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The Implications of Medicaid Managed Care for Long-Term Care on Nursing Facility Providers

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Executive Summary

We were engaged by the American Health Care Association (AHCA) to identify the implications of Medicaid managed care plans for long term care services on nursing facility providers. While we identified all the states with Medicaid managed care programs for long term care, we concentrated on the two that have had the most significant impact on nursing home providers due to their longevity, market penetration, geographic coverage area, and rate setting approaches. These were Arizona and Minnesota. Relative to these two states, we did the following:

1. Conducted a literature review on their Medicaid managed care program for long term care services;
2. Obtained data on utilization and expenditure trends;
3. Reviewed the capitated rate setting process;
4. Prepared questionnaires and/or interviewed the managed care program contractors on contracting and rate negotiation with nursing home providers, operational issues and quality monitoring, utilization trends relative to institutional and home and community-based services, and integration of services for dually-eligible recipients; and
5. Prepared questionnaires and/or interviewed providers on issues such as rate negotiation and timeliness of payment, trends in occupancy, payer mix and length of stay, quality reporting, and integration of services for dually-eligible recipients.

The Arizona Long Term Care System (ALTCS) and Minnesota's long-term care managed care delivery system entitled Minnesota Senior Health Options (MSHO) are different in design and application to nursing home providers. ALTCS enrollment is mandatory in order to receive Medicaid-covered long-term care services while enrollment into the MSHO program is voluntary.

In Minnesota, Medicaid recipients must enroll in a Medicaid managed care plan (called PMAP-Prepaid Medical Assistance Program) to be eligible for primary and acute care benefits. However, to facilitate enrollment of Medicaid participants into Part D in 2005, recipients in Minnesota's Medicaid managed care plans were passively enrolled into Medicare Special Needs Plans (SNP). All of the Medicaid managed care plans became SNPs and almost all offered the MSHO program. As a result, a high percentage of the dual-eligible elderly were passively enrolled in MSHO. As of January 2006, almost 80% of the seniors enrolled in managed care plans in Minnesota were in a plan that participated in MSHO. As of July 2006, 64% of nursing home certifiable recipients were in an MSHO plan[1].

Nursing home coverage under the two programs are different, in that in Arizona, the program contractors are responsible for the complete array of Medicaid-covered services including acute, institutional and home and community-based services while the MSHO benefits include all Medicare and Medicaid covered services including home and community-based waiver services but only 180 days of nursing home care. With MSHO, nursing home care exceeding 180 days is paid by the state for Medicaid enrollees based upon the rate setting mechanism in the Medicaid state plan. Rates for Medicaid-covered nursing facility services during the MSHO 180 day coverage period are typically paid at these same rates although nursing homes and MSHO plans are free to negotiate their own payment arrangements. However, based upon our discussion with the plans and providers, rate negotiations typically relate only to Medicare-covered services.

In Arizona, nursing home providers are negotiating rates with the program contractors for Medicaid services and for Medicare as well, if the program contractor is a SNP or Medicare Advantage plan and the dually-eligible recipient is enrolled in that plan for their Medicare benefits. Just as in Minnesota, the dually-eligible recipients in Arizona were passively enrolled in such plans to

[1] MSHO Enrollment Data provided by Minnesota Department of Hunan Services.

facilitate the Part D enrollment process, and most of the managed care program contractors in Arizona were either SNPs or Medicare Advantage plans. However, as of the date of this Report, the two new program contractors in Maricopa County (Phoenix area) were not yet certified by CMS as SNPs, so Medicare managed care utilization by nursing home provider can and will vary considerably.

Implications-ALTCS Program

The major implications that the ALTCS program has had on Arizona nursing home providers are as follows:

1. The current capitated rates paid to the program contractors by the state assume that only 37% of the enrollees will utilize nursing facility services while the other 63% utilize home and community-based services, meaning the program contractors are penalized if institutional long term care utilization exceeds 37% and correspondingly rewarded, if less than that. For the year ending December 31, 2005, institutional "member months" represented 37% of total "member months" ranging from 28% to 41.5% for the 8 managed care plans for which data was available[2];
2. The percentage of ALTCS enrollees that are in nursing homes has declined from 54% in January 2000 to 37% in January 2006. The remaining enrollees receive long term care services in their home or in an assisted living setting[3];
3. On average, Medicaid rates paid by the program contractors to nursing facilities are 5% less than the amount paid to the program contractors by the state for these services (called fee for service rates) through their monthly capitation rates. The fee for service rates are intended to represent a reasonable payment level, and are rebased every four years through analysis of industry wage data and Medicare cost report

[2] Capitated rate data provided by the Arizona Health Care Cost Containment System.
[3] Annual HCBS Report CY 2006 (10/01/04- 09/30/05).

information. However, the fee for service rates ultimately established are no better than industry median costs;

4. Medicare days paid through managed care plans range from 17% to almost 60% of total Medicare days for the providers we interviewed;
5. Medicare rates paid by the plans range from 70% to 110% of the Medicare PPS rates;
6. The average Medicare length of stay for nursing home beneficiaries in managed care plans is half to two-thirds that of Medicare beneficiaries whose stay is covered under the traditional Medicare Prospective Payment System (PPS);
7. The ability of nursing home providers to negotiate Medicaid rates at or above fee for service rates and Medicare rates at or above Medicare PPS rates is primarily dependent on a company having a "critical mass" of beds or residents within a given locale or with a specific contractor and providing services to special needs populations;
8. High Quality Indicator and Quality Measure scores, a good state survey compliance record, and higher staffing levels can also impact the rate negotiation process with greater negotiating leverage in counties with multiple program contractors;
9. Some contractors focus quality tracking on disease management services relating to diabetes, osteoporosis and congestive heart failure. Bonus incentives are also tied to pressure ulcer rates and avoidance of urinary track infections;
10. The three level of care Medicaid payment system used by the program contractors does not reflect significant increases in the percentages of patients in the higher care levels. In fact, between 2003 and 2005, the percentage of patients in the lowest care level went from 43% to 46%, with the percentage in the highest care level remaining steady at 11%. This three care level system does not use the MDS as the assessment tool;
11. The latest study on patient acuity utilizing MDS data was the "Profiling Arizona's Nursing Home Residents", conducted by the University of

Arizona College of Nursing and Arizona Center on Aging[4]. This 2005 study examined MDS data from 1999-2002 and found a 5% or greater increase from 1999 to 2002 in activity of daily living (ADL) scores of patients at admission and found more chronic care and longer stay residents requiring extensive or total assistance in ADLs. The number of patients on multiple medications (9 or more) increased by over 20% between 1999 and 2002;

12. Providers indicate that only one contractor (EverCare) has successfully achieved Medicare and Medicaid service integration (balancing and integrating acute care and post-acute care delivery). According to providers, most ALTCS case managers are not involved or concerned in relation to acute care utilization, with the exception of approving bed hold days;
13. Providers who also contract to provide assisted living services to ALTCS enrollees indicate that the negotiated rates with the program contractors for these services do result in modest margins;
14. Neither of the program contractors we interviewed contract with nursing homes for case management or home-based personal care services; and
15. The Medicaid state agency entitled AHCCCS (Arizona Health Care Cost Containment System) has taken the position that termination of a contract between a program contractor and facility does <u>not</u> require the residents in that facility to immediately change plans or transfer to a different facility. AHCCCS and the providers have tentatively agreed to a timeline of up to one year to transition residents to a new facility should the resident not change plans. During the transition period, the program contractor will continue to provide case management to their enrollees in that facility but payment will be at the fee for service rate, instead of the negotiated rate. In essence, relative to existing enrollees of a plan in their nursing home, the provider must continue to work with the contractor for up to a year after contract termination and cannot immediately terminate the relationship.

