

Three State Paths to Improve Medicaid Managed Long-Term Care: Florida, New Jersey, and Virginia

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JULY 2013

State Medicaid programs are transforming their long-term services and supports (LTSS) delivery systems from fee-for-service to managed care to better integrate LTSS with primary, acute, and behavioral health care. By 2014, 26 states are projected to have Medicaid managed long-term services and supports (MLTSS) programs.¹ Given strong state management and oversight, these programs enable states to provide high-quality, person-centered, and cost-effective care to eligible beneficiaries in the setting of their choice. They also provide budget predictability and the opportunity to use payment incentives that encourage care in community settings rather than institutions.²

The pathways states follow in the design and implementation of MLTSS programs are shaped by a number of factors. Stakeholders including Medicaid beneficiaries and LTSS providers have a major influence on the design, scope, and timing of a MLTSS program and its implementation. Working with stakeholders from the start of program design and incorporating their input increases the likelihood that the MLTSS program will improve quality, enhance beneficiary experience, and realize efficiencies. State readiness and existing resources to take on LTSS transformation are also factors shaping program design and implementation. By identifying these factors and actively addressing them, states can better navigate their paths to MLTSS program implementation.

This brief, made possible through The SCAN Foundation, traces the progress of three states—Florida, New Jersey, and Virginia—through the design and early implementation of their MLTSS programs. Their experiences related to program design and implementation can be instructive for other states in developing strategies for MLTSS programs.

Florida: Implementing Statewide Medicaid Managed Care

Florida is expanding its regional programs to implement a statewide MLTSS program that will use managed care plans to deliver all Medicaid services for most beneficiaries.

IN BRIEF

State efforts to improve care for frail older adults and individuals with disabilities are increasingly leading them to implement Medicaid managed long-term services and supports (MLTSS) programs. These emerging MLTSS strategies are shaped not only by states' internal resources, but also by their experiences in interacting with long-term service and support providers, managed care plans, and beneficiaries.

This brief looks at the paths pursued by Florida, New Jersey, and Virginia in implementing MLTSS approaches to keep individuals in their communities. Their program design and implementation decisions can be instructive to other states in developing MLTSS programs. The brief also identifies how states' MLTSS program efforts establish a platform for future coordination of Medicare and Medicaid benefits.

Approximately 87,000 Medicaid beneficiaries will be eligible for the new MLTSS program.

Current Status

Implementation of MLTSS in Florida is part of an overall effort directed by the legislature to enroll most of the state's Medicaid beneficiaries in managed care. A 2011 law mandated the creation of the Statewide Medicaid Managed Care (SMMC) program.³ The law was very prescriptive as to program and service structure. The SMMC program has two key components: the Managed Medical Assistance program; and the Long-term Care Managed Care program. The Centers for Medicare and Medicaid Services (CMS) has approved implementation of the Managed Medical Assistance program through a Section 1115 demonstration waiver amendment expanding managed care enrollment statewide, and it has approved the Long-term Care Managed Care program under concurrent 1915(b)(c) waivers.⁴

Florida's Nursing Home Diversion program introduced frail beneficiaries to managed care and helped stakeholders better understand the benefits of a more coordinated and integrated service delivery system.

Under SMMC, most Medicaid beneficiaries will receive primary, acute, and behavioral health services through the Managed Medical Assistance program and most individuals requiring a nursing facility level of care will receive HCBS and nursing facility services through the Long-term Care Managed Care program.⁶ The legislation allowed for comprehensive managed care organizations (MCOs) that provide both LTSS and medical services. The state is designing a blended capitation rate for MCOs receiving contracts for both programs. Seven MCOs have been selected as Long-term Care Managed Care programs. Florida will begin serving individuals in the Long-term Care Managed Care program August 1, 2013 with plan selection for Managed Medical Assistance program participation in September 2013.⁷

Path to MLTSS

Florida's road to implementation of MLTSS began in 1996 with the state's Nursing Home Diversion program, a 1915(c) waiver program covering all medical and long-term care services through a capitated rate to participating providers. Beneficiaries dually eligible for Medicare and Medicaid requiring a nursing facility level of care can voluntarily enroll in this program. The program introduced providers and beneficiaries to managed care's benefits.

