations, the state established a framework that was formalized through the passage of the Long-Term Care Community Choices Act of 2008. An illustration of the broad support the state cemented for this legislation is that it passed unanimously in both the House and Senate of the Tennessee General Assembly without a single “no” vote in any committee. This was a critical step in achieving necessary buy-in for the CHOICES program from community stakeholders.

By initially focusing on the end goal — e.g., providing greater choices for receiving care in the community — rather than the method for getting there, the state could build support for the overall program before having to address potential stakeholder concerns regarding managed care. The Governor also played a critical role in moving the program forward as did the unanimous passage of legislation that helped shore up initial support for the program.

All of the states interviewed conducted extensive initial stakeholder outreach during the program design process. States consistently reached out to both advocacy groups and provider organizations, noting that the latter often foment and/or financially support opposition from the former. They found that provider groups are often the most apprehensive when it comes to transitioning to a new LTSS system since it can result in changes to roles, how they are paid, etc.

In Tennessee, for example, state staff worked with Area Agencies on Aging and Disability (AAADs) to identify what role they should play in the new MLTS system. This entailed discussing what the AAADs thought they were doing well in their previous role as operators of the HCBS waiver program and what responsibilities they would be comfortable transitioning to managed care contractors. Based on the discussion, the AAADs continue to serve as the point of entry into the Medicaid MLTS system, but some of their previous responsibilities for building provider networks and facilitating provider reimbursement are now handled by MCOs. In addition, Tennessee realized it was important for the state to address providers' financial concerns and design incentives to ensure provider participation. In particular, the state decided that it would set provider rates for the first few years of the program so that providers would not have to worry that the MCOs were going to reduce costs simply by cutting provider reimbursement rates.

Engaging stakeholders not only entails working with policymakers, providers, and/or the advocacy community, but also with managed care contractors. Successful MLTS states have sought to create a culture of collaboration with their plan partners. This collaborative partnership has allowed the states to ensure that plans fully understand the state's program goals and vision and have a vested interest in seeing the MLTS programs succeed.

During the design phase of the CHOICES program, Tennessee met with its MCOs every week for six to eight months to ensure that the policies and procedures being developed were understood and agreed upon by all those involved. Such collaboration can also lead to the development of innovative processes as a program matures. Arizona, for example, wanted to implement a standardized assessment tool for determining level of care and worked with its plans to develop an agreed-upon approach based on their collective experiences.

To truly ensure that the needs of the beneficiaries are being met on an ongoing basis, it is important for stakeholder engagement to happen at the MCO level as well. In Wisconsin, for example, several of the Family Care contractors have developed their own committees that include consumer and provider

Texas: Working with Stakeholders in "HealthCare Matters"

In the early days of STAR+PLUS, advocates in Texas had concerns about managed care, so the state decided to engage consumers to be partners in the design and implementation of its proposed MLTS program. The Texas Health and Human Services Commission (THHSC) contracted with Healthcare Matters in 1998 to conduct a series of consumer focus groups to provide feedback to THHSC on STAR+PLUS. Four focus group meetings were held in Houston, to address a variety of topics including access, quality of care, complaints, coordination, and provider choice.

In addition, Healthcare Matters assisted the STAR+PLUS Program with consumer, provider, and community trainings, and brokered a meeting of MCOs and small providers. Over time, Healthcare Matters developed a close working relationship with the Texas HHSC, and helped to ensure that consumer advocacy input was included in plans, materials, and media products.

As advocates were given the opportunity to learn more about what the program could do (e.g., eliminate wait lists and provide additional benefits), they became STAR+PLUS champions, taking responsibility for working to alleviate the concerns of potential beneficiaries

representatives to make sure that local stakeholder needs — e.g., high quality care or sufficient reimbursement rates — are being addressed.

3. Use a uniform assessment tool that is conducted independently from providers.

Health Reform Intersections: §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 the proportion of LTSS provided in the community. States must meet several requirements to qualify for this incentive payment. 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. This incentive payment will increase the federal match (FMAP) on a state’s total HCBS spending by either two or five percentage points. More guidance on this provision is expected in the next several months.

One of the hallmarks of having a successful long-term care program is the implementation of a needs assessment system (including level of care) that is independent of the agencies that directly provide services. This increases the likelihood that consumers are being assessed objectively and that services are being provided to meet consumer needs rather than provider revenue needs. In some states, as in Wisconsin, this tool can also serve as the basis for capitated rate setting and provide consistent, reliable data for program review and analysis. The states that participated in this project were selected, in part, because of their use of a uniform assessment tool.

Most MLTS states rely on MCOs to perform assessment functions, with MCOs’ built-in incentives to align care serving to eliminate conflict. In Hawaii, service coordinators who are employees or contractors of the health plans are responsible for conducting health and functional assessments annually. These assessments are the basis of care plan and service arrangements, determined in collaboration with the beneficiary and their family. In addition, service coordinators conduct the nursing facility level of care functional eligibility review, using the state’s standard tool. Once completed, the tools are transferred to the external quality review organization, which reviews them on behalf of the state.