[4] Profiling Arizona's Nursing Home Residents, 2002 Update; The University of Arizona College of Nursing and Arizona Center on Aging.

The provider community is awaiting final written policy from AHCCCS on this matter.

Implications-MSHO Program

The major implications that the MSHO program has had on Minnesota nursing facility providers are as follows:

1. Occupancy in Minnesota nursing homes has trended downward in the last few years but providers attribute that to expansion of home and community-based waiver programs rather than the MSHO program. According to information furnished by the Minnesota Medicaid state agency, there are 5,600 fewer Medicaid recipients in nursing homes in Minnesota in 2006 than in 2000 (a 21% decline). For the same time period, the average number of Medicaid recipients receiving home and community-based waiver services, home health, personal care or private duty nursing services increased almost 80%, from 27,000 in 2000 to 48,000 in 2006;
2. Historically, with MSHO previously limited to the Twin City metro area, only 15% to 30% of Medicare patient days were paid through MSHO contracts. With statewide expansion and passive enrollment of dual-eligibles into SNPs with MSHO contracts, that percentage is expected to increase;
3. The average Medicare length of stay for MSHO beneficiaries in nursing homes is half to two-thirds that of Medicare beneficiaries whose stay is covered under the traditional Medicare Prospective Payment System (PPS);
4. Many of the managed care contractors in the MSHO program, especially those in urban counties, do not pay at the Medicare PPS rates. Many have a four or five care level pricing system with rates that average 10% to 20% less than the Medicare PPS rates;

5. There is little willingness on the part of the program contractors to negotiate Medicare rates, other than for patients with specialized needs and to avoid hospital admission or re-admission;
6. There is an emphasis on reductions in hospital readmissions, especially on the part of one of the program contractors (EverCare) who has some risk-sharing agreements in place with providers for reductions in re-hospitalizations. A 2003 evaluation of the program by the University of Minnesota School of Public Health indicates fewer hospital admissions and preventable hospital admissions from nursing homes for MSHO enrollees as well as fewer emergency room and preventable emergency room visits[5];
7. There are some contractors providing quality incentive payments but the practice does not appear widespread based upon our interviews with providers. In one case, the incentive payments were based upon a number of factors, including customer satisfaction, CMS Quality Indicators and Measures scores, and the annual state survey; and
8. Payment for services is slow, averaging 60 days or longer for some plans but denials after services are rendered do not appear to be a major problem except when sub-capitation partners such as physicians and clinics are involved and responsibility for authorization and payment for services is not properly coordinated among the partners.

Summary of Implications

Our analysis and findings clearly demonstrate that Medicaid managed care for long-term care has major implications for providers. First, in this environment, it is highly likely that Medicaid occupancy will decline as new nursing home eligibles are diverted to home and community-based programs. Second, serving long-term chronic Medicaid patients in an institutional setting will be highly price competitive. Successful rate negotiation for Medicaid residents will depend

[5] Multi-State Evaluation of Dual-Eligibles Demonstration; Minnesota Senior Health Options Evaluation Focusing on Utilization, Cost and Quality of Care; October 2002, revised January and August 2003.

upon a number of factors including location and number of other providers in close proximity; competition among program contractors; having a critical mass of facilities and/or residents with a given program contractor; meeting program contractor performance expectations; and serving specialized populations, including patients in advanced stages of dementia and those with behavioral problems. It is also imperative that an empirically valid patient classification system be in place so that as the acuity of long stay residents residing in nursing homes increase, the additional resource requirements are properly identified and factored in the rates.

Greater opportunities appear to exist in serving short-term stay patients. Managed care plans that are responsible for both Medicare and Medicaid services for their enrollees are highly incentivized to provide services that meet quality and safety standards as efficiently and cost effectively as possible. Their goals include reduced hospitalization and shorter hospital lengths of stay, reduced re-hospitalizations and fewer emergency room visits. To the extent that nursing home providers can develop programs and services that help the plans achieve these goals, the better position they will be in relative to increased admissions and rate negotiation.

The goals of the provider and plan may not be initially aligned (for example, the plan expects the average Medicare length of stay to be 10-15 days, while the provider's experience with PPS is double that), but the trade off may be increasing nursing home short stay admissions, more complex cases and greater leverage in negotiating rates including bonus incentives. Of course, the provider must ensure that the care treatment plans and protocols of the managed care plans are consistent with theirs and the necessary staffing resources and expertise are in place.

Timeliness of payment will also be a major issue and concern in a managed care environment. Payment will be slower than providers typically experience with a

state agency-administered program, compounded by a greater number of issues involving service authorizations, covered services and contract exclusions.

Finally, based upon our discussions with providers and the program contractors, the managed care plans are not currently contracting with nursing homes to provide home-based services or case management. Relative to personal care and home-based services, the rates offered for the services may not be adequate to make this a financially feasible option for nursing home providers. However, some of the providers we interviewed are providing Medicaid-covered assisted living and have indicated that the endeavor is financially feasible.

Engagement Description

We were engaged by the American Health Care Association (AHCA) to identify the implications of Medicaid managed care plans for long term care services on nursing facility providers. Through our research, we identified seven states with managed long term care programs currently in place (excluding Programs for All Inclusive Care for the Elderly-PACE) These seven states are Arizona, Florida, Massachusetts, Minnesota, New York, Texas and Wisconsin. All of these plans are summarized in the 2005 Policy Brief on “The Past Present and Future of Managed Long Term Care” prepared by Thomson/MEDSTAT and the University of Southern Maine, Muskie School of Public Service. The Brief is included as Appendix I.

Since 2005, other states have considered or filed waivers for new or expanded managed long term care programs. These states include Florida (“Senior Care” managed care pilot in the Panhandle and Central Florida areas), Maryland (“Community Choice” managed long term care pilot in the metro Baltimore and Washington, DC areas) and New Hampshire (“Granite Care” managed long term care waiver program).

By reviewing the target populations, geographic coverage, plan longevity, benefits, covered services, and provider payment methodologies for these programs, we identified the two states where these programs have had the most significant impact on nursing facility providers; those being Arizona and Minnesota.

In these two states, we did the following:

1. Conducted a literature review on their Medicaid managed care program for long term care services;
2. Obtained data on utilization and expenditure trends;

3. Reviewed the capitated rate setting process;
4. Developed questionnaires and/or interviewed the managed care program contractors on contracting and rate negotiation with nursing home providers, operational issues and quality monitoring, utilization trends relative to institutional and home and community-based services, and integration of services for dually-eligible recipients. We received completed questionnaires and/or interviewed two of the program contractors in Arizona and two as well in Minnesota; and
5. Developed questionnaires and/or interviewed providers on issues such as rate negotiation and timeliness of payment, trends in occupancy, payer mix and length of stay; quality reporting, and integration of services for dually-eligible recipients. In Arizona, we received completed questionnaires and/or interviewed three companies owning or operating 37 facilities in that state, while in Minnesota, the three companies we interviewed and/or received completed questionnaire from represented 34 nursing homes.

The questions we asked of the managed care program contractors and nursing home providers are included as Appendix II.

