Long-Term Care Capitation Models:

A Description of Available Program Authorities and Several Program Examples

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August, 2007

Acknowledgments

CMS would like to acknowledge the assistance of Alan Schafer (Arizona), Pam Parker (Minnesota), Charles Jones (Wisconsin), and Diane Flanders (Massachusetts) who each reviewed the information pertaining to the capitation model in their State. CMS is responsible for any errors that may remain.

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Introduction

The aging of the Baby Boom Generation will soon create an unprecedented demand for long-term care (LTC) services that will place additional strain on State budgets. To address the need to manage costs, and to provide high quality care, a growing number of States have developed capitated models to pay for LTC services, including institutional and community-based services.

Capitated models have several potential cost benefits. Most importantly, they may encourage at-risk health plans to use Medicaid services more judiciously and to provide LTC services in the least costly setting. Use of capitation arrangements may also provide more budget predictability for State budget planners.

Several promising State models target dual eligible beneficiaries and integrate both Medicare-and Medicaid-covered services through managed care systems. Integrating the full array of Medicare and Medicaid benefits – including LTC benefits – has the potential to produce a more seamless and well-coordinated service delivery experience for dual eligible beneficiaries, thereby reducing the fragmentation and associated inefficiencies and quality issues that can often occur in fee-for-service systems.

The purpose of this paper is to provide States with information on Medicaid and Medicare program authorities that can be used to implement capitated LTC models. On the Medicaid side, these include State plan amendment, waiver and demonstration authorities, and a new State plan option that became available through the Deficit Reduction Act (DRA) of 2005. On the Medicare side, demonstration authority is generally no longer needed to implement integrated models due to the introduction of Medicare Advantage Special Needs Plans (SNPs) into the Medicare Advantage program in 2004.

The paper concludes by providing examples of programs that capitate LTC services and utilize different program authorities. These include the Program of All-inclusive Care for the Elderly (PACE); Arizona Long-Term Care System (ALTCS); Minnesota Senior Health Options (MSHO); the Wisconsin Partnership Program (WPP); and Massachusetts Senior Care Options (SCO). All of the programs have been pilot programs or demonstrations at some point and offer valuable lessons for States considering similar programs.

Medicaid Program Authorities

Each authority described below has a distinct purpose and distinct requirements. States and CMS will need to work together to decide what approach will work best for a particular State.

Regardless of the Medicaid authority a State may choose, capitated health plans may always provide additional health-related services that are not in the State Plan by using their own profits/savings. However, the State cannot contractually require that plans provide these services. This approach is permitted under 42 CFR 438.6(e).

Capitated health plans may also provide "in lieu of" services, which are health-related services that directly replace State plan services which are included in the State capitation rate, but are more cost-effective or efficient. The flexibility of this approach allows a health plan to, for example, pay for home and community-based services in lieu of providing more costly institutional services. The State cannot pay for these services explicitly, but can include payment for them in the capitation rate for the State plan services which they would replace. In setting capitation rates that include a component for substitute or in lieu of services, the unit cost of these services should be less than the unit cost of the State plan services they replace.

Program of All-Inclusive Care for the Elderly (PACE)

The Balanced Budget Act (BBA) of 1997 established The Program of All-inclusive Care for the Elderly (PACE) as a permanent State plan option within the Medicaid program. The State plan must include PACE as an optional Medicaid benefit before the State and the Secretary of the Department of Health and Human Services (DHHS) can enter into program agreements with PACE providers. The PACE legal authority is described in the Federal regulations at 42 CFR Part 460.

PACE, which was modeled on the system of acute and long-term care services developed by On Lok Senior Health Services in San Francisco, was the first program tested by CMS to capitate all Medicare and Medicaid services for elderly beneficiaries requiring a nursing home level of care. The program is described in greater detail in the section of the paper entitled "Examples of Long-Term Capitation Models."

Medicaid Section 1915(a) Exception to State Plan Requirements for Voluntary Managed Care

This section of the Social Security Act (the Act) provides States the authority to implement voluntary managed care through contracts and to do so without violating Medicaid "freedom of choice," "comparability of services," or "statewideness" requirements[1]. There is no waiver or waiver application with this approach; only approval of the Medicaid managed care contract by the CMS Regional Office. This

[1] "Freedom of choice" requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State; "comparability of services" requires all services for categorically needy individuals to be equal in amount, duration, and scope; and "statewideness" requires a Medicaid State plan to be in effect in all political subdivisions of the State.

authority cannot be used by the State to mandate enrollment in managed care or to selectively contract with qualified managed care plans.

Medicaid Section 1932(a) State Plan Amendment Authority

This section of the Act enables States to implement mandatory managed care for certain populations, such as families and most children, on a statewide basis or in limited geographic areas without a waiver. As with the 1915(a) authority, States can implement these programs without regard to Medicaid "freedom of choice," "comparability of services," or "statewideness" requirements. A State cannot use this authority to mandate enrollment for dual eligibles and certain other exempted populations.