Enrollment and provider participation has grown tremendously over the past 17 years. As of 2013, 20,000 individuals are enrolled in 17 plans including established health plans and community-based regional plans, some of which emerged from HCBS

providers that transformed their network and infrastructure to meet nursing home diversion plan requirements.⁸ The program introduced increasing numbers of frail beneficiaries to managed care, paving the way to stakeholder understanding of the benefits of a more coordinated and integrated service delivery system.⁹

Efforts to create a MLTSS program, Florida Senior Care, began in 2003 with concentrated work occurring in 2005 through 2008. Although the program was not ultimately implemented, it laid the groundwork informing the 2011 law that directed the state to create SMMC and specific aspects of program design. Many of the legislative staffers who contributed to the 2011 law had also worked on Florida Senior Care efforts. The separation of LTSS from other medical and behavioral health services in a distinct managed care program may be a direct result of work undertaken to launch Florida Senior Care. Experience highlighted the need to maintain a focus on areas of LTSS specialization and ensure that LTSS receives needed policy and stakeholder attention to support a successful program.¹⁰

When it came time to design the Long-term Care Managed Care program, Florida sought extensive stakeholder input. The state reached out to the advocacy community, beneficiaries, and providers. Stakeholders in Florida including industry representatives, elder and disability advocates, and the Elder Law Section of the Florida Bar Association have a history of robust engagement and were eager to be involved. The state conducted 13 public meetings prior to

Florida Pursues Both Section 1115 and Concurrent 1915(b)(c) Waivers

To comply with the legislative mandate to implement SMMC, Florida obtained authority to implement Managed Medical Assistance through a Section 1115 demonstration waiver amendment to provide primary, acute, and behavioral health care through MCOs. The state submitted concurrent 1915(b)(c) waivers to implement the Long-term Care Managed Care program. The state made the decision to pursue two separate waiver authorities to implement the MLTSS component of SMMC in August 2013. A 1915(b)(c) concurrent waiver submission has prescribed timeframes for CMS response and approval while the 1115 demonstration waiver does not.⁵ Florida used this option to make the target implementation date of August 1, 2013 viable. The state plans to amend its 1115 demonstration to include Long-term Care Managed Care program components in the future to operate SMMC under one federal waiver authority.

submission of SMMC waivers to CMS. Prior opponents to Florida Senior Care, including AARP and providers, are now engaged and sharing input into design and implementation. Current collaboration includes incorporating beneficiary protections and policies that support individuals safely in the community. Stakeholders had an opportunity to provide comments on draft managed care contracts as well as communication materials (e.g., choice counseling materials). The state is building permanent pathways for communication with stakeholders to inform program policies beyond program launch on August 1, 2013.

While the state is focusing on SMMC, better integration of care for dually eligible beneficiaries remains a priority. Although Florida decided not to pursue CMS' opportunities for integrating care for dual eligibles in order to direct all available state resources to SMMC implementation, the state is tracking national efforts to integrate care for dual eligibles and is building in opportunities for Medicare-Medicaid alignment into SMMC. The state will assign dual eligible beneficiaries currently enrolled for Medicare services with a Medicare Advantage plan, including D-SNPs, with the same plan for Medicaid services if the plan is participating in SMMC.¹¹ Further, through three-way contracting with Medicare Advantage dual eligible special needs plans (D-SNPs), CMS, and the state, Florida is requiring coordination of benefit agreements to share encounter data and outlining standard contract language with covered services and benefits.

New Jersey: Undertaking a Comprehensive Section 1115 Demonstration

New Jersey's implementation of MLTSS for older adults and persons with disabilities is part of a comprehensive Section 1115 waiver demonstration reforming the state's entire Medicaid program. The MLTSS

program is part of a staged strategy to provide all Medicaid services to individuals requiring home- and community-based services (HCBS) or nursing facility care through a managed care delivery system.

Current Status

New Jersey's path to MLTSS implementation was through a comprehensive Section 1115 demonstration waiver program. A goal of the waiver is to move from a fee-for-service to a managed care-based system for delivering LTSS, thereby supporting more people in the community. Under the new waiver, five separate existing 1915(c) HCBS waivers are collapsed into one MLTSS program. Other key policy objectives of this waiver, approved by CMS in October 2012, include better budget predictability; reduced reliance on for institutional care; increased use of HCBS; integrated and coordinated patient-centered care; and improved health outcomes.¹² Through the demonstration, New Jersey is expanding HCBS to any Medicaid-eligible enrollee who qualifies for a nursing facility level-of-care, not just those individuals eligible for HCBS waiver programs. New Jersey plans to amend its existing MCO contracts to include all LTSS (including HCBS and nursing facilities for adults age 65 and over and individuals with physical disabilities), as well as primary, acute, and behavioral health services. The state will additionally offer HCBS to a new category of Medicaid eligible individuals.¹³