Summary of Medicaid Managed Care Plans in Arizona and Minnesota

Arizona

The Arizona Long Term Care System (ALTCS) was implemented on January 1, 1989 and, as of October 1, 2005, served almost 25,000 elderly or physically disabled individuals. ALTCS offers a complete array of acute medical care services, institutional long-term care services, behavioral health services, home and community-based services and case management services. All covered services are integrated into a single delivery package, coordinated and managed by program contractors. Medical eligibility is limited to those at immediate risk of institutionalization, utilizing a Pre-Admission Screening (PAS) instrument.

Program contractors are paid prospectively on a capitated, per member, per month basis. The capitated rates are based on fee for services rates for services set by the state, service utilization data, historical trends, and contractor financial performance. The program contractors then negotiate or establish rates with their service providers. A more detailed summary of the ALTCS program is included in Appendix III.

Nursing home providers are negotiating rates with the program contractors for ALTCS covered services and for Medicare as well if the program contractor is a Special Needs Plan (SNP) or Medicare Advantage plan and the dually-eligible recipient is enrolled in that plan for their Medicare benefits. The dually-eligible recipients in Arizona were passively enrolled in such plans to facilitate the Part D enrollment process, and most of the managed care program contractors in Arizona are either SNPs or Medicare Advantage plans. However, as of the date of this Report, the two new program contractors in Maricopa County (Phoenix area) were not yet certified by CMS as SNPs, so Medicare managed care utilization by nursing home provider can and will vary considerably.

Minnesota

The Minnesota Senior Health Options (MSHO) is a managed health care program that combines Medicare and Medicaid financing and services for seniors age 65 and over who are eligible for Medicaid, with or without Medicare. MSHO offers all medically necessary Medicaid state plan services including home and community-based waiver services and all Medicare services. The health plan also pays for the first 180 days of nursing facility care for enrollees who enter a nursing facility after enrollment. Enrollment into MSHO is voluntary but is available in 83 counties being served by nine MSHO health plans.

Even though a voluntary program, a high percentage of the dual-eligible elderly were indirectly passively enrolled in MSHOs. Dual-eligible seniors in Minnesota's Medicaid managed care plans were passively enrolled into SNPs in 2005 in order to facilitate enrollment into Part D. In Minnesota, all Medicaid-eligible seniors are enrolled in Medicaid managed care and almost all the Medicaid managed care plans are SNPs and participate in MSHO. As a result, as of January 2006, almost 80% of the seniors enrolled in managed care plans in Minnesota were in a plan that participated in MSHO. As of July 2006, 64% of nursing home certifiable recipients were in an MSHO plan. A more detailed summary of the ALTCS program is included in Appendix IV.

Payments to the MSHO plans are capitated based upon level of need of the enrollee with risk-adjustments to the Medicare payments for nursing home certifiable enrollees who live in the community. The MSHO plans negotiate rates with nursing homes for Medicare services while rates for Medicaid-covered nursing facility services during the MSHO 180 day coverage period are typically paid at the rates established based upon the state reimbursement methodology. Although nursing homes and MSHO plans are free to negotiate their own Medicaid payment arrangements, based upon our discussion with the plans and providers, rate negotiations typically relate only to Medicare-covered services.

Implications to Providers-Key Findings in Arizona

Nursing Home Occupancy

The current capitated rates paid to the program contractors by the state assume that only 37% of the enrollees will utilize nursing facility services with the other 63% utilizing home and community-based services, meaning the program contractors are penalized if institutional long term care utilization exceeds 37% and correspondingly rewarded, if less than that. Table 1, provided to us by the Arizona Health Care Cost Containment System (AHCCCS), reflects the statewide average monthly capitation rates paid to program contractors for ALTCS services by service component. The capitation rate is a combination of the rates for long term care services (Nursing Facility, HCBS Home and HCBS Community) times the expected utilization of each of these components plus the rates for acute care, case management, administration, and risk/contingency. The capitation rates in this table reflect a monthly nursing home rate of $4,426 with a predicted utilization rate for these services of 36.8%. Average monthly rates for home and community-based services are approximately $1,350 with a predicted utilization of 63.2% (Combination of HCBS Home and HCBS Community from Table 1).

Table 1

Arizona Long Term Care System (ALTCS) CYE '07 Capitation Rates	
Rate Component	**Weighted Statewide All Counties**
Nursing Facility	$4,426.03
Nursing Facility Mix	36.83%
Share of Cost	-$263.66
Net Nursing Facility	$1,366.63
HCBS Home	$1,341.94
HCBS Home Mix	45.27%
HCBS Community	$1,349.28
HCBS Community Mix	17.90%
HCBS Combination Rate	$848.96
Final Acute- net of reinsurance and excluding Part D drugs	$550.56
Case Management	$104.86
Admin	$198.21
Risk/Contingency	$76.22
Net Capitation	$3,145.45
Premium Tax ((98%) 2.04082% of Final Cap)	$64.19
Net Cap w/ Premium Tax	$3,209.64

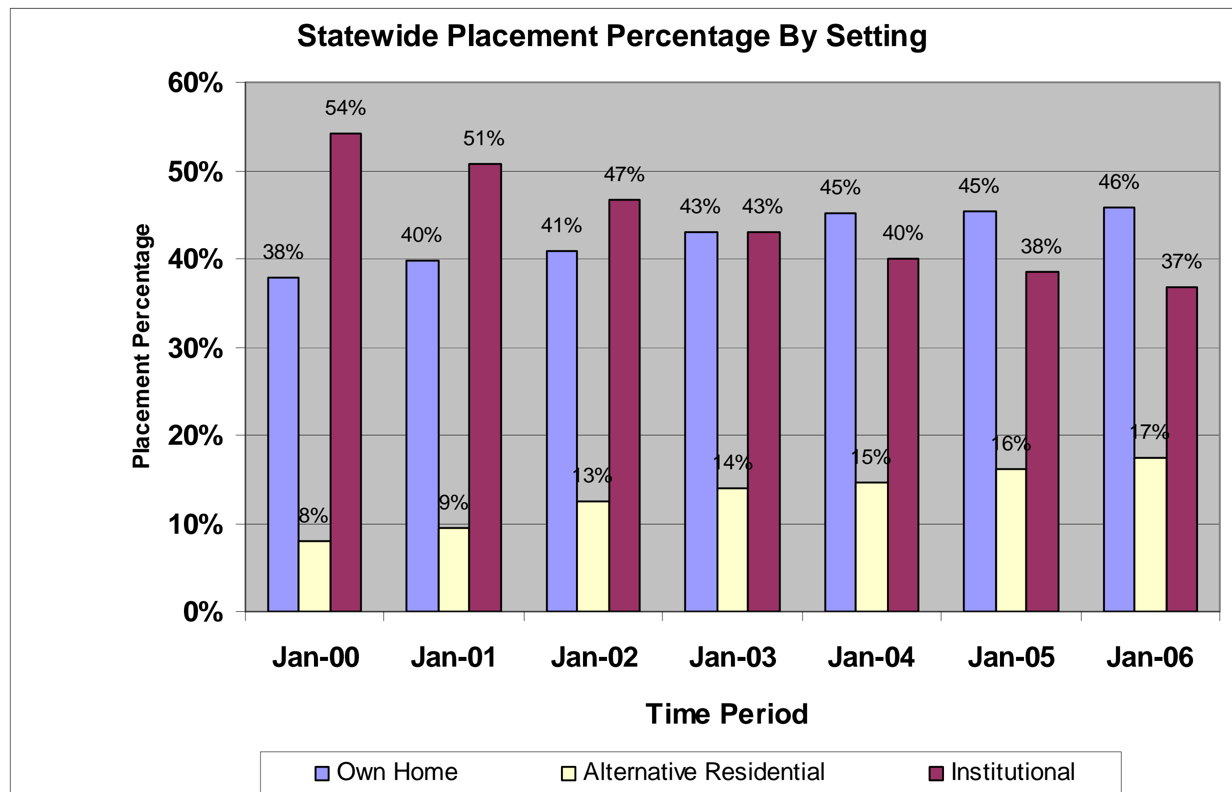
Table 2 below examines contractor performance relative to the institutional/ non-institutional mix for the 12 months ending June 30, 2005 based upon information furnished to us by AHCCCS.