Similar to section 1915(a), this section also allows a State to implement voluntary Medicaid managed care for any population group. However, the benefit of using the 1932(a) authority is that States have the ability to selectively contract with Medicaid managed care entities without a 1915(b) waiver. If a State wanted to implement a voluntary, capitated LTC program but contract with fewer than all qualified Medicaid managed care plans, 1932(a) would be an option.

Medicaid Section 1915(b) Managed Care/Freedom of Choice Waiver

This section of the Act provides the Secretary authority to grant waivers that allow States to implement mandatory enrollment in Medicaid managed care delivery systems and/or selectively contract with providers. Under this authority, CMS can waive many requirements in section 1902 of the Act. Section 1915(b) waivers allow States to restrict freedom of choice for any and all Medicaid groups, permitting mandatory enrollment in Medicaid managed care entities.

A section 1915(b) waiver program cannot substantially restrict beneficiary access to medically necessary services of adequate quality, and must be cost-effective. States may use the CMS waiver template and submit the application for review. States must request specific authority under one or more of the four 1915(b) subsections, consistent with the purpose of the program. Section 1915(b) waivers do not carry the evaluation requirements necessary for section 1115 demonstrations (described below), but an independent assessment is due for the first two waiver periods. Section 1915(b) waiver programs are approved for 2-year periods, and States may submit renewal applications to continue these programs.

There are two significant differences between section 1915(b) authority and sections 1915(a) or 1932(a) described above. First, under 1915(b), States may require enrollment of dual eligibles and other aged, blind, or disabled populations into managed care. Second, section 1915(b) waivers provide the opportunity for States to offer additional services to enrollees that are paid for through savings achieved under

the waiver. These additional services may be in the form of health-related items or services not in the State plan, or the elimination or reduction in cost sharing or service limitations. In order to provide such services, CMS must approve a State's request for authority under subsection 1915(b)(3) in conjunction with either subsection 1915(b)(1) and/or (b)(4). Through the use of 1915(b)(3), the State can require the delivery of the additional services in the Medicaid managed care contract, and pay the contractor for them.

Medicaid Section 1915(c) Home and Community-Based Services Waivers

This section provides the Secretary authority to waive Medicaid provisions in order to allow long-term-care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term-care services in institutional settings.

States may limit the total number of individuals in the State that will be served through the waiver program. Section 1915(c) waivers also allow States to target particular populations. For example, a State could develop a waiver to serve the aged/disabled or individuals with mental retardation/ developmental disabilities (MR/DD). (However, a State could not serve both of these populations under a single waiver.)

The State Medicaid agency must submit a 1915(c) waiver application to CMS for review and approval. The State agency has ultimate responsibility for the waiver program, although it may delegate the day-to-day program operations to another entity. Initial 1915(c) waivers are approved for a three-year period, and waivers are renewable at five-year intervals. Section 1915(c) waiver programs must be cost-neutral, ensure that measures are taken to protect the health and welfare of individuals in the program, and require that services are provided in accordance with a plan of care. Section 1915(c) waivers are not permitted to restrict enrollee "freedom of choice" of providers and, used by themselves, would not authorize a capitated LTC program.

Forty-eight (48) States and the District of Columbia offer services through 1915(c) waivers, and Arizona operates a similar program under section 1115 demonstration authority. There is no Federal requirement limiting the number of 1915(c) waiver programs a State may operate at any given time, and currently there are approximately 287 active 1915(c) waiver programs in operation throughout the country.

Medicaid State Plan Option for Home and Community-Based Services

The Deficit Reduction Act (DRA) of 2005 amended section 1915 of the Act to add a new subsection (i) which allows States to provide home and community-based services (HCBS) under their Medicaid State Plans.

In contrast to 1915(c) waivers, the State plan option allows States to offer HCBS to individuals without being required to establish that they would otherwise require institutional care. States must establish needs-based criteria that individuals must meet in order to receive State plan HCBS, and these criteria must be less stringent than the eligibility criteria to receive institutional care. In addition, States are not required to demonstrate that State plan HCBS are cost-neutral in relation to institutional services.

As with 1915(c) waivers, the new State plan option allows States to specify the total number of individuals in the State who may receive services and to disregard the statewideness requirement. However, unlike 1915(c) waivers, the State plan option does not allow States to waive comparability of service requirements. This means that States may not target State plan home and community-based services to certain groups (such as the elderly or the MR/DD population), but must make these services available to all financially eligible individuals who meet the State-defined needs-based criteria.

The services available under the State plan option include most of the HCBS specified in 1915(c)(4)(B) of the Act. The exception is the category of "other" services that the State may request and the Secretary may approve under 1915(c) waivers. The State may offer self-direction, in which beneficiaries receive employer authority, budget authority, or both to direct 1915(i) services. All services must meet Federal and State guidelines for quality assurance.

Once a State has added the State plan option through the State plan amendment process, the option remains in place indefinitely unless the State chooses to submit a State Plan Amendment. Section 1915(c) waivers, in contrast, must be renewed every 5 years.

Medicaid Concurrent Use of 1915(a) authority and 1915(c) Waivers

States may opt to simultaneously utilize section 1915(a) and 1915(c) program authorities to develop a voluntary managed care program that includes LTC services provided in both institutional and home and community-based settings. The 1915(c) authority is used to target eligibility for the program and provide home and community-based services and the 1915(a) is used to authorize the voluntary enrollment into a managed care plan that includes home and community-based services in the capitation payment.