In addition to offering examples of best practices that can be used to guide MLTS programs, the states interviewed also shared missteps that other states may want to avoid. One of the concerns with Tennessee's previous LTSS system was that it had an inadvertent institutional bias. Because the state's nursing facility level of care criteria was extremely low, it essentially served as an open door to nursing homes. As a result, those whose care could have been safely provided in a home or community setting were often entering nursing facilities. The state is now struggling to "tighten the door" by raising level of care requirements, targeting nursing facility services to those with higher acuity needs, while at the same time allowing individuals with lesser levels of need (i.e., at risk of institutionalization) to receive HCBS. Unfortunately maintenance of effort requirements in the American Resource and Recovery Act and, more recently, the Patient Protection and Affordable Care Act are unintentionally creating obstacles for the state. Because of these requirements, states that raise eligibility standards — e.g., by tightening the nursing home level of care requirements in Tennessee's case — may no longer be eligible for enhanced federal matching funds.

Wisconsin: Screening Tool for Determining HCBS Eligibility

With input from stakeholders, consumers, and providers, Wisconsin developed a uniform web-based assessment tool in 2001 to determine eligibility for HCBS waivers in Family Care pilot counties. The resulting Long Term Care Functional Screen (LTCFS) offers an automated and objective way to determine the long-term care needs of elders and people with physical or developmental disabilities throughout the state. The LTCFS has multiple uses including: establishing level of care for Family Care eligibility; providing information to help people making decisions about how to meet their long-term care needs; informing the development of capitation rates; and evaluating the program.

The LTCFS inventories needs across key areas affecting an individual's risk/need for institutionalization, including:

- Activities of daily living (ADLs) such as bathing, dressing, toileting, transferring, mobility, and eating;
- Instrumental activities of daily living (IADLs) such as meal preparation, using the telephone, medication management, and money management;
- Diagnoses and health-related services or tasks;
- Communication and cognition (e.g., memory loss, decision-making ability);
- Behaviors and/or mental health (e.g., wandering, substance abuse); and
- Available transportation or employment.

Upon completion, the clinical professional who administered the screen can instantly see the consumer's level of care and eligibility for Family Care and/or other available LTSS programs. To ensure the quality of the information that is collected through the LTCFS, the state has developed the following requirements:

- Provide all screeners with a single online training program;
- Test and certify all screeners with a single online certification test;
- Provide all screeners with a single written instruction manual;
- Conduct routine and ad hoc monitoring of submitted screens; and
- Schedule regular statewide skills and knowledge testing.

Additional information on Wisconsin's LTCFS can be found at:
<http://dhs.wisconsin.gov/lc/FUNCTIONALSCREEN/Index.htm>.

4. Structure a benefit package that will appropriately incentivize the right care in the right setting at the right time, including coordination with acute care.

Health Reform Intersections: Historically, states have been required to obtain Medicaid waiver authority in order to provide HCBS. The *Deficit Reduction Act of 2005* (DRA) enabled states to include HCBS in their state plans through the creation of the §1915(i) State Plan Option. To date, however, few states have used the §1915(i) State Plan Option and other states have voiced concerns about the barriers to using this provision.

The ACA attempted to alleviate some of states' concerns by amending §1915(i). Section 2402, *Removal of Barriers to Providing Home- and Community-Based Services*, amends the §1915(i) State Plan Option by expanding certain eligibility requirements and allowing states to target services to specific populations. The ACA expands this provision in some areas; however, it eliminates states' flexibility in others. For example, states can no longer require that individuals accessing HCBS through the §1915(i) State Plan Option meet an institutional level of care. Further, states cannot limit the number of participants that receive §1915(i) State Plan Option services.

§2402 creates additional options for states regarding the provision of HCBS; however, its usefulness may be limited due to current state budget limitations and the need for many states to manage enrollment.

States often vary in deciding what services to include in their MLTS benefit packages. However, among the states interviewed for this project, all agreed that it is critical that the benefit package be structured to align incentives to ensure that beneficiaries receive the right care in the right setting at the right time. Arizona, Hawaii, and Tennessee all felt that the success of a managed long-term care program relies heavily on the development of a comprehensive benefit package that includes all relevant acute and LTSS services, including nursing facility care. These states felt that the only way to truly align all of the incentives was to place the plans at risk for the full array of Medicaid acute and LTSS services so that there would be a greater focus on keeping consumers in the community for as long as appropriate.

While Wisconsin chose not to include acute care in its Family Care program, it has still taken great pains to ensure that the acute and long-term supports and services are coordinated as closely as possible for beneficiaries. The decision to focus solely on LTSS was due, in large part, to the feeling among many Wisconsin advocates that the integration of acute and LTSS would lead to more of a "medical model" focused primarily on the underlying diagnosis and medical/acute care treatment rather than providing the social supports and community-based services often needed to keep people out of institutions. As a result, the state decided that at a minimum, managed care organizations should be responsible for all institutional and community-based LTSS and have specific requirements and/or incentives to actively coordinate with acute care and/or other services not included in the benefit package. For example, the Family Care team includes a registered nurse who is responsible for contacting a member's acute care providers within the first 90 days of enrollment to set up a plan for coordinating care. The plan includes a system for sharing test results, prescriptions, and/or other information that would potentially have implications for the member's overall health. The nurse is also responsible for working with physicians and pharmacists on medication reconciliation every six months. Generally speaking, the state has found this process to work well. However, the nurses often need to educate acute care providers about how Family Care's resource allocation system works when beneficiaries come away from office visits with "prescriptions" for items such as scooters or other LTSS-related services.