Path to MLTSS

New Jersey sought broad stakeholder input to guide the design and implementation of its Section 1115 demonstration waiver. In May 2011, almost three years prior to planned implementation, the state released a concept paper, *State of New Jersey Section 1115 Demonstration "Comprehensive Waiver,"* to public stakeholders soliciting feedback.¹⁴ While the resulting comments showed little opposition to MLTSS, there were many questions about how such a program would be implemented. For example, nursing facilities acknowledged

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that managed care was going to occur, but questioned how it would affect them.¹⁵

To gather additional stakeholder input, New Jersey’s legislatively created Long-Term Care Funding Advisory Council was tasked with convening an implementation steering committee to navigate the transition to MLTSS. The steering committee created stakeholder workgroups that met during spring 2012 to develop recommendations for MLTSS implementation. The steering committee presented the workgroups’ recommendations to New Jersey Medicaid and state aging agency leadership.

As a direct result of the recommendations, New Jersey adopted an “any willing provider” policy for nursing facilities, assisted living facilities, and community residential service providers for the first two years of MLTSS. Thus, any of these providers that satisfy routine health plan provider credentialing qualifications may enter into a contract with MLTSS MCOs. Long-term care pharmacies will have permanent any willing provider status. Based on stakeholder input, the state incorporated “217 like” eligibility as an additional eligibility category enabling beneficiaries in the community receiving HCBS to qualify for Medicaid under

medically needy eligibility criteria, and it included AARP’s LTSS-specific quality measure suggestions in MCO contracts.

New Jersey gradually introduced older adults and individuals with disabilities to managed care, allowing both providers and beneficiaries to acclimate to receiving first some, and then more, of their services through MCOs. The state plans to begin MLTSS enrollment in January 2014 for individuals receiving HCBS and in July 2014 for those getting nursing facility services. Consistent with this stepped approach, New Jersey is working with D-SNPs to better coordinate Medicaid and Medicare benefits. The state will add MLTSS to D-SNPs beginning in January 2015, paving the way for better integration of Medicaid and Medicare services.¹⁶

Virginia: Learning from Past Experience

Virginia is pursuing a financial alignment demonstration through CMS for dually eligible beneficiaries. Based on past experience, Virginia will begin enrolling Medicaid beneficiaries into managed care on a voluntary basis for their Medicaid services, with mandatory enrollment into a coordinated delivery system as the next step.

New Jersey’s Incremental Approach to Managed Care

New Jersey has taken an incremental approach to enrolling adults age 65 and over and individuals with physical disabilities into Medicaid managed care.

Steps Prior to MLTSS Implementation:

- Enrolled all adults age 65 and over and individuals with physical disabilities in MCOs for primary and acute care. Those dually eligible for Medicare and Medicaid were able to enroll in MCOs on a voluntary basis with the exception of those receiving HCBS services.
- Mandatorily enrolled all beneficiaries dually eligible for Medicare and Medicaid and individuals receiving HCBS services in MCOs for primary and acute care.

Steps Under MLTSS:

- Add MLTSS to the MCO benefit package for all members receiving HCBS. This will result in all Medicaid services including acute, primary, behavioral health, and LTSS under managed care.
- Enroll all individuals receiving nursing facility services into MCOs for receipt of all Medicaid services including acute, primary, behavioral health, and LTSS services.
- Contract with D-SNPs as MLTSS MCOs enabling coordination of Medicaid and Medicare benefits for dually eligible beneficiaries choosing the same plan for services provided by both programs.

Current Status

Virginia signed a memorandum of understanding with CMS in May 2013 to pursue a capitated financial alignment demonstration for individuals dually eligible for Medicare and Medicaid. As a result, dual eligible beneficiaries will be able to receive all their benefits through a single integrated MCO-based program, Commonwealth Coordinated Care (CCC). The legislature mandated that in the future all individuals in Medicaid, including those receiving nursing facility-based care or HCBS be placed into a managed delivery system. Mandatory enrollment into coordinated care will come only after the state, providers, and stakeholders become familiar with, and address any issues identified, by delivering LTSS through a managed care environment.