Table 2

Program Contractor	Institutional Months	Total Member Months	Percentage Institutional
Mercy Care	16,487	59146	27.9%
Maricopa	32,368	77958	41.5%
Cochise	4,686	11316	41.4%
Pinal	4,897	14180	34.5%
Pima	18,473	47526	38.9%
Yavapai	5,226	12630	41.4%
EverCare Select	13,598	36087	37.7%
Total	95,735	258,843	37.0%

The actual placement percentages by service setting (home, assisted living, nursing home) from January, 2000 to January, 2006 are reflected in Chart 1.

Chart 1



AHCCCS Annual HCBS Report, March 2006

As expected, the emphasis on home and community-based placement has had a negative impact on nursing home occupancy. Occupancy has fallen over 8% between 2000 and 2006 with 8,204 individuals in nursing homes in January 2006 compared to 8,939 in January 2000. Table 3 reflects the declining trend in nursing home occupancy as well as the increasing use of non-institutional services between 2000 and 2006.

Table 3

ALTCS Placement by Setting	Number of Individuals							Percentage Change: 2000-2006
	1/1/2000	1/1/2001	1/1/2002	1/1/2003	1/1/2004	1/1/2005	1/1/2006	
Institutional	8,939	8,425	8,654	8,591	8,387	8,504	8,204	-8.2%
Non-Institutional	7,570	10,206	9,899	11,361	12,549	13,612	14,052	85.6%
Total	16,509	18,631	18,553	19,952	20,936	22,116	22,256	34.8%

AHCCCS Annual HCBS Report, March 2006

ALTCS (Medicaid) Rates

In fiscal year 2007, as part of their monthly capitation, the program contractors are paid, on average, $4,426 (prior to patient share) for nursing home services. This equates to an average daily rate of $145.50. This is exclusive of capitation payments the program contractors receive for administrative costs and risk contingencies. These payments (called 'fee for service" FFS rates) are intended to represent a reasonable payment level, and are rebased every four years through analysis of industry wage data and Medicare cost report information. However, the fee for service rates ultimately established are no better than industry median costs.

There is no mandate that these FFS rates be passed through to the providers. Instead, the program contractors establish or negotiate rates with the nursing home providers for needed services. In fiscal year 2006, for the very first time, AHCCCS mandated that the program contractors pass-through, in the aggregate,

95% of the increases in their monthly capitation rates for nursing home services to the providers. There was also a mandate of a minimum percentage increase as well. AHCCCS has indicated that it is not their intent to continue the pass-through mandate in future years.

We examined the rates paid to providers in comparison to FFS rates based upon rate information supplied to us by AHCCCS. The paid rates provided to us by AHCCCS were statewide weighted average rates. Statewide average FFS rates for the same time period were not available but FFS rates for urban and rural settings by care level and by year were available on the AHCCCS website. We calculated a statewide average FFS rate by weighting rates on the website by the statewide percentage of days at each care level (supplied by AHCCCS) and by the statewide percentage of urban and rural ALTCS patient days. The results, as reflected in Table 4 for fiscal years 2004 and 2005, indicate that on average, the program contractors are paying providers approximately 95% of FFS rates.

Table 4

FFS v. Paid Rates	FY 2004	FY 2005
Weighted Average FFS rate	$126.47	$132.16
Weighted Average Rates Paid by Program Contractors	$120.72	$ 125.54
Rates Paid as a Percent of FFS	95.5%	95.0%

The majority of the providers we talked to did indicate that, on average, their negotiated Medicaid rates were 5%-7% below FFS rates. However, one provider group with 2000 nursing home beds in five counties indicated that, in the aggregate, their contracted rates are approximately 6% higher than the FFS rates. Providers indicate that the factors most influential in rate negotiation include:

1. Location (having a significant number of unrelated providers in close proximity can limit negotiating ability);

2. Number of total beds (the greater the number of facilities operated by a company within a given market, the greater the leverage in negotiation);
3. The number of program contractor in a county (greater competition among contractors for development of provider networks can positively impact rate negotiations);
4. Perceived quality of care; and
5. Provision of service to specialized populations including patients in advanced stages of dementia and those with behavioral problems.

According to one provider group, elements reported and considered in rate negotiation relative to quality include:

1. Quality Indicator and Quality Measure incidence benchmarked against state and national averages;
2. Number of deficiencies by facility from annual licensure and complaint surveys versus state averages;
3. State quality ratings by facility; and
4. Hours of nursing service per patient per day by facility versus state and national averages.

Medicare Managed Care Rates and Length of Stay

Medicare days paid through managed care plans range from 17% to almost 60% of total Medicare days for the providers we interviewed. One large program contractor estimated that approximately 70% of their ALTCS Plan dual-eligibles were also in their Medicare SNP.

While some contractors pay as a direct percentage of Medicare Prospective Payment System (PPS) rates, most have a four or five care level system based upon clinical need. Based upon our discussions and interviews with providers, the rates paid by the Medicare managed care plans (some of which are also ALTCS program contractors) typically range between 90% to 110% of Medicare

PPS rates although one provider indicated an average Medicare managed care rate that was 30% below Medicare PPS rates. Another provider group we interviewed indicated that, on average, their Medicare managed care rates average approximately 2% higher than corresponding Medicare PPS rates.

The one common denominator among providers relative to Medicare managed care is lower Medicare lengths of stay. The average length of stay for Medicare managed care patients was typically one third to 50% lower than for Medicare beneficiaries whose stay was covered under Medicare PPS. Data received from one of the larger program contractors confirms that, reflecting average lengths of stay of 11-14 days. However, providers did indicate that the lower lengths of stay were offset, to some degree, by an increasing number of Medicare admissions.

Patient Acuity

Providers indicate a clear increase in the acuity of their nursing home patients due to the significant shift of lower acuity enrollees to home and community-based settings. However, ALTCS does not utilize a RUGs-based classification system so acuity scores on ALTCS patients derived from the MDS assessment are not available. For payment purposes, ALTCS utilizes a state-specific assessment tool with patients classifying into one of three acuity classes; class 3 being the highest. In addition to established FFS rates for the three care levels, there are negotiated rate levels between contractors and providers for highly specialized populations. Patient day information received from AHCCCS relative to each of the three care levels does not reflect an increasing percentage of patients classifying into the highest payment category but rather an increase in the percentage of days in the lowest care level. Table 5 reflects the distribution of ALTCS nursing home days by class level from 2003-2005.

Table 5

ALTCS NF Days Distribution Percentage			
Class Level	2003	2004	2005
Class 1	43.00%	43.00%	46.00%
Class 2	46.00%	47.00%	43.00%
Class 3	11.00%	10.00%	11.00%

Providers argue that to some degree, the designated class level is driven, not by patient acuity, but instead by payment. They indicate that the classification tool is highly subjective and levels assigned by program contractors are not always consistent with patient resource requirements.