Where and how care coordination/case management is provided also varies among state MLTS programs. In some states services are provided by an entity separate from the health plan, generally through a sub-contract between the plan and the organization providing the care coordination/care management services. Such arrangements can help quell stakeholder concerns that a managed care entity will deny costly services even if such services are believed to be needed and appropriate. However, both Wisconsin and Tennessee felt that it was critical that care coordination/case management be vested within the managed care entity in order to ensure that a single organization is responsible for the totality of care provided to a consumer. These states believe that is the only way in which care can truly be integrated and incentives aligned. They assert that if managed care entities are at risk for the full range of services that may be needed by the member, the care coordinator working for the MCO will be able to ensure that members receive the care they need to live safely in the community, and avoid the more costly institutional setting.

A state's MLTS benefit package is often influenced by the needs and concerns of the broader stakeholder community including providers, policymakers, and advocates. While it is important to listen to and address these concerns whenever possible, states should balance those concerns with their own vision for MLTS and the program's long-term sustainability. During the development of the STAR+PLUS program, Texas faced significant opposition from the nursing home industry which did not want to participate in managed care. After months of negotiations, the state carved nursing facility care out of the benefit package for fear that the initial STAR+PLUS pilot would never get off the ground if it placed plans at risk for those services. More than 10 years later, the state is finding that it is difficult to incentivize greater use of HCBS options when institutional care is carved-out of the program. Over time, the state hopes to adjust its MLTS program to include more of the risk for institutionalization.

Texas' experience with institutional care highlights another important lesson for states pursuing MLTS programs — if possible, states should include all desired benefits and/or program design elements at the start of an MLTS program. Hawaii's leadership was emphatic about this as well, saying that if they had implemented acute care only, "we would still be here two years later planning to include long-term care

Tennessee: Use of Existing Infrastructure to Facilitate MLTS Approach

During Tennessee's initial stakeholder process, the state examined a variety of LTSS delivery system options to achieve its overall goal of improving access and choices for consumers needing LTSS. Given that the state's Medicaid acute care system has long relied on managed care, the state was concerned that a separate LTSS program would only perpetuate the fragmentation that characterized its current LTSS system. After much deliberation, the state concluded that the best vehicle was to integrate the long-term care system within TennCare — its existing managed care delivery system. The state felt that this was the only way to truly align all parts of the Medicaid system.

Once this decision was made, the state began working with its existing managed care contractors (several of which are national plans with experience in managing LTSS in other states). Together, they designed ways to provide a single set of Medicaid services to covered beneficiaries, expand access to HCBS in order to divert nursing home placement, and transition beneficiaries out of nursing facilities and into HCBS where appropriate. In addition, the state began working with stakeholders to address concerns that providers and/or advocates might have with managed care and to build strong consumer protections into the program.

Today, the three TennCare managed care organizations are responsible and at-risk for providing the full continuum of LTSS services, including nursing facility and HCBS, in addition to all primary, acute, and behavioral health services for eligible members. Care coordination is provided by the health plans, and focuses on support for member preferences regarding services and settings as well as intensive management of transitions between care settings. Tennessee is one of the few states with experience in integrating all services, including behavioral health, into managed care. This integration positions the state for undertaking a unique demonstration of how to integrate all care for adults who are dually eligible.

benefits.” State experience demonstrates that it can be more difficult to add things in or make substantial changes to existing MLTS programs. This may mean taking more time during the planning stage to work with relevant stakeholders or to develop systems for implementation, but it is usually time well-spent that will save states resources in the long-run.

5. Include attendant care and/or paid family caregivers within the benefit package as these services often play an important role in keeping consumers out of institutions.

Health Reform Intersections: The ACA contains numerous provisions related to expanding the pool of caregivers and providing training opportunities for these individuals.

- §2401 -- *The Community First Choice Option* establishes a new state plan option through §1915(k) of the *Social Security Act* for attendant services and includes a provision for the compensation of family members (to be defined by the Secretary). States that meet certain requirements related to this provision may be eligible for a six percentage point increase in federal match (FMAP) for services provided through §1915(k).
- §2402 -- *Removal of Barriers to Providing Home- and Community-Based Services* amends the §1915(i) State Plan Option by expanding certain eligibility requirements and allowing states to target services to specific populations. As discussed in Milepost #4, the ACA expands this provision to allow a greater range of services to be provided through the state plan. This provision limited some state flexibility in providing HCBS through §1915(i); however, states may wish to review this section to see whether it is a good fit for their state for expanding access to attendant care services.

One of the first things a state can do when trying to shift care away from institutions toward more home- and community-based settings is to focus on the development of in-home programs. By starting with the expansion of in-home services, a state can build upon existing systems rather than invest considerable resources in developing new and/or additional infrastructure (e.g., alternative residential settings). In addition, it is typically far less complicated to build programs aimed at keeping consumers out of nursing facilities than transitioning them out of institutions. As a result, it may make sense for a state to start with diversion and move toward transition and relocation once more community-based services and options are in place.

For many states this may mean starting with the development or expansion of attendant care programs as part of the overall MLTS benefit structure. Attendant care is a term that usually covers a variety of services that are provided in a consumer’s home as an alternative to nursing facility care. These services may include homemaking, personal care, general supervision, and/or companionship. Hawaii includes personal assistance services (level 1 chore services), which were previously covered as a state-only benefit, in its 1115 waiver. By doing so, the program has been able to double the number of clients receiving these benefits since QExA was implemented. All of the states interviewed include attendant care in their respective MLTS programs. In the majority of the interviewed states, attendant care may also be provided through consumer-directed programs offered in conjunction with an MLTS program. In this scenario, consumers are given the opportunity to directly hire, fire, and supervise their own attendant care providers without going through a home care agency. In addition, consumers have the ability to make decisions about how best to get their needs met, including who will provide services and when the services will be provided.