Medicaid Concurrent Use of 1915(b) and 1915(c) Waivers

States may opt to simultaneously utilize section 1915(b) and 1915(c) program authorities to provide a continuum of services to disabled and/or elderly populations. In essence, States use the 1915(b) authority to mandate enrollment in a Medicaid

managed care plan and limit freedom of choice and/or selectively contract with providers and 1915(c) authority to target eligibility for the program and provide home and community-based services. By doing this, States can provide long-term care services in a managed care environment or use a limited pool of providers.
In addition to providing traditional long-term care State plan services (such as home health, personal care, and institutional services,) States may propose to include non-traditional home and community-based "1915(c)-like" services (such as homemaker services, adult day health services, and respite care) in their managed care programs.

States can implement 1915(b) and 1915(c) concurrent waivers as long as all Federal requirements for both programs are met. Therefore, when submitting applications for concurrent 1915(b)/(c) programs, States must submit a separate application for each waiver type and satisfy all of the applicable requirements. For example, States must demonstrate cost neutrality in the 1915(c) waiver and cost effectiveness in the 1915(b) waiver. States must also comply with the separate reporting requirements for each waiver. Because the waivers are approved for different time periods, renewal requests must be prepared separately and submitted at different points in time. Meeting these separate requirements can be a potential barrier for States that are considering going forward with such a program. However, the ability to develop an innovative, mandatory managed care program that integrates home and community-based services with traditional State plan services is appealing enough to some States to outweigh the potential barriers.

Medicaid Section 1115 Research & Demonstration Projects

This section of the Social Security Act (the Act) provides the Secretary broad authority to approve projects that test policy innovations likely to assist in promoting the objectives of the Medicaid program. These projects are intended to demonstrate and evaluate a policy or approach that has not been demonstrated on a widespread basis. Some States expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems. Projects are generally approved to operate for a five-year period, and States may submit renewal requests to continue the project for additional periods of time. Demonstrations must be "budget neutral". There is no standardized format to apply for a section 1115 demonstration, but the application must be submitted by the single State Medicaid agency. States often work collaboratively with CMS from the concept phase to further develop the proposal.

CMS would prefer that States attempt to meet their programmatic goals using other waiver or State plan authorities, the primary reason being that the innovation and budget neutrality requirements for these demonstration projects are difficult to meet. Section 1115 demonstrations also require a formal evaluation.

Medicare Program Authorities

Program of All-Inclusive Care for the Elderly (PACE)

The Balanced Budget Act (BBA) of 1997 established The Program of All-inclusive Care for the Elderly (PACE) as a permanent entity within the Medicare program. More specifically, the PACE statutory authority, which is described in the Federal regulations at 42 CFR Part 460, authorizes "Medicare payments to, and coverage of benefits under, PACE."

PACE, which was modeled on the system of acute and long-term care services developed by On Lok Senior Health Services in San Francisco, was the first program tested by CMS to capitate all Medicare and Medicaid services for elderly beneficiaries requiring a nursing home level of care. The program is described in greater detail in the section of the paper entitled "Examples of Long-Term Capitation Models."

Medicare Advantage (MA) Program

The Medicare Advantage (MA) program was established in the Balanced Budget Act (BBA) of 1997, and was originally known as the "Medicare + Choice" program. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) made significant changes to the Medicare+Choice program, and renamed the program the Medicare Advantage program. The Federal regulations for the MA program are described at 42 CFR Part 422.

Among the changes made by the MMA were the addition of two new private health plan options for Medicare beneficiaries, which are regional preferred provider organizations (PPOs) and special needs plans (SNPs). A regional PPO is a coordinated care plan structured as a PPO that serves one or more entire regions. SNPs are described in the next section of the paper.

In addition, the MA program introduced a new competitive bidding system under which MA plans confidentially submit bids to CMS with the benefit packages they will offer to beneficiaries. The plans must submit their applications, bids and other materials by specific deadlines in order to be able to offer an MA product in the upcoming contract year. MA contracts are effective from January 1st to December 31st. Each plan must offer the benefit package described in its bid for the entire contract year. With several exceptions, Medicare beneficiaries who wish to enroll in an MA plan can do so during the annual enrollment period from November 15th to December 31st.

Medicare Advantage Special Needs Plans (SNPs)

The Medicare Modernization Act (MMA) of 2003 (Section 231) authorized a new type of Medicare Advantage coordinated care plan called Special Needs Plans (SNPs). SNPs are distinct from other MA plans in that they can restrict enrollment to a group of "special needs individuals", defined by Congress as: 1) long-term institutionalized beneficiaries; 2) beneficiaries who are dually eligible for Medicare and Medicaid; and/or 3) individuals with severe or disabling chronic conditions. Legislative authority for the MA SNP program expires in December 2008.

Unless expressly excluded, SNPs are subject to all of the regulations applicable to MA coordinated care plans at 42 CFR Part 422. The special rules applicable to SNPs define special needs individuals, specialized plans, and institutionalized individuals for purposes of enrollment in a SNP (Section 422.2); describe the requirements for exclusive or disproportionate share SNPs (Section 422.4(a)(1)(iv)); and describe the eligibility rules for SNPs (Section 422.52).