Path to MLTSS

Beginning in 2006, Virginia laid out a plan to implement mandatory MLTSS through the Virginia Acute and Long-Term Care (VALTC) program. VALTC was intended to allow Medicare-Medicaid enrollees over the age of 21 in the Tidewater area to receive both their medical and long-term care services through a single coordinated system. For three years, the Virginia Department of Medical Assistance worked to gain buy-in from stakeholders, but encountered opposition from the long-term

care provider community. Planning and stakeholder meetings occurred until the end of 2008 when the state ultimately decided it was no longer feasible to pursue the program in its entirety.¹⁷ The first phase of VALTC was implemented, and similar to New Jersey, included the introduction of beneficiaries to managed care for receipt of acute and primary care services.

Since second phase of VALTC was abandoned in 2008, both providers and beneficiaries have had time to observe the implementation of Medicaid managed care in other states. Additionally, experience with Medicare Advantage has created a higher level of understanding and better working relationships between MCOs and long-term care providers. This confluence of factors supports Virginia's current efforts to integrate Medicare and Medicaid and its goal to implement mandatory Medicaid coordinated LTSS in the near future.

Virginia expects that over the course of CCC, there will be further opportunities to learn how to best deliver LTSS in a managed care environment prior to implementation of mandatory enrollment in coordinated LTSS. Initial enrollment in CCC will be voluntary. The Commonwealth's experience trying to implement mandatory enrollment in VALTC informed its decision to start with

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Past Lessons Inform Virginia's Path to MLTSS

While VALTC was never fully implemented, it provides critical lessons to guide the development and implementation of state MLTSS approaches:

Build Relationships with Program Champions: Since VALTC ended over five years ago, the Virginia Department of Medical Assistance has continued to strengthen its relationships with providers and stakeholders invested in the LTSS system. Nursing facilities emerged as a critical stakeholder group for collaboration. The state also established connections with adult day health centers, centers for independent living, and specific HCBS providers such as personal care attendants. Community service boards emerged as champions of Virginia's new CCC program. Depending upon the MLTSS program proposed, additional stakeholder groups including health plans may be critically important to partner with to increase the likelihood of program success.

Take Incremental Steps to Ensure Success: In deciding who to include, and who not to include in the duals demonstration, Virginia had to consider how the program's success would be affected by mandating enrollment. Ultimately, the state chose to pursue a voluntary integration strategy using 1932(a) Medicaid state plan amendment. The legislature decided to wait a few years before requiring all LTSS-eligible individuals be enrolled into a managed or coordinated care environment. Adding individuals incrementally into a managed care delivery system will help ensure the system can handle the influx of beneficiaries, as well as create confidence in stakeholders regarding the benefits of managed care.

States may need to rethink approaches to and timing for MLTSS program implementation based on input from providers and beneficiaries in order to better meet their needs and ultimately the goal of the state to implement a successful MLTSS program.

voluntary enrollment and then pursue mandatory enrollment into MLTSS after implementation of CCC.

Conclusion

Experiences and paths taken to MLTSS program implementation by Florida, New Jersey, and Virginia can help inform other states as they embark on MLTSS program design and implementation. Florida and New Jersey are planning mandatory enrollment into MLTSS programs in the near future, while Virginia plans mandatory enrollment as a next step as part of its financial alignment demonstration for dually eligible beneficiaries. State resources and stakeholder readiness influenced timing and program design in all three states.

Experience on the path to MLTSS created a platform for efforts to further coordinate and integrate care for individuals dually eligible for Medicare and Medicaid. Virginia's experience with its stakeholders and direction from its legislature influenced the Commonwealth to pursue its dual eligible demonstration program, CCC, prior to moving forward with mandatory enrollment into MLTSS. While Florida and New Jersey

both identify Medicare and Medicaid integration as a priority, they have directed state resources toward MLTSS program implementation. New Jersey is working with D-SNPs to better coordinate Medicaid and Medicare benefits and adding MLTSS to D-SNPs in January 2015. Florida is assigning dual eligible beneficiaries to their D-SNP plans for SMMC if the D-SNP is a MLTSS-participating plan. The state also is using its three-way contract with CMS and D-SNPs to obtain Medicare encounter data and put standard contract language in place for covered services and benefits.