Many states have found that allowing family members, neighbors, and friends to participate in attendant care programs is a way to increase the available direct care workforce. States vary in how they implement this benefit. In Tennessee, the consumer direction benefit offers a formal pathway for hiring family members (excluding spouses) as well as others with whom a consumer has a close personal relationship. All consumer-directed care providers in Tennessee are required to undergo background checks, even family members. In Hawaii, the employment of family members reinforces the traditional value of family-centeredness, and allows families to maintain close living arrangements preferred by many ethnic subcultures in Hawaii (e.g., Native Hawaiians, Asian Americans, etc.). In Arizona, family caregivers can participate both in the self-directed attendant care program as well as the traditional attendant caregiver program (see sidebar for more detail).

Arizona: Providing Options for Family Caregivers

Arizona, which has one of the highest percentages of consumers receiving care in home- and community-based settings in the country, attributes much of its success in keeping consumers out of institutions to the inclusion of family members as paid caregivers in its attendant care program. However, the state has developed a series of requirements and protocols to ensure the quality of care.

To be eligible for the benefit, the person needing care must qualify medically and financially for ALTCS. Family members providing the care must be trained and hired by a qualified home health or attendant care agency. This training, which lasts only a couple of days, provides the new caregiver with knowledge and training in CPR, basic first aid, and infection and disease control. Once the training is complete and the family member is certified by the agency, the family caregiver is paid an hourly rate by the home health or attendant care agency for care authorized for the consumer. The care manager and home health agency are still involved in determining the types of services and number of hours that will be provided through the ALTCS program.

Notably, Arizona recently added the Spouse as Paid Caregiver option to its overall attendant care program. Under this option, the ALTCS consumer's husband or wife can be compensated to provide up to 40 hours a week of attendant care or similar services. The state believes that allowing spouses to serve as paid caregivers will help reduce the challenges of ensuring an adequate caregiver workforce and allow additional ALTCS consumers to remain at home.

6. Ensure that the program design sufficiently addresses the varied needs of MLTS consumers.

Health Reform Intersections: §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 the proportion of LTSS provided in the community. States must meet three specific conditions to qualify for this incentive payment. One condition is that states must use a core standardized assessment instrument to determine eligibility for HCBS and to develop individual service plans to address identified needs. To ensure that *all* of an MLTS consumer's needs are adequately addressed in his or her service plan, states should consider incorporating behavioral health assessment questions into this standardized assessment instrument.

More than 10 million Americans currently need some type of long-term supports and services to assist them with life's daily activities.⁸ While much of the LTSS population is elderly, almost 42 percent are under age

⁸ Kaiser Commission on Medicaid and the Uninsured. "Medicaid and Long Term Services and Supports," February 2009. Available at http://www.kff.org/medicaid/upload/2186_06.pdf.

65. These younger beneficiaries include both children and adults with disabilities, encompassing individuals with physical as well as behavioral or developmental disabilities. While there may be some overlap in the type of care provided from one group of beneficiaries to the next, the needs and preferences of a 30-year-old with paraplegia differ significantly from those of an 85-year-old with multiple chronic conditions in need of a hip replacement. Given the population's heterogeneity, a one-size-fits-all approach to the benefit package will not meet the varied needs of every MLTS beneficiary. It is important that states recognize this from the outset and ensure that all aspects of the MLTS program — from the benefit structure to the care management approach to the provider networks — are designed with commensurate flexibility.

One area often overlooked or inadequately addressed by states is the intersection of LTSS and behavioral health. The majority of the interviewed states indicated a need to focus attention on the behavioral health issues of beneficiaries. Tennessee has fully integrated behavioral health benefits into its MLTS program. Hawaii includes treatment for chemical dependency and acute behavioral health services in its MLTS system. In some states, among them Wisconsin, more than half of the beneficiaries receiving LTSS also have a mental health diagnosis.

As Wisconsin's Family Care has expanded to additional counties, the state has seen a significant increase in the number of consumers previously served primarily by the local mental health system enrolled in the program. For many managed care entities serving as Family Care contractors this is a significant challenge since they have had little prior experience in providing care to consumers with severe mental illness and, in many areas, community-based resources are lacking. The state has begun to address this concern by providing web-based trainings to MLTS staff around mental health diagnoses, related needs, and available resources. In addition, Wisconsin is working with its contracted MCOs to find creative ways to provide psycho-social rehabilitation services to help deter acute psychiatric hospitalization for those with mental health diagnoses or developmental disabilities.

Another way that the varied needs of the LTSS population can be addressed is to require the use of interdisciplinary (or multidisciplinary) care teams as part of the care planning and care management

Arizona: Interdisciplinary Care Teams Focus on Behavioral Health Needs

Given the prevalence of mental health diagnoses among many of its beneficiaries needing LTSS, Arizona believes that the appropriate placement of consumers with severe mental illness is critical. To that end, the state has ensured that the ALTCS program has sufficient flexibility to allow its managed care contractors to establish additional services.