SNPs represent the first time that Medicare is permitting plans to restrict enrollment to dual eligible beneficiaries, long-term institutionalized beneficiaries, and beneficiaries with severe or disabling chronic conditions. In addition, Medicare is allowing managed care plans to restrict enrollment to beneficiaries who require an institutional level of care but reside in home and community-based settings.

Medicare Section 402 Demonstration

Section 402 of the Social Security Amendments of 1967, as amended, allows for experiments and demonstrations to test alternative methods of paying for Medicare services. The demonstrations may involve fee-for-service or Medicare Advantage payment methodologies, and/or risk sharing arrangements that are not permitted under Medicare statute.

Considerations in Choosing the Appropriate Medicaid Authority

In choosing which Medicaid authority or authorities to apply for, the State should keep in mind the following considerations:

Mandatory vs. Voluntary Enrollment

If the State wants to require dually eligible individuals to enroll in a Medicaid managed care plan, the State will need section 1915(b) waiver authority or section

1115 demonstration authority. If enrollment in the capitated arrangement will be voluntary, the State may use 1915(a), 1915(b) or 1932(a) authorities.

Automatic enrollment into Medicaid managed care may be considered voluntary if the following criteria are met: (1) the beneficiary does not elect to be enrolled in fee-for-service after being given a designated time frame to make such a choice; (2) the State gives the beneficiary sufficient notice that, in the absence of their election to do otherwise, they will be automatically enrolled into a managed care plan; and (3) the beneficiary is allowed to disenroll from the managed care plan after the assignment has been made (without cause for the first 90 days of enrollment or with cause thereafter).

Medicaid Managed Care Payment

If the State intends to pay on a capitated basis, the State will need to meet all the Medicaid managed care requirements in 42 CFR Part 438 that apply to risk contracts, which includes the requirement for actuarially sound rates. Depending on whether services beyond those in the State plan are to be provided under the Medicaid managed care contract, the State may need sections 1915(b) or 1915(c) waiver authority or section 1115 demonstration authority. If a State wants to require the Medicaid health plan to provide services not authorized under the current State Plan, either a 1915(b)(3) waiver (using identified savings of State plan services), a 1915(c) concurrent waiver (to cover HCBS services), or a 1115 demonstration may be necessary. However, Medicaid health plans may always provide additional health related services not in the State Plan using their own profits/savings as long as the State does not contractually require the service.

Number of Sustainable Medicaid Managed Care Plans

The law and regulations require that beneficiaries enrolled in a mandatory Medicaid managed care program be given a choice of at least two managed care entities (e.g., a managed care entity is defined as a Managed Care Organization (MCO) or a Primary Care Case Manager (PCCM)). However, in service areas outside of Metropolitan Statistical Areas (MSAs), the State can be granted a rural exception under which a single Medicaid MCO is allowed to provide services as long as the State meets the requirements of Section 438.52(b) (e.g., permission to access out of network providers under specified circumstances). If the State intends to contract with a single Medicaid MCO within an MSA, a section 1115 demonstration would be required. If a State chooses to limit the number of Medicaid health plans that can participate in administering the program, the State would need authority under sections 1115, 1915(b)(4), or 1932(a) of the Act.

Geographic Area

The State must consider whether it wants to integrate care on a statewide basis or only a specific area of the State. Sections 1115, 1915(a), 1915(b), and 1932(a) allow States to limit managed care programs to specific geographic areas.

Examples of Long-Term Care Capitation Models

Below are several examples of programs that capitate LTC services. All of the programs have been pilot programs or demonstrations at some point and offer valuable lessons for States considering similar programs.

Program for the All-Inclusive Care for the Elderly (PACE)

- Medicaid program authority**:** Medicaid statute (section 1934) in the Social Security Act
- Medicare program authority**:** Medicare statute (section 1894) in the Social Security Act

Program Description

The Program of All-Inclusive Care for the Elderly (PACE), which was modeled on the system of acute and long-term care services developed by On Lok Senior Health Services in San Francisco, was the first program tested by CMS to capitate all Medicare and Medicaid services for elderly beneficiaries requiring a nursing home level of care. The primary goal of the PACE model is to help frail elderly remain in the community.

There are currently 37 PACE Programs operating in 20 States, serving approximately 13,000 enrollees across the country. Approximately 95% of PACE enrollees are dually eligible for Medicare and Medicaid. PACE programs are small, serving between 100 and 2,000 participants. The average organization serves about 300 participants.

Under the PACE model, an interdisciplinary team of professionals coordinates services for each enrollee and adult day health centers serve as the central locations for delivering medical and social services. Enrollees must choose a PACE physician. PACE emphasizes the use of comprehensive assessments and monitoring in order to maximize the probability that enrollees will be able to remain in the community. The PACE service package must include all Medicare services and Medicaid services provided by the State as well as any services deemed necessary by the enrollee's interdisciplinary team.