We were able to identify only one study that examined acuity levels of patients in Arizona nursing homes utilizing MDS data. Unfortunately, the study only examined MDS data from 1999 to 2002. This 2005 study, "Profiling Arizona's Nursing Home Residents", conducted by the University of Arizona College of Nursing and Arizona Center on Aging, examined MDS data from 1999-2002. The researchers did find a 5% or greater increase from 1999 to 2002 in activity of daily living (ADL) scores of patients at admission and found more chronic care and longer stay residents requiring extensive or total assistance in activities of daily living. The study also indicated that the number of patients on multiple medications (9 or more) increased by over 20% between 1999 and 2002.

One would expect that with increasing diversion from institutionalization and lower nursing home occupancy, patient acuity in nursing homes would be higher. One program contractor indicated that anecdotally, it appears that folks are living at home longer, so when they do go into a SNF, they are sicker and frailer. Another stated that patients admitted to nursing facilities have a very high acuity compared to several years ago.

Unfortunately, the care levels assigned for payment purposes in Arizona do not reflect this, emphasizing the need for an empirically valid classification system,

which reduces the opportunity for payment gaming on the part of either program contractors or providers.

Quality Monitoring Requirements

It appears that each program contractor has their own quality management program and requirements. Some program contractors require disease management quality tracking. For example, one contractor requires tracking as follows:

1. Diabetes - HgA1c, lipids, eye check, foot checks;
2. Osteoporosis – "at risk" patients should be on medication/Tums;
3. CHF – echos and ace inhibitors are tracked;
4. Pressure Ulcer rates- tied to incentive bonuses; and
5. UTI - tied to incentive bonuses

Others focus on other measures such as immunizations, pain management, unexplained weight loss, survey results, number of complaints and results of investigations, and staffing.

Integration of Medicare and ALTCS Services

Providers indicate that, with the exception of one program contractor (EverCare), integration of services among providers (acute, post acute, and long term care) and care delivery practices that reduce hospitalizations, result in fewer emergency room visits and increase physician and physician-assistant involvement, are not commonplace. According to one provider group, "physician service is "patchy" and largely absentee telephone medicine". Providers indicate that most ALTCS case managers are not involved or concerned with acute care utilization, with the exception of approving bed-holds. However, many of the program contractors have just recently become Medicare Special Needs Plans and may lack the expertise and experience in program and provider integration at this point.

Even one rural program contractor, not participating as a Medicare SNP, indicates that "integration of services is still a nightmare with everyone incentivized to duck out on payment". The contractor, while endorsing the concept of SNPs, believes that most rural contractors do not have sufficient enrollment to absorb the risk. Another contractor indicated that integration of benefits and services should improve for those contractors that are SNPs, but acknowledged that it is more difficult to coordinate care between two program contractors unless you have a formal contractual relationship.

Timeliness of Payment

Timeliness of payment by some program contractors has been a persistent problem for providers. Some do pay timely and one indicated that payment turnaround averages 18 days. However, with the inordinate collection problems, especially relative to one contractor, the Arizona Health Care Association is seeking a legislative solution requiring timely payment on "clean claims" and financial sanctions for untimely payment.

Other Issues

AHCCCS has taken the position that termination of a contract between a program contractor and facility does not require the residents in that facility to immediately change plans or transfer to a different facility. AHCCCS and the providers have tentatively agreed to a timeline of up to one year to transition residents to a new facility should the resident not change plans. During the transition period, the program contractor will continue to provide case management to their enrollees in that facility but payment will be at the fee for service rate, instead of the negotiated rate. In essence, relative to existing enrollees of a plan in their nursing home, the provider must continue to work with the contractor for up to a year after contract termination and cannot immediately terminate the relationship. The provider community is awaiting final written policy from AHCCCS on this matter.

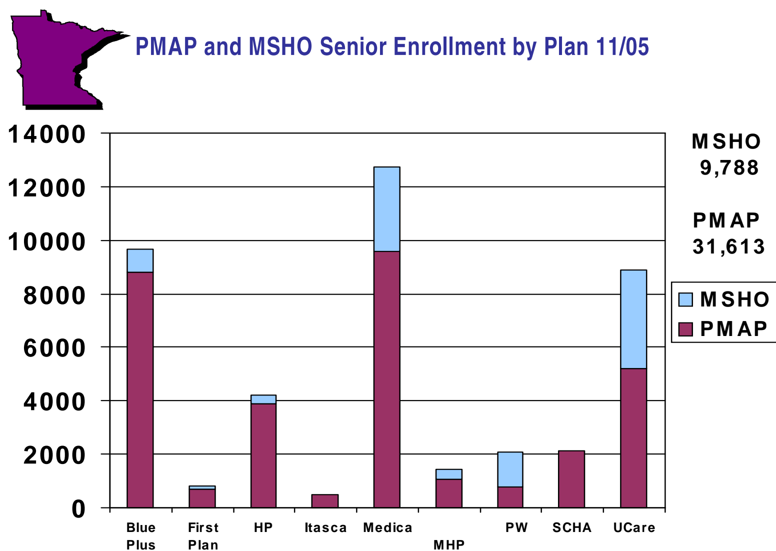
Implications to Providers-Key Findings in Minnesota

Nursing Home Occupancy

Nursing home census has declined significantly from 2000 to 2006. Average Medicaid recipients per month in nursing homes have dropped from 26,400 in 2000 to 20,775 in 2006; a decrease of 21% over the six years[6]. Over that time period approximately 50 nursing homes have closed and many others have reduced their licensed bed capacity. However, this census decline cannot be directly attributable to the MSHO program, in that prior to 2006, only 24% of seniors in Minnesota's mandatory Medicaid prepaid managed care program (PMAP) were also enrolled in the voluntary MSHO program.

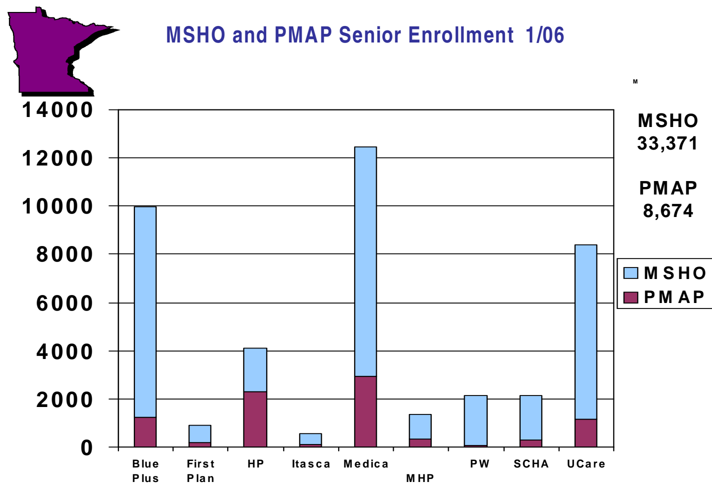
The significant growth in MSHO enrollment did not occur until late 2005 when dually-eligible enrollees in PMAP were passively enrolled into Medicare Special Needs Plans (SNP) to facilitate enrollment of Medicaid participants into Part D. Almost all the Medicaid managed care plans are SNPs and participate in MSHO. As a result, a high percentage of the dual-eligible elderly were passively enrolled in MSHO. Charts 2 and 3 below reflect the enrollment in the MSHO program prior to 2006 and thereafter[7].