For example, Mercy Care Plan has developed an interdisciplinary team (IDT) model for consumers identified as high-need and high-cost who have had two or more inpatient admissions for behavioral health issues in the past 30 days and/or other internal or external referrals. Members of the IDT include the consumer's case manager as well as the plan's medical director, a variety of nurses, and the behavioral health medical director, and behavioral health coordinator. The IDT meets on a regular basis to discuss participating consumers' needs, preferences, barriers to care, etc. and make recommendations for a care plan that will prevent future hospitalizations/ED visits and increase overall health and satisfaction outcomes. Consumer readmissions are monitored at 30-, 60-, and 90-day intervals. In addition, Mercy Care has 12 certified behavioral health case managers to assist in care coordination for consumers with behavioral health needs.

Bridgeway Health Solutions, another ALTCS contractor, also employs an IDT model for its enrollees and includes a behavioral health specialist on the team. In addition, because medication often plays such a critical role in the treatment of certain mental illnesses and because behavioral health providers may not be as connected to the acute or LTSS community, Bridgeway includes a pharmacist as part of the IDT to address poly-pharmacy issues.

processes. Several of the states interviewed require that managed care entities use an interdisciplinary team to develop an individualized plan of care based on each beneficiary's needs and preferences and to help ensure that care is being properly coordinated across all aspects of the system (e.g., acute, LTSS, behavioral health, etc.). Although the composition of these teams varies depending on the level and type of care needed by individual beneficiaries, teams typically include the following mix of professionals: physicians; nurses; social workers; community resource specialists; certified case managers; pharmacists; and other specialists.

Building a program that is designed to meet the varied needs of all eligible beneficiaries may mean establishing clear linkages between the MLTS program and other systems in the state that affect it. For example, Wisconsin has worked to develop close ties between Family Care and Adult Protective Services as well as the mental health system outside of what is covered by Medicaid. As the benefit design in Texas wavered between including and excluding behavioral health services, health plans actively worked to maintain bridges to the mental health system. In 2007, Tennessee moved to full integration of behavioral and physical health services in the managed care delivery system. Tennessee MCO's contracted with existing Community Mental Health Centers in order to ensure the stability of the mental health system and continuity of care for members.

7. Recognize that moving from a 1915(c) waiver system to risk-based managed care represents a fundamental shift in how both the state and managed care entities think about LTSS financing.

Implementing a managed care system can be a significant challenge for many states, often requiring the development of additional infrastructure and skill sets at the state level. For example, in the fee-for-service setting providers are paid based on a pre-determined rate for every unit of service provided. These rates may be in place for a number of years before any adjustments are made. In a managed care setting, states must set rates for multiple contractors, usually on an annual or semi-annual basis. In setting these rates, states must make assumptions about the types and amount of services beneficiaries will use in the future. In order to effectively set rates, states must often invest in new data systems and infrastructure to analyze encounter data from managed care entities as well as information regarding the functional status or acuity of the target population.

In addition, managed care also introduces new requirements such as actuarial soundness to ensure that Medicaid managed care entities are adequately reimbursed based on predicted health care expenditures for the populations served. Most states have elected to engage actuarial firms to assist in the development of MLTS rates, at least until this internal capacity set can be developed.

As a state's knowledge of and comfort with the rate-setting process grows, it can take on more responsibility in-house. In Wisconsin, for example, the state has taken a shared actuarial approach in which its staff adjusts pre-established rates, but relies on its independent actuary to provide an un-biased, outside perspective. Arizona now employs its own in-house actuary to develop rates more efficiently and effectively. Arizona does acknowledge, however, that this would not have been possible in the early years of the program. It is important to note, however, that relatively few actuarial firms are experienced in setting capitated rates for LTSS, so states and their actuarial partners may be on a learning curve together.

In some states, pre-existing HCBS waivers have operated at a local level with community organizations or county-based entities responsible for the day-to-day management of the LTSS system. As these states move toward a more standardized, statewide approach via an MLTS program, they may be faced with payment variations among provider groups in different parts of the state. Wisconsin has faced such challenges. Prior to Family Care, the LTSS system was run out of county-based entities with each responsible for setting its own rates. Now that Family Care is expanding statewide, the state seeks to develop a standardized set of rates for the various HCBS provider groups.

Given the fact that relatively few states have implemented MLTS to date, accepting risk for LTSS can represent a change for the managed care entities as well. Three national firms have extensive experience with managed LTSS — United, AmeriGroup, and Aetna/Schaller Anderson. National firms like Molina and Centene as well as regional entities such as Massachusetts’ Community Care Alliance and Wisconsin’s Family Care organizations, are also becoming significant players in MLTS. States will need to work closely with their selected plans to develop and implement successful programs. However, even for national plans that have experience with MLTS, states have found that ongoing collaboration between the state and managed care contractors is critical for ensuring that the state’s program goals and financial incentives are aligned in the rate-setting process. Wisconsin, for example, meets with health plan staff on a monthly basis during the rate-setting process each year. Hawaii is moving to blended rates in the next contract cycle in order to improve its incentive structure.

Texas: Building In-House Expertise in Rate-Setting and Financial Oversight

It is important for states to hire staff with both technical rate-setting knowledge as well as a comprehensive understanding of how MCOs operate on a business level. Texas, for example, has a financial group comprised of staff who primarily come from the private sector and know the MCO business model. By knowing where to look, these state staff have found examples of inaccurate data and aggressive accounting techniques, saving the state millions of dollars.