PACE organizations receive a Medicare capitation rate from CMS that includes a payment adjustment (i.e., a frailty adjuster) to account for the relative frailty of the

population enrolled in PACE. The Medicaid capitation rate from the State is less than the fee-for-service equivalent of what would be paid if the person were not enrolled in the PACE plan. PACE providers assume full financial risk for the cost of caring for their enrollees.

Results/Lessons Learned

1. PACE has generally produced positive health outcomes for beneficiaries, improved beneficiary quality of life, and achieved its goal of enabling beneficiaries to remain in the home.

2. States save money under PACE since the Medicaid capitation rate is less than what the State would have paid if the beneficiary were enrolled in fee-for-service.

3. In PACE, adult day health centers serve as the central location for delivering medical and social services. For this reason, most PACE programs have been established in metropolitan areas. However, in September 2006, CMS awarded 15 grants of $500,000 each to organizations in rural areas to assist in the diffusion of this model.

4. PACE has high start-up costs. These costs include the renovation or establishment of a PACE center and fixed costs for personnel while trying to enroll members (the average PACE plan only has 3 net enrollments per month).

5. Health plans that operate PACE may have difficulty being financially viable due to the relatively small number of enrollees in each program and the lack of flexibility in the PACE model of care. Health plans that operate PACE programs are required to be non-profits. Some plans actually start off as adult day health plans and convert their existing enrollment into PACE.

Arizona Long-Term Care System (ALTCS)

- Medicaid Program Authority: Section 1115 Research & Demonstration Project
- Medicare Program Authority: Some health plan contractors are MA SNPs. Going forward, the State is requiring that all contractors be SNPs or have a formal relationship with a SNP.

Program Description

Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), has operated as a statewide 1115 Medicaid managed care demonstration since 1982. Covered services include acute care, behavioral health, home and

community-based services and nursing home care. Long-term care services are provided through the Arizona Long-Term Care System (ALTCS), which was implemented in 1988. Arizona contracts with program contractors to provide acute and long-term care services to ALTCS members. Currently, the State has contracts with eight program contractors, which were generally awarded by Geographic Service Areas (GSAs). All Medicaid beneficiaries, with the exception of Native Americans and individuals who receive services through the Federal Emergency Services (FES) program, are required to enroll in an AHCCCS health plan (for children and families) or contractor (for ALTCS members).

As of June 1, 2007, the ALTCS program served 43,376 members, including 18,959 developmentally disabled (DD) beneficiaries and 24,417 elderly and/or physically disabled (EPD) beneficiaries. Approximately 84% of the EPD members were dually eligible for Medicare and Medicaid. Dual eligible beneficiaries receive Medicare-covered services on a fee-for-service basis unless they choose to enroll in a Medicaid managed care plan. On January 2006, two of the program contractors (Mercy Care and Evercare Select) were SNPs and enrolled approximately 15,600 members. A third plan (SCAN Long-Term Care) became an ALTCS program contractor in October 2006 and a SNP in January of 2007. A fourth plan (Bridgeway Health) also became an ALTCS program contractor in October 2006 and will likely become a SNP in January of 2008.

All ALTCS members must require a nursing home level of care. A registered nurse or social worker administers a Pre-Admission Screening (PAS) process for each potential enrollee to ensure that persons enrolled in the program are at immediate risk for institutionalization. Targeted groups are reassessed on an annual basis or when a change in condition occurs. Beneficiaries who are no longer at immediate risk for institutionalization can be transferred to the Transitional Program, which limits institutional services to 90 days per admission and provides the member with acute care services, home and community-based care, behavioral health and case management.

Although beneficiaries must require a nursing home level of care to be eligible for ALTCS, they do not need to reside in a nursing home to receive services. In fact, as described in more detail below, the majority of ALTCS members currently reside in the community. For members who reside in institutions, case managers are required to determine at every six month reassessment if the member can be more appropriately placed in the community. Home and community-based services include home health, respite, attendant care, personal care, homemaker services, transportation, adult day treatment, home-delivered meals, and habilitation services. Each ALTCS member has a case manager that coordinates care with the primary care provider and works to ensure that the member has access to needed services.

ALTCS pays contractors prospectively on a capitated, per member, per month basis. The program develops rates separately for acute care, home and community-based services, institutional care, behavioral health, case management and administration,

and then blends them for one capitation rate. Individual capitation rates are calculated based on utilization trends and medical cost inflation factors. Contractors receive two capitation rates that vary based on whether the member also has Medicare benefits. Otherwise the capitation rate remains the same regardless of where the member resides, which creates an incentive for contractors to care for members in the least costly setting. Some programs have special payment arrangements for disease specific conditions such as traumatic brain injury and Alzheimer's/dementia.

Finally, it should be noted that while there are some important lessons to be learned from ALTCS, CMS is unlikely to approve similar demonstrations in other States. The DRA and other authorities give States the flexibility to do much of what Arizona is doing using the 1115 demonstration authority.

Results/Lessons Learned

1. The State payment rates for long-term care do not vary based on where the enrollee resides, which creates an incentive for plans to provide care in the least costly setting. Approximately 5% of EPD members were living in home and community-based settings during the first year of the program, compared to 64% of EPD members in April, 2007.