Chart 2



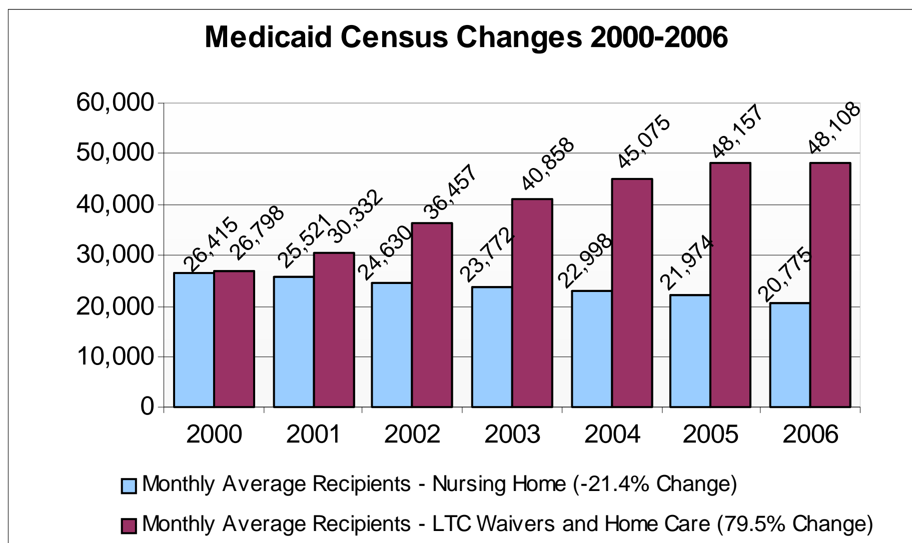
[6] Minnesota Department of Human Services, Medical Assistance Program; State Cost Projections.
[7] Minnesota Department of Human Services, Medical Assistance Program; Enrollment Data.

Chart 3



Providers indicate that expansion and growth of home and community-based waiver programs, rather than MSHO, has had the greatest impact on nursing home occupancy. Data from the Minnesota state agency bears this out. Between 2000 and 2006, the average number of Medicaid recipients receiving home and community-based waiver services, home health, personal care or private duty nursing services increased almost 80%, from 27,000 in 2000 to 48,000 in 2006[8]. Chart 4 compares the change in Medicaid nursing home census to the change in recipients using home-based programs from 2000 to 2006.

Chart 4



[8] Minnesota Department of Human Services, Medical Assistance Program; State Cost Projections.

Medicaid Rates

Rates for Medicaid-covered nursing home services during the MSHO 180 day coverage period are typically paid at the rates established based upon the state reimbursement methodology. Although nursing homes and MSHO plans are free to negotiate their own Medicaid payment arrangements, based upon our discussion with the plans and providers, rate negotiations typically relate only to Medicare-covered services. According to the providers we interviewed, historically MSHO Medicaid days have represented less than 2% of total Medicaid nursing home census but that percentage may increase with the increased passive enrollment of the dual-eligibles into MSHO in late 2005.

Medicare Managed Care Rates and Length of Stay

The providers we interviewed indicated that 15% to 30% of Medicare patient days are paid through MSHO contracts, but that percentage is expected to increase with statewide expansion of the MSHO program and the increased enrollment of dual-eligibles into MSHOs. The rates paid for Medicare services vary by contractor. Some plans pay the Medicare PPS rates while others have only 3-5 Medicare rates which vary based upon care level. Providers indicate that payment typically ranges between 90% and 100% of Medicare PPS rates although one company indicated their average Medicare managed care rate was only 80% of average PPS rates. All the providers indicated there was little negotiating room relative to Medicare rates except with special needs (outlier) cases.

Similar to our findings in Arizona, providers experience a much lower length of stay relative to Medicare managed care. The average length of stay for Medicare managed care patients again was typically a third to 50% lower than for Medicare beneficiaries whose stay was covered under the traditional Medicare Prospective Payment System (PPS). As in Arizona, providers did indicate that the lower lengths of stay were offset, to a limited degree, by an increasing number of Medicare admissions.

Patient Acuity

Providers have not experienced significant changes in Medicaid acuity scores under the RUGs system (which is used for Medicaid payment) as a result of the MSHO program. This is primarily due to the low historical volumes (less than 2%) that MSHO Medicaid nursing home residents represent of total Medicaid census.

Quality Monitoring Requirements

Two of the three companies we interviewed indicated that no quality reporting or monitoring was required, but the third represented that some of the MSHO plans provide "quality" incentive payments driven off a combination of customer satisfaction surveys, CMS quality Indicators and Measures, and the nursing home's annual state survey.

Integration of Medicare and Medicaid Services

As in Arizona, providers indicate that from their perspective, only the EverCare model has impacted integration of services among providers (acute, post acute, and long term care) and care delivery practices. In fact, one of the companies, in collaboration with two other provider groups, has a risk-sharing agreement with EverCare, primarily driven off of savings from fewer re-hospitalizations as well as other factors. Under this agreement, the three provider groups are at risk for a percentage of any shortfall incurred by EverCare relative to their enrollees in these nursing homes and rewarded by the same percentage of any surplus generated. As such, the three-company consortium, like EverCare, is incentivised to focus on prevention and early intervention, and reduction of costly hospitalizations and emergency room visits. The company indicated that this opportunity would likely not be available to every provider, but more realistically negotiated on a selective basis.

A 2003 evaluation of the MSHO program by the University of Minnesota, School of Public Health indicates fewer hospital admissions and preventable hospital admissions from nursing homes for MSHO enrollees as well as fewer emergency room and preventable emergency room visits[9].

Timeliness of Payment

All the providers indicated that claims payment is slow and varies by plan. On average, claims are paid within 60 to 90 days. Two of the three companies had few problems with claim denials in full or in part, while the other indicated significant issues associated with prior authorizations for service and denials relative to "excludable" services under the contract. These issues appeared to be more problematic when sub-capitation partners such as physicians and clinics were involved and responsibility for authorization and payment for services was not properly coordinated among the partners.

[9] Multi-State Evaluation of Dual-Eligibles Demonstration; Minnesota Senior Health Options Evaluation Focusing on Utilization, Cost and Quality of Care; October 2002, revised January and August 2003.

Appendices

Appendix I

“The Past Present and Future of Managed Long Term Care” prepared by Thomson/MEDSTAT and the University of Southern Maine, Muskie School of Public Service

U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

THE PAST, PRESENT AND FUTURE OF MANAGED LONG-TERM CARE

April 2005

Office of the Assistant Secretary for Planning and Evaluation

The Office of the Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the Department of Health and Human Services (HHS) on policy development issues, and is responsible for major activities in the areas of legislative and budget development, strategic planning, policy research and evaluation, and economic analysis.

ASPE develops or reviews issues from the viewpoint of the Secretary, providing a perspective that is broader in scope than the specific focus of the various operating agencies. ASPE also works closely with the HHS operating divisions. It assists these agencies in developing policies, and planning policy research, evaluation and data collection within broad HHS and administration initiatives. ASPE often serves a coordinating role for crosscutting policy and administrative activities.

ASPE plans and conducts evaluations and research--both in-house and through support of projects by external researchers--of current and proposed programs and topics of particular interest to the Secretary, the Administration and the Congress.