For example, it is a useful skill for state staff to be able to comprehend and compare health plan reports submitted to the Securities and Exchange Commission with other financial reports filed with the state. Texas also has the contract teeth to back up its demand for accurate encounter data, which is used to validate service utilization. Payment withholds are applied for inaccurate data. They have achieved a 96 percent accuracy rate across their encounter data, which is used to set rates going forward.

8. Develop financial performance incentives to achieve the stated goals of the program.

State MLTS programs should use contractual incentives to achieve their goals. In Tennessee for example, the capitation rates are being set with the expectation that the CHOICES program will result in a fundamental shift in how and where LTSS care is provided. In order to promote movement away from institutional care and toward more home and community options, Tennessee factors in assumptions about the impact the CHOICES program will have on the mix of institutional and HCBS services provided to LTSS beneficiaries. In determining these assumptions, which include a three to four percent decrease in institutional care over two years, the state has had to find a balance between incentivizing appropriate HCBS use while being realistic about what plans can do in relatively short periods. The state plans to reassess these assumptions on an annual basis. In Hawaii, incentive payments are incorporated into contracts to reward increasing the use of HCBS and decreasing institutional care.

Arizona uses a similar process to encourage greater reliance on home- and community-based options through the development of its rates. As in Tennessee, the state uses an HCBS-nursing facility mix to help set the rates. However, if a given contractor provides HCBS to a greater number of beneficiaries than projected, it is rewarded in a reconciliation process at the end of the year.

Despite the nursing facility carve-out, Texas has incorporated a number of disincentives into the STAR+PLUS program to prevent potentially avoidable institutionalizations. The state structured the contract so that plans face a financial penalty if they go above the nursing home occupancy baseline based on the previous year. As a result, the state has reduced nursing facility utilization month by month.

Texas: Incentives to Support HCBS

In 2001, Texas became one of the first states to implement a Money Follows the Person program. Over the years, the state's managed care STAR+PLUS program has had great success using this program to divert beneficiaries (and dollars) from nursing home care. In fact, more consumers within managed care have chosen consumer direction than those in traditional fee-for-service. In STAR+PLUS service areas, MCO representatives are required by contract to visit beneficiaries when they are admitted to a nursing facility to identify opportunities to transition individuals back into the community. In addition, through a separate budget, the state provides extra financial incentives to consumers to help them move out of institutions and into the community.

Since the MFP program began, more than 20,000 individuals have been relocated to the community. A pilot project in San Antonio, including the state, MCOs, the Center for Independent Living, and the behavioral health agency, is providing services beyond those in the 1915c waiver to ease transition. Beneficiaries and their families are prepared for what it will like to be back in community, and are given post-relocation assistance for 365 days. Keys to success in Texas include the availability of specialized providers, housing alternatives for beneficiaries with complex needs, transportation, and financial support for rent deposits.

9. Establish robust contractor oversight and monitoring requirements to maintain and improve the MLTS program.

In working with large national plans, states, including Arizona, Tennessee, and Texas, have found it necessary to be very prescriptive, particularly during the early program stage, to ensure that contractors are providing a state-specific model rather than an off-the-shelf product. To that end, they have taken a “manage or be managed” approach and have developed very specific contracts that set clear standards and expectations for plan performance. To ensure these expectations are being met, states have established robust mechanisms for monitoring performance, including monthly/quarterly reports and program dashboards.

Arizona believes that its significant oversight of the program during the early years was a key factor to its success. State staff believe that by working very closely with the plans during the two to three years it took for the ALTCS program to completely transition from fee-for-service to managed care, the state was able to gain a better understanding of how the program would really work, what the challenges were, and what it would take to resolve them. As the managed care entities got their models in place and case managers gained experience, the state was able to cut back on some of its initial requirements — including a 60-page audit guide — and focus on the most important issues. At the same time, since the program's inception the

state has seen a shift from local, non-profit plans to large national, for-profit plans that would prefer to use their own standardized care models. The state has held firm in its specific contracting requirements (e.g., maximum case manager ratios, etc.) and has developed additional requirements. An example is a network development plan designed to examine network capacity over the long-term in order to keep contractors “on their toes.” Texas and Tennessee have taken similar approaches in developing specific contract requirements with consequences for failure to meet specified standards.

Even in states like Wisconsin that contract almost exclusively with local managed care entities, robust contract and monitoring requirements help ensure that consumers are receiving comparable benefits from plan to plan. This is particularly important as the state continues to move away from local, county-based long-term supports and service systems in expanding Family Care statewide.

Hawaii initially focused on overseeing provider network adequacy to ensure access to care. In taking a patient-oriented approach, the state built in many reporting requirements for health plans to demonstrate their provision of all medically necessary care and appropriate denial of inappropriate services. The contracts have prescriptive requirements for the handling of grievances and appeals, and an on-site visit occurred to verify compliance. Additionally, an active quality strategy committee reviews health plan quality reports.

Strong, standardized requirements help providers acclimate to a managed care program. For example, Texas requires that all STAR+PLUS contractors use a uniform billing process with the same set of forms across plans and providers. Not only does this make the billing process easier for providers, the plans, and the state, it also allows the state to offer training and technical assistance across plans. Similarly, Tennessee has chosen to take on some of the traditional managed care duties in the first few years of the CHOICES program to ensure a smooth transition from fee-for-service. In particular, the state elected to set all nursing facility and home-and community-based provider rates and even required that plans offer contracts to all currently operating nursing facilities to ensure some control over the initial provider networks and maintain stability in the system during the transitional years of the program.