2. Providing long-term-care services in home and community-based settings has proven to be cost-effective. Additionally, enrollee satisfaction and provider performance specifically in community settings has been positive overall.

3. The rigorous screening process used to assess institutional need – both at the time of enrollment and on an ongoing basis - ensures that individuals receive the most appropriate care.

4. Under its demonstration authority, the State uses a single plan model for health care delivery, except in Maricopa County. This means there is only one ALTCS managed care organization per geographic service area. Geographic service areas can be made up of a single or multiple counties. Awarding single-plan contracts helps to ensure that the plans have sufficient enrollment to be financially viable.

5. The State uses a risk corridor for its two newest plans which ensures the success of those plans during the start-up.

Minnesota Senior Health Options (MSHO)

- Medicaid Program Authority: 1915(a) and 1915(c) Waivers
- Medicare Program Authority: MA SNP authority; 402 Demonstration

Program Description

Minnesota Senior Health Options (MSHO) was first implemented in 1997 as a Medicaid 1115 demonstration and a Medicare demonstration. Participating health plans converted to Medicaid 1915(a) and (c) waivers in 2003 and became Medicare Advantage Special Needs Plans in 2006. The program continues to operate under a Medicare section 402 demonstration to allow for payment differences from other MA plans.

Program enrollment is voluntary and open to dual eligible seniors who are either nursing home certifiable (NHC) or non-NHC. As of August 2007, approximately 35,430 beneficiaries were enrolled.

MSHO contracts with non-profit health systems to provide enrollees with all Medicare and Medicaid benefits, including home and community based waiver services. Each enrollee is assigned a care coordinator who is generally a nurse or social worker, but could also be a nurse practitioner. The care coordinator serves as a liaison to the primary care physician (PCP), coordinates the delivery of medical and social services, assesses service needs annually, and adjusts services as needed. Many institutional members are served by the Evercare model or a similar nurse practitioner-based model of care delivery through subcontracts between MSHO contractors and care systems. Evercare is not permitted to obtain a managed care license in Minnesota because it is a for-profit company.

In 2007, Medicare payments to MSHO plans are based 25% on the Average Adjusted Per Capita Costs (AAPCC) methodology and 75% on the Hierarchical Condition Category (HCC) risk adjustment methodology. Beginning in 2008, the payments will be based entirely on the HCC methodology. Under Medicare 402 demonstration authority, MSHO plans receive an additional payment (called a "frailty adjuster") to account for the relative frailty of the population enrolled in the program. (The 402 demonstration authority was originally scheduled to expire on December 31, 2007, but CMS has arranged to phase out the frailty adjuster over a period of three years (ending on December 31, 2010) to ease the plans' transition to being paid according to MA payment rules.)

For Medicaid, MSHO enrollees are assigned to one of three rate cells to determine the capitation rate paid to the health plan on behalf of the enrollee. The rate cell mechanism takes into account potential variation in the care needs of different segments of the dual eligible population. The rate cells are: Community dwelling, non-NHC, not enrolled in Elderly Waiver (Cell A); Community dwelling, NHC (Cell B); and Institutionalized at enrollment, or after for at least 30 days (Cell D).

The Medicaid rate structure includes the Medicaid State plan basic care rates; the average monthly Elderly Waiver payments for home and community-based long-term care services; and 180 days of nursing home care. The State pays nursing home costs on a fee-for-service basis after 180 days for enrollees who initially reside in the

community, and immediately for enrollees who join MSHO directly from nursing homes.

Results/Lessons Learned

1. At the outset of the program, approximately 80% of enrollees resided in a nursing home. In June 2007, about 38% of enrollees reside in a nursing home. Thirty-two percent (32%) of enrollees meet the criteria for nursing home placement but are being served in the community through home and community-based services.

2. Based on an evaluation by the University of Minnesota from Fall 1999 to Fall 2000, MSHO community enrollees showed a lower rate of preventable hospital admissions and preventable emergency room visits than eligible persons who lived in covered counties but did not enroll. Both findings were statistically significant.

3. Nursing home enrollees had lower rates of hospitalization, ER visits, and preventable emergency services than both eligible persons who lived in covered counties but did not enroll and eligible persons who lived in a comparable area not covered by the program. Hospital days and preventable hospital admissions were also lower for MSHO nursing home enrollees compared to eligible persons who lived in covered counties but did not enroll. All findings were statistically significant.

4. MSHO is the first statewide system of Medicare and Medicaid integration for elderly dual eligible beneficiaries. The MSHO model effectively combines the contractual arrangements of the MA program with those of the State Medicaid program in a transparent system of care from the beneficiary perspective. The contracting model has been successfully adapted to the group practice environment that is prevalent in Minnesota in a State in which all managed care plans are mandated to be non-profit organizations.

5. Under MSHO, Medicare and Medicaid payments are combined at the health plan level. The combining of payments and benefits under one health plan gives care coordinators and care providers maximum flexibility to design treatment plans that may keep beneficiaries more independent, provide alternatives to higher cost services, and prevent, defer, or reduce lengths of stay in both acute and long-term care settings.