Office of Disability, Aging and Long-Term Care Policy

The Office of Disability, Aging and Long-Term Care Policy (DALTCP), within ASPE, is responsible for the development, coordination, analysis, research and evaluation of HHS policies and programs which support the independence, health and long-term care of persons with disabilities--children, working aging adults, and older persons. DALTCP is also responsible for policy coordination and research to promote the economic and social well-being of the elderly.

In particular, DALTCP addresses policies concerning: nursing home and community-based services, informal caregiving, the integration of acute and long-term care, Medicare post-acute services and home care, managed care for people with disabilities, long-term rehabilitation services, children's disability, and linkages between employment and health policies. These activities are carried out through policy planning, policy and program analysis, regulatory reviews, formulation of legislative proposals, policy research, evaluation and data planning.

This report was prepared under contract #HHS-100-97-0019 between HHS's ASPE/DALTCP and the MEDSTAT Group. For additional information about this subject, you can visit the DALTCP home page at http://aspe.hhs.gov/_/office_specific/daltcp.cfm or contact the ASPE Project Officer, Hunter McKay, at HHS/ASPE/DALTCP, Room 424E, H.H. Humphrey Building, 200 Independence Avenue, S.W., Washington, D.C. 20201. His e-mail address is: Hunter.McKay@hhs.gov.

THE PAST, PRESENT AND FUTURE OF MANAGED LONG-TERM CARE

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The opinions and views expressed in this report are those of the authors. They do not necessarily reflect the views of the Department of Health and Human Services, the contractor or any other funding organization.

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SUMMARY

A decade ago, managed long-term care appeared poised for dramatic growth, but despite significant activity in a handful of states, today only 2.3% of persons using public long-term care services are receiving those services in managed care programs, and Arizona remains the only state that provides all long-term care through managed care. The number of enrollees in managed long-term care is likely to grow in the next few years. Texas has proposed a large expansion of its initiative. Other states with established programs, including Florida, Minnesota and Massachusetts, also expect growth but more incrementally and on a smaller base than Texas. States with plans to add managed long-term care initiatives in the near future include California (San Diego County), Washington, Hawaii and Maryland.

Managed long-term care suppliers are largely local non-profit plans or provider organizations that evolved specifically to respond to a single state's procurement. However, two national commercial HMOs, Evercare and AmeriGroup, have multi-state presence and account for a substantial portion of all managed long-term care enrollment.

Several factors have contributed to the slow growth of managed long-term care, including complex program design choices (including payment methodology), relatively long planning and start-up periods, resistance of long-term care providers and advocates, difficult state-federal policy issues, the need for a substantial population base, limited interest among potential suppliers, and inadequate state infrastructure in an era of government downsizing.

Despite these challenges, managed long-term care is popular in states where it is established and is likely to grow in the future. Studies of managed long-term care programs have been largely positive, finding high consumer satisfaction levels, lower utilization of institutional services and increased access to home- and community-based services. Cost studies have been more mixed, with no clear consensus emerging as to whether managed long-term care saves money for public purchasers. Savings notwithstanding, the budget predictability that comes with capitated payments is appealing to state policymakers as growing numbers of long-term care consumers place increasing pressure on Medicaid budgets. Evolving legal authority has resulted in simplified program designs and faster federal approval. Supply may expand as commercial HMOs experience aging members and add products to retain them, local plans attempt replication in new states, and Medicare Advantage plans experiment with the specialized plan provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

1. BACKGROUND

Issue Summary

In 2003, about 3.1 million older persons and persons with physical disabilities received Medicaid-financed longterm care services (Table 1).[1] Just over half (55%) were in nursing homes and the remainder received services in community-based settings, either through the Medicaid home and community-based waiver services program or through a state Medicaid plan benefit, such as personal care services. A large majority of them were also eligible for Medicare. Total combined Medicaid and Medicare expenditures for these 3.1 million persons were approximately $132 billion in 2003. Although Medicare does not pay for long-term care, its acute and post-acute care expenditures are much higher for long-term care users. Average expenditures for Medicare beneficiaries with ADL limitations (an indicator of long-term care need) are four times higher than for persons with no ADL limitations.[2] The number of people using long-term care and their public expenditures promise to rise more rapidly in the coming decades as the baby boomers age and the number of non-elderly adults with disabilities increases.

Long-term care users need a variety of services across numerous settings (e.g., home, doctor's office, hospital, day center, nursing home), but in the Medicaid and Medicare fee for service systems, no single person or organization is responsible for or can impact all needed care, resulting in services that are often characterized as fragmented, uncoordinated and rife with unintended financial incentives. State home-and community-based services (HCBS) programs almost always provide case management, but the management does not extend into the hospital or nursing home when someone is admitted. Often, a community case manager learns about a hospital discharge after the fact, with no ability to ensure a smooth transition across settings. Avoidable hospital admissions, unnecessary use of nursing home care, and medication mismanagement are among the risks faced by the population.

The application of managed care strategies to aged and disabled long-term care beneficiaries holds intrinsic appeal. In the mid-1990s, many states were actively planning initiatives that would build on their Medicaid managed care experience to create managed long-term programs, but by 2004, less than 3% of the publicly-funded long-term care population received their long-term care benefits through a managed care program.

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[1] See Appendix 1 for an explanation of how Table 1 estimates were derived.

[2] Komisar, H.L., Hunt-McCool, J. and Feder, J. "Medicare Spending for Elderly Beneficiaries Who Need Long Term Care." *Inquiry* 34 (Winter 1997/98): 302-310.

TABLE 1: Estimated Size of the Public Long-Term Care Market, 2003		
Beneficiaries	In Nursing Homes	1,700,000
	In HCBS Waiver Programs	550,000
	Receiving Personal Care Services	830,000
	TOTAL	**3,080,000**
Expenditures	**For Institutionalized Beneficiaries:**	
	Medicaid NF Expenditures	$44.8 billion
	Other Medicaid Expenditures	$19.2 billion
	Medicare Expenditures	$22.5 billion
	TOTAL	**$86.5 billion**
	For Community-Based Long-Term Care Beneficiaries:	
	HCBS Waiver Expenditures	$4.1 billion
	Personal Care Expenditures	$5.0 billion
	Other Medicaid Expenditures	$10.6 billion
	Medicare Expenditures	$26.1 billion
	TOTAL	**$45.8 billion**
NOTE: These are preliminary estimates. Estimates only include aged and disabled Medicaid beneficiaries receiving long-term care benefits. Excludes persons with developmental disabilities and/or severe mental illness.		

Why has the market grown so slowly, and where is it headed? This study assesses the state of the managed long-term care market from the perspective of purchasers (states) and suppliers (managed long-term care contractors), addressing the following questions:

- What is the current state of the managed long-term care market?
- What value do managed long-term care products offer relative to the fee-for-service system?
- What is the market outlook in terms of future demand from state purchasers and supply from existing and new organizations?

Methods

We define managed long-term care as any arrangement in which a Medicaid program contracts with an organization to provide a package of benefits which includes at least some long-term care benefits on a risk basis. The focus of the study is Medicaid-financed long-term care, though the discussion includes Medicare since most Medicaid long-term care beneficiaries are dually eligible. Thus the study includes both Medicaid-only programs and integrated programs that manage both Medicaid and Medicare benefits. We focused on older persons and persons with physical disabilities, and excluded programs that are primarily targeted to persons with developmental disabilities or severe and persistent mental illness.