Tennessee: Electronic Alert System Ensures HCBS Care Accountability

Careful monitoring to assure that consumers receive needed care on a timely basis is essential, particularly when care is provided outside of more formal care settings. Tennessee implemented an electronic visit verification (EVV) system that provides the state, managed care organizations, and home care agencies with real-time information regarding when consumers are receiving needed HCBS and when they are not.

HCBS providers log into the EVV system when they arrive at the consumer’s home to deliver pre-determined/scheduled care and log-out upon their departure. The phone-based system can track where the call originated. When a provider does not log into the system on schedule, a notification is immediately generated and sent to both the home care agency and managed care organization which can then arrange for back-up care. This enhances the ability of both entities to detect and resolve problems. In addition, a claim can be generated from each login, thus facilitating timely payment for providers. The EVV is used both for formal HCBS providers and those hired by consumers in the self-directed option included under CHOICES.

To further ensure accountability for HCBS services the state receives a monthly report from each managed care organization outlining service gaps and delays in service delivery. These are assessed against managed care performance standards and benchmarks. The system helps ensure financial accountability by ensuring that only services provided are reimbursed, and moreover, improves quality of care by quickly identifying and resolving gaps in care. MCOs benefit from the system because it ensures that consumers get services and providers get paid.

10. Recognize that performance measurement is not possible without LTSS-focused measures.

Health Reform Intersections: §2701 -- *Adult Health Quality Measures* directs the Secretary to release an initial set of quality measures for Medicaid-enrolled adults no later than January 1, 2011. This provision further directs the Secretary to work with states to develop a standardized format for reporting information based on the selected measures by January 1, 2013. This provision does not specifically include LTSS-focused measures; however, this may provide an opportunity for states to help develop national LTSS benchmarks.

Performance measurement is a critical element of any managed care program, giving states, providers, consumers, and the managed care entities themselves valuable information about the quality and utilization of care provided. This information can be used to track performance over time, identify areas for improvement, facilitate comparisons across plans, and determine priorities for special initiatives.

States are addressing this barrier in a number of ways. For instance, Arizona and Wisconsin have developed additional tools and/or measures of their own with which to assess health plan performance. In Arizona, ALTCS contractors are required to examine the initiation of home- and community-based services for elderly and physically disabled members on an annual basis. This measures the percentage of newly placed HCBS ALTCS members who receive specific services within 30 days of enrollment.⁹ In 2009, the performance standard for this measure was 92 percent. In Hawaii, the state partnered with both of its health plans to develop an evaluation tool to objectively and consistently assess need for HCBS.

Wisconsin: Person-Centered Performance Measurement Approach

Wisconsin's Family Care program seeks to provide cost-effective care to achieve individual consumer-identified outcomes. In 2006, Wisconsin contracted with the University of Wisconsin's Center for Health Systems Research and Analysis to develop its own method to identify individuals' desired outcomes. The resulting Personal Experience Outcomes Integrated Interview and Evaluation System (PEONIES) is structured around 12 domains:

1. Living in a preferred setting;
2. Making one's own decisions;
3. Deciding one's own daily schedule;
4. Maintaining personal relationships;
5. Working or pursuing other interests;
6. Being involved in the community;
7. Having stable/predictable living conditions;
8. Being treated fairly and with respect;
9. Having the amount of privacy desired;
10. Being comfortable with one's health situation;
11. Feeling safe; and
12. Feeling free from abuse and neglect.

The interview tool was completed in June 2008 and has been validated. Because Wisconsin Family Care focuses on providing cost-effective support to achieve a consumer's desired outcomes, PEONIES was a critical step in ensuring plan and case management performance.

⁹ <http://www.azahcccs.gov/reporting/Downloads/PerformanceMeasures/altcs/ALTCS-HCBS-2009.pdf>

Conclusion

Developing and implementing a managed long-term supports and services program can be challenging. Success depends on a variety of factors including state leadership, existing state infrastructure and/or familiarity with managed care in general, as well as an appetite for managed care among stakeholders. Despite the challenges, however, by following in the footsteps of Arizona, Hawaii, Tennessee, Texas, and Wisconsin (while avoiding some of the landmines that befell them on their own roads to success), states should feel that MLTS is within their reach. While this roadmap can serve states as a guide to the stops along the way as they go down the path toward MLTS, it is important that those interested in doing so move forward *not* expecting to be able to “replicate” existing programs to the last detail. Every state is different and programs will need to be developed according to the needs of the local environment. Medicaid agencies can, however, borrow heavily from the elements that have worked in existing programs and incorporate them into their own — new models of MLTS.