States may take the lessons captured from Florida, New Jersey and Virginia as they proceed with MLTSS program planning. Assessing internal state resources for readiness for implementation is critical to moving forward. States may also need to rethink approaches to and timing for program implementation based upon input from providers and beneficiaries in order to better meet their needs and ultimately the goal of the state to implement a successful MLTSS program. Providers, beneficiaries, states and their legislatures can partner to put forward strong MLTSS programs.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs.

This policy brief is a product of CHCS' Implementing the Roadmaps: Innovations in Long-Term Supports and Services program, made possible through The SCAN Foundation. Through this program, CHCS is helping participating states to rebalance and better manage an array of long-term services and supports for Medicaid populations. For more information, visit www.chcs.org.

Endnotes

- ¹ P. Saucier, J. Kasten, B. Burwell, and L. Gold. *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update*. Truven Health Analytics, July 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf.
- ² S. Barth, B. Ensslin, and N. Archibald. *State Trends and Innovations in Medicaid Long-Term Services and Supports*. Center for Health Care Strategies, December, 2012. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261467.
- ³ Chapter 2011-134, Laws of Florida Available at: <http://laws.flrules.org/2011/134>.
- ⁴ Florida Agency for Health Care Administration. *Florida Medicaid*. Available at: http://ahca.myflorida.com/medicaid/statewide_mc/index.shtml.
- ⁵ CMS must make decisions 1915 (b) (c) concurrent waivers within 90 days of submission unless a request for additional information from the state is made 42 CFR §430.25.
- ⁶ SMMC LTC Minimum Covered Services: Adult companion care; Adult day health care; assisted living; assistive care services; attendant care; behavioral management; care coordination/case management; caregiver training; home accessibility adaptation; home-delivered meals; homemaker; hospice; intermittent and skilled nursing; medical equipment and supplies; medication administration; medication management; nursing facility; nutritional assessment/risk reduction; personal care; personal emergency response system; respite care; therapies, occupation, physical, respiratory and speech; and transportation, non-emergency. "A Snapshot of the Florida Medicaid Long-term Care Program", Florida Agency for Health Care Administration, May 29, 2013.

⁷ June 5, 2013 Interview with Beth Kidder, Assistant Deputy Secretary for Medicaid Operations and Kym Holcomb, Program Administrator for Long-Term Care, Agency for Health Care Administration, State of Florida.

⁸ July 10, 2013 Interview with Melanie Brown-Woofter, Bureau Chief for Bureau of Health System Development, Agency for Health Care Administration, State of Florida.

⁹ Beth Kidder, op. cit.

¹⁰ Beth Kidder, op. cit.

¹¹ Part IV, Chapter 409, Florida Statutes (2012) Medicaid Managed Care, Section 409.984(1) states: If a recipient is deemed dually eligible for Medicaid and Medicare services and is currently receiving Medicare services from an entity qualified under 42 C.F.R. part 422 as a Medicare Advantage Preferred Provider Organization, Medicare Advantage Provider-sponsored Organization, or Medicare Advantage Special Needs Plan, the agency shall automatically enroll the recipient in such plan for Medicaid services if the plan is currently participating in the long-term care managed care program. Except as otherwise provided in this part, the agency may not engage in practices that are designed to favor one managed care plan over another.

¹² New Jersey Department of Human Services. *Medicaid Comprehensive Waiver Framework*. Available at:

<http://www.state.nj.us/humanservices/dmahs/home/Medicaid%20Comprehensive%20Waiver%20Power%20Point.pdf>.

¹³ New Jersey Department of Human Services. *Testimony Before the Assembly Budget Committee, February 29, 2012, Jennifer Velez, Commissioner, NJ Department of Human Services*. Available at: <http://www.state.nj.us/humanservices/dmahs/home/VelezABUhearing2-29.pdf>.

¹⁴ State of New Jersey. *Section 1115 Demonstration "Comprehensive Waiver" Concept Paper*. May 2011. Available at:

<http://www.state.nj.us/humanservices/dmahs/home/Comprehensive%20Waiver%20Concept%20Paper.pdf>.

¹⁵ June 5, 2013 interview with Kathleen Mason, Director, Division of Aging Services, Department of Human Services, State of New Jersey.

¹⁶ Ibid.

¹⁷ May 28, 2013 and July 16, 2013 Interviews with Suzanne Gore, Senior Executive Advisor, Department of Medical Assistance Services, State of Virginia.