6. Although MSHO does not capitate nursing home benefits beyond 180 days of care, the inclusion of capitated financing for both community-based long-term care and nursing facility care enable MSHO a broader range of care delivery options.

7. SNPs working with State Medicaid programs may implement programs similar to MSHO without requiring Medicare demonstration authority. Therefore, the developmental efforts that were required for the MSHO program are no longer a barrier to implementing arrangements similar to MSHO.

Wisconsin Partnership Program (WPP)

- Medicaid Program Authority: Moving to 1932(a) State Plan Amendment and 1915(c) Waiver
- Medicare Program Authority: Beginning 1/1/2008, all health plans will be MA SNPs; 402 Demonstration

Program Description

The Wisconsin Partnership Program (WPP) was first implemented in 1999.
It is a voluntary program that offers a comprehensive array of acute and long-term care services to nursing home certifiable elders and adults (>18) with physical disabilities. The benefit package is the same for both groups. Four non-profit contractors enroll approximately 2,500 enrollees in Milwaukee, Madison, Chippewa, Dunn and Eau Claire counties in Wisconsin. Fully capitated Medicare and Medicaid payments have been integrated at the health plan level since 1999.

The WPP was modeled on the PACE program, but expands on PACE to cover persons with disabilities as well as older persons eligible for an institutional level of care. It differs from PACE in other important ways. For example, the WPP allows enrollees to choose their own primary care physician (PCP). Under PACE, enrollees use a PACE physician, who is often based in a PACE-operated day care center. In addition, the WPP does not require the use of adult day care center and services are delivered in the enrollee's site of choice, which is typically at home.

The WPP has modified the collaborative-teams approach used in PACE for the delivery of health care services. WPP relies on core team members (like PACE) but includes a network of independent practice physicians who must be oriented to the philosophy of the WPP and whose services must be integrated. The WPP care coordination team typically consists of a nurse practitioner, one or two registered nurses, one or two social workers and a service coordinator, all of whom are employed by the health plan. The team visits the participant at home to assess his/her needs and plan and authorize services. The nurse practitioner oversees every case and often acts as coordinator with the primary care physician (PCP), who does not participate directly on the care coordination team.

The State of Wisconsin implements capitation contracts to provide or arrange for the provision of all Medicaid covered services to WPP enrollees, including all Medicaid-covered primary and acute health care services, community-based long-term care

services and nursing facility services. No services are reimbursed to these contractors on a fee-for-service basis. These organizations are community-based and serve different populations and geographical areas. Two of the programs serve both the elderly and the physically disabled, one serves only the physically disabled, and one serves only the elderly.

In 2007, Medicare payments to WPP plans are based 25% on the Average Adjusted Per Capita Costs (AAPCC) methodology and 75% on the Hierarchical Condition Category (HCC) risk adjustment methodology. Beginning in 2008, the payments will be based entirely on the HCC methodology. Under Medicare 402 demonstration authority, WPP plans receive an additional payment (called a "frailty adjuster") to account for the relative frailty of the population enrolled in the program. (The 402 demonstration authority was originally scheduled to expire on December 31, 2007, but CMS has arranged to phase out the frailty adjuster over a period of three years (ending on December 31, 2010) to ease the plans' transition to being paid according to MA payment rules.)

The Medicaid rate is designed to be less than the cost of providing the same services to a comparable Medicaid population on a fee-for-service basis. Specifically, the rate is a risk adjusted, weighted average of payments made to FFS participants in the COP-W program (a 1915(c) HCBS waiver program) and residents in nursing homes. Roughly 8% of WPP members are in nursing homes, so 8% of their rate is based on the nursing home payments and the remainder on COP-W. The final rate is 95% of the weighted average meaning that the State realizes an automatic saving of 5% over what is spent for comparable beneficiaries in COP-W and nursing homes. There is also an annual retrospective case mix adjustment to the WPP rates so that if the rates change based on actual plan experience, the State pays or collects the difference. The payment structure is the same regardless of where the enrollee resides, which provides an incentive for the plan to care for the enrollee in the least costly setting.

Results/Lessons Learned

1. The University of Minnesota evaluated the WPP during the first three years of the demonstration, from 1999 through 2001. The study was limited by the fact that less than two thirds of the study population was exposed to the program for at least 12 months, and individuals with the longest exposure were, by definition, those who enrolled early in the program and thus gained much of their exposure during the early, start-up phase of the demonstration. Nonetheless, WPP disabled enrollees showed a lower rate of preventable hospital admissions than eligible persons who lived in covered counties but did not enroll and lower rates of emergency services and preventable emergency services than eligible persons who lived in a comparable area not covered by the program. All findings were statistically significant.

2. WPP elderly enrollees had fewer hospital admissions and days compared to both eligible persons who lived in covered counties but did not enroll and

eligible persons who lived in a comparable area not covered by the program. They had fewer preventable hospital admissions compared to eligible persons who lived in covered counties but did not enroll. However, the differences were not statistically significant. When WPP elderly enrollees were compared to PACE enrollees, there was no difference in hospital days, however PACE enrollees had lower hospital admission rates and fewer ER admissions than WPP enrollees.

3. WPP demonstrated that integrated programs can be successfully implemented by small, community-based, non-profit organizations in both urban and rural settings.