Appendix A: List of State and Plan Interviewees

Arizona

Arizona Health Care Cost Containment System (AHCCCS) Staff:

Kate Aurelius, Deputy Director
Kim Elliot, Administrator, Clinical Quality Management
Alan Schafer, ALTCS Manager

Bridgeway Health Solutions Staff:

Duane Angulo, Director of Pharmacy
Richard L. Fredrickson, Chief Executive Officer
Robert Krauss, MD, Medical Director
Nicole Larson, Vice President of Operations and Compliance
Mary Reiss, Director of ALTCS Case Management

Mercy Care Plan Staff:

Kathy Eskra, Vice President of Long Term Care for Aetna Medicaid
Chad Corbett, Director Long Term Care
Mark Fisher, President and Chief Executive Officer

Yavapai County Long Term Care Staff:

Leona Brown, Compliance/Program Development Manager
Jesse Eller, Director

Hawaii

Hawaii Department of Human Services Med-Quest Division:

Patti Bazin, Health Care Services Branch Administrator

Evercare Hawaii:

Dave Heywood, Executive Director
Bill Guptail, COO
Jeri Kakuno, Director of Operations, MDX Hawaii
Mary Campos, Director, Field Clinical Services
Debbie Hughes, Director of Operations
Cheryl Ellis, MD, Medical Director

Ohana Health Plan

Erhardt Preitauer, President, Hawaii Region

Linda Morrison, Senior Director, Operations and IT

Wendy Morriarty, Senior Director, Field Clinical Programs

Jayme Pu'u, Senior Manager, Network Management

James Tan, MD, Senior Medical Director

Tennessee

TennCare Bureau of Long Term Care Staff:

Carolyn Fulghum, Director of Quality and Administration for Elderly and Disabled Services

Keith Gaither, Managed Care Director

Jarrett Hallcox, Director of Long Term Care Project Management

Patti Killingsworth, Assistant Commissioner and Chief of Long Term Care

Julie Johnson, LTC Appeals Manager

Casey Dungan, Assistant Director, Fiscal/Budget

Texas

Texas Health and Human Services Commission Staff:

Pam Coleman, Former Deputy Director for Managed Care Operations (has since retired from state)

Joe Vesowate, Deputy Director for Managed Care Operations

David "DJ" Johnson, STAR+PLUS Project Specialist

Ivan Libson, Implementation Coordinator Managed Care operations

Scott Schalechlin, Director for Health Plan Operations

Rich Stebbins, Manager of Finance

Paula Swenson, Director of Health Plan Management

Marc Gold, Special Advisor for Policy and Promoting Independence, Texas Department of Aging and Disability Services

Evercare of Texas:

Leah Rummel, Vice President, Strategic Account Development

Catherine Anderson, Vice President, Business Development

Beth Mandell, Regional Executive Director

Superior Health Plan:

Cindy Adams, Chief Operating Officer

Ceseley Rollins, Vice President, SSI

Amerigroup:

Cathy Rossberg, Chief Operating Officer

Wisconsin

Wisconsin Department of Health and Family Services

Division of Long Term Care Staff:

Fredi-Ellen Bove, Deputy Administrator

Susan Crowley, Administrator

Monica Deignan, Managed Care Section Chief

Charles Jones, Family Care Program Manager

Tom Lawless, Fiscal Management and Business

Systems Section Chief

Kathleen Luedtke, Planning and Analysis

Administrator

Karen McKim, Quality and Research Manager

Alice Mirk, Care Management Services Manager

Portage Aging and Disability Resource Center:

Janet Zander, Director

Cindy Pitrowski, Assistant Director

Community Care of Central Wisconsin Staff:

Darren Bienvenue, Director of Service

Coordination

Jim Canales, Chief Executive Officer

Dana Cyra, Director of Quality Management

Rick Foss, Director of Service Coordination

Mark Hilliker, Chief Operations Officer

Julie Strenn, Director of Provider Network

Services

Appendix B: National Advisory Group Members & CMS Participants (in addition to State Interviewees)

Joseph Caldwell

Director, Long-Term Services and Supports Policy
National Council on Aging

Mike Cheek

National Association of State United for Aging and Disabilities

Sara Galantowicz

Senior Research Leader, Thomson Reuters Research Department, Community Living Systems Group

Cyndy Johnson

Independent Consultant

Diane Justice

Senior Program Director, National Academy for State Health Policy

Enid Kassner

Director, Independent Living/LTC
AARP Public Policy Institute

Harriet L. Komisar

Senior Research Analyst, University of Maryland, Baltimore County, The Hilltop Institute

Barbara Lyons

Vice President, Deputy Director KCMU
Kaiser Family Foundation

Anne H. Montgomery

Senior Policy Advisor, Senate Special Committee on Aging

Martha Roherty

Executive Director, National Association of State United for Aging & Disabilities

James M. Verdier

Senior Fellow, Mathematica Policy Research, Inc.

Centers for Medicare & Medicaid Services

Linda Peltz

Director, Division of Coverage and Integration

Carrie Smith

Technical Director, Division of Coverage and Integration

Mary Sowers

Director, Division of Community and Institutional Services

Center for Medicaid, CHIP & Survey Certification

Disabled and Elderly Health Programs Group

CHCS Online Resources

This roadmap is part of CHCS' *Profiles of State Innovation* series, made possible through The SCAN Foundation to help Medicaid programs develop high-quality, cost-effective, and consumer-focused approaches for delivering long-term supports and services. Following are additional documents in the series as well as further resources available at www.chcs.org.

- ***Profiles of State Innovation: Roadmap for Rebalancing Long-Term Supports and Services*** – Outlines key mileposts to help states achieve an equitable balance between institutional and home-and community-based care.
- ***Profiles of State Innovation: Roadmap for Improving Systems of Care for Dual Eligibles*** – Outlines key considerations to help states decide what direction to choose in designing integrated approaches for duals.
- ***Medicaid-Funded Long-Term Supports and Services: Snapshots of Innovation*** – Presents novel alternatives for reforming the delivery of Medicaid-funded long-term care, including both innovations that have been implemented as well as promising practices.

www.chcs.org

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