4. WPP's unique Medicaid payment structure successfully attracted health plans to participate in the program, created incentives for health plans to care for enrollees in the least costly setting, and saved the State money. The State Medicaid program pays the WPP plans 5% less than they pay for a comparable mix of enrollees in nursing homes and HCBS waiver programs.

5. In the WPP model, the care coordination team both provides care and arranges for care by program contractors. Some of the contractors are pharmacy consultants who have expertise in medication therapy management. The WPP health plans view the combination of care coordination activity by staff clinicians and the added services provided by outside contractors as key to serving nursing home level of care members successfully in both nursing homes and community settings.

Massachusetts Senior Care Options (SCO)

- Medicaid Program Authority: Moving to 1915(a) and 1915(c) Waivers
- Medicare Program Authority: MA SNP authority; 402 Demonstration

<u>Program Description</u>

Massachusetts Senior Care Options was implemented in 2004. It is a voluntary program available to all Medicaid beneficiaries, age 65 and over, who reside in areas where SCO health plans are located. As of June 2007, the program enrolled approximately 7,600 beneficiaries, 91% of whom were dually eligible for Medicare and Medicaid. The State and CMS contract with three health plans, two for-profits and one non-profit, to provide services to enrollees. All of the health plans are Medicare Advantage SNPs. Medicare and Medicaid funding streams are combined at the health plan level so that benefits and expenditures can be coordinated.

The SCO benefit package consists of all Medicare and Medicaid benefits, including community long-term care services, and social work services. A primary care physician (PCP) coordinates care for enrollees who are non-NHC (as determined by

the State) and a primary care team (PCT), which consists of a primary care physician, a nurse and a social worker, coordinates care for enrollees who are NHC. The social worker on the PCT must be retained through a contract with the Area Agencies on Aging, which runs the State-funded home care and Medicaid waiver programs. Enrollees receive any SCO service that is authorized by the PCP (for non-NHC enrollees) or the PCT (for NHC enrollees). All enrollees also have access to 24/7 case management through a 1-800 number. Centralized Enrollee Records are a unique feature of SCO which allow clinicians access to important medical information 24 hours a day regardless of provider location.

In 2007, Medicare payments to SCO plans are based 25% on the Average Adjusted Per Capita Costs (AAPCC) methodology and 75% on the Hierarchical Condition Category (HCC) risk adjustment methodology. Beginning in 2008, the payments will be based entirely on the HCC methodology. Under Medicare 402 demonstration authority, SCO plans receive an additional payment (called a "frailty adjuster") to account for the relative frailty of the population enrolled in the program. (The 402 demonstration authority was originally scheduled to expire on December 31, 2007, but CMS has arranged to phase out the frailty adjuster over a period of three years (ending on December 31, 2010) to ease the plans' transition to being paid according to MA payment rules.)

To determine Medicaid payments, enrollees are assigned to one of 24 rating categories. The categories differentiate enrollees based on their residence, required level of care, eligibility status and geographic location. The residence/level of care categories are: the community "well"; community with Alzheimer's, dementia or a chronic mental illness (ADCMI); community NHC; and three categories for institutionalized beneficiaries with various acuity levels. Each category has a progressively higher capitation rate. In 2007, approximately 65% of enrollees are the community "well", 25% are community NHC, 10% are institutionalized, and a small number are community with ADCMI.

To complete determining the Medicaid rating category, each residence/level of care category is divided into four groups: dual eligibles living in Boston; dual eligibles living outside of Boston; Medicaid only beneficiaries living in Boston; and Medicaid only beneficiaries living outside of Boston. As mentioned, approximately 91% of enrollees are dual eligibles.

The Medicaid payment methodology incorporates incentives for plans to care for enrollees in home and community-based settings. If a health plan transitions an institutionalized individual into the community, the plan continues to receive its institutional rate – which is higher than any of the community rates - for 90 days, after which the plan receives the appropriate community rate. If a health plan transitions an individual from the community into an institution, the health plan continues to receive its community rate for 90 days, after which the plan receives the appropriate institutional rate. For the first 3 years of operation, Massachusetts participated in a risk-sharing arrangement with the health plans, which limited overall

profits and losses on Medicaid reimbursement and services within pre-defined risk corridors. (This arrangement ended at the end of 2006.)

Lessons Learned (note that SCO has not yet been formally evaluated)[2]:

1. SCO plans have enrolled individuals in underserved communities by going out into the communities and talking with potential enrollees on a one-to-one basis.

2. Centralized Enrollee Records appear to be an important vehicle for maintaining coordination and integration of services. These records give physicians and nurse case managers immediate access to pertinent medical information.

Conclusion

Long-term care capitation models are likely to offer States an opportunity to better manage costs and improve quality of care. This paper provides States with information on the Medicaid authorities needed to implement these programs and various models States may consider in designing their own programs. As the models show, there is potential to integrate acute and LTC for Medicaid beneficiaries in ways that best meet their needs.

[2] Two program evaluations are underway. The first one will look at utilization and compare SCO enrollees to eligible persons who chose not to enroll. The second one will focus on the beneficiaries' experience in the program.