We collected data from a number of sources. Site visits were conducted to programs in three states, in which state officials and managed care organization officials were interviewed. Telephone interviews were held with key informants in four additional states and at several national organizations. A literature review was conducted to identify studies of managed long-term care programs. Finally, descriptive information

was gathered at the managed care organization level for all programs that met our definition.

Due to the sensitive nature of the information gathered, the responses of individuals remain confidential.

History of Managed Long-Term Care

Most states have similar histories and concerns with Medicaid-funded long-term care. The 1970s were marked by large increases in nursing home expenditures and growing concern about the sustainability of a long-term care system dominated by institutional care. In 1981, Congress created the home- and community-based waiver option (HCBS waiver), allowing states to create flexible community-based services and cover them under the same financial and clinical eligibility provisions as nursing home benefits. The HCBS waiver program grew rapidly, from six states spending $3.8 million in 1982 to 48 states spending just under $1.7 billion in 1991.[3] However, Medicaid nursing home expenditures continued to grow in the 1980s, from $10.5 billion to $17.9 billion, making it clear that HCBS waiver programs would not alone control the growth of institutional care. Despite efforts to control the supply of nursing homes and ease consumer entry into community-based services with "single entry point" systems, nursing home expenditures in the 1990s continued to grow more rapidly than Medicaid expenditures generally, limiting states' fiscal capacity to expand HCBS options.

By the early 1990s, managed care had become the dominant mode of acute health care financing and delivery in commercial markets, and states were enrolling substantial numbers of women and children in Medicaid managed care plans. A few early managed long-term care programs (Arizona's Long Term Care System, Florida's Frail Elder Option and initial PACE replication of San Francisco's On Lok program) had been implemented in the 1980s. The Social HMO, a Medicare demonstration that added a limited long-term care benefit to Medicare, had also been implemented in the late 1980s.

In the 1990s, a number of states wanted to build on their Medicaid managed acute care experience to add long-term care. Minnesota, Colorado and Wisconsin were among the states that provided leadership by developing innovative models that borrowed concepts from PACE, ALTCS and S/HMO. Minnesota was the first state to implement a fully integrated model that combines both Medicare and Medicaid financing for the entire spectrum of older people, from well to frail. After many years in development, the Minnesota Senior Health Options (MSHO) program was implemented in 1997 under a combined Section 1115 Medicaid demonstration waiver and Section 222 Medicare payment waiver. A key design feature of MSHO is the employment of a single contract between the state and the MSHO plans for both Medicare and Medicaid terms and conditions. A significant effort was made during the MSHO development process to

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[3] Miller, N.A. "Medicaid 2176 Home and Community-Based Care Waivers: The First Ten Years." *Health Affairs* (Winter 1992): 162-171.

“align” Medicare and Medicaid managed care requirements into a comprehensive and uniform contract. (Based on its experience with MSHO, Minnesota implemented a similar program for people with physical disabilities--the Minnesota Disability Health Options (MnDHO) Program--in 2001.)

Many states demonstrated considerable interest in launching Minnesota-like initiatives in the mid-1990s, and the Robert Wood Johnson Foundation supported a number of planning and development grants in this area through the Medicare/Medicaid Integration Program (MMIP) at the University of Maryland, which served as a focal point for research and collaboration among states for program development activities.

With funding from the Commonwealth Fund, New York State supported demonstration programs in managed long-term care beginning in 1994. In 1997, New York consolidated its PACE and other managed long-term care plans under one legislative authority. The legislation is flexible, and plan sponsors can develop varying models of delivery and financing. Currently, there are 15 separate managed long-term care plans operating under the authority. Four of the 15 are fully certified PACE sites, and a fifth is a partially capitated “pre-PACE” site. With the exception of the plan operated by the Visiting Nursing Service of New York, with an enrollment of 3,700 members, most of the New York plans have fewer than 500 members.

In 1995, the Texas Legislature authorized the development of managed long-term care pilot programs, which led to the implementation of Texas Star+Plus in 1998, the second mandatory program after ALTCS, but only in a single county (Harris). Unlike Minnesota, Texas decided to begin its Star+Plus initiative as a capitated Medicaid program, while providing beneficiaries with access and incentives to join optional companion Medicare managed care plans. This was a conscious decision by state program administrators to quickly bring Texas Star+Plus to scale as a mandatory Medicaid program, but incorporate mechanisms to integrate Medicare incrementally.

In 1996, Wisconsin began implementing its Partnership Program, a variation on PACE that includes both older and younger people with disabilities and allows beneficiaries to bring their existing doctors into the program network. Partnership began operating as a partially capitated Medicaid managed care program and added capitated Medicare benefits in 1999. When the Partnership Program was held out as a model for statewide comprehensive redesign of the long-term care system, advocates and counties opposed the move, and in 2000, the state instead piloted the Family Care Program, which capitates only long-term care funding. A unique feature of the Family Care program is that counties serve as the managed care contractor, accepting financial risk for meeting the needs of all persons requiring long-term care services in the county.

The creation of the Florida Diversion Program in 1998 added another managed LTC option to the already existing Frail Elder Option that had operated in Southeast Florida since 1987. The voluntary Diversion program was initially implemented in four Florida counties. In 2003, the Florida legislature granted additional funding to expand the

program to cover 25 counties, and in 2004, it further mandated that the Frail Elder Option be folded into the newly expanding Diversion program.

While a number of states successfully launched managed long-term care initiatives in the 1990s, there were quite a few initiatives in other states that were not successful. A number of states announced their intention to implement managed long-term care programs, either on a demonstration basis or on a larger statewide basis, only to have the initiative cease at some point during the development stage. Two major challenges were: (1) resistance from long-term care providers and the aging network; and (2) lack of willing suppliers, particularly in rural areas. Long-term care providers, particularly nursing home providers, often saw the selective contracting aspect of managed care as an economic threat. Providers were also concerned about the delegation of Medicaid rate setting authority from state agencies to private contractors. Elderly advocacy organizations were often unconvinced that improved care coordination could lead to better outcomes for program participants. They feared that managed care contracting would result in reduced access to medical and long-term care services or that plans would pull out as they had done in the Medicare managed care market. Another occasional source of resistance was state workers, particularly if the initiative involved the outsourcing of case management jobs or other administrative positions to managed care contractors.

During the late 1990s, and early in the new millennium, there was very little activity in the managed long-term care market. Some wondered whether managed long-term care was an idea whose time had come and gone. But then after almost eight years of development, Massachusetts and CMS finally issued a procurement for the Senior Care Options (SCO) program in 2003. A key factor in these negotiations concerned the risk adjuster that would be used for Medicare capitation payments for SCO members with long-term care needs. CMS agreed to use the PACE risk adjuster of 2.39 for this group. Another key provision of the agreement was that CMS and Massachusetts would jointly negotiate the Medicare contracts with the participating plans. In 2003, Massachusetts selected three plans to participate in the SCO program, and enrollment in the program began in early 2004.

Current Status of the Managed Long-Term Care Market

Table 2 presents estimated enrollment in managed long-term care programs in 2003-2004. The estimates include only persons who are receiving long-term care benefits in the designated programs. For example, total enrollment in the Texas Star+Plus Program is approximately 60,000 members, but the majority of the members are SSI Disabled beneficiaries who do not receive long-term care benefits under the program. Similarly, the Minnesota Senior Health Options Program enrolls “well” elderly persons as well as persons with long-term care needs. The Table 2 estimates also include only aged individuals and adults with physical disabilities enrolled in managed long-term care programs, and do not include persons with developmental disabilities or persons with severe mental illness enrolled in managed long-term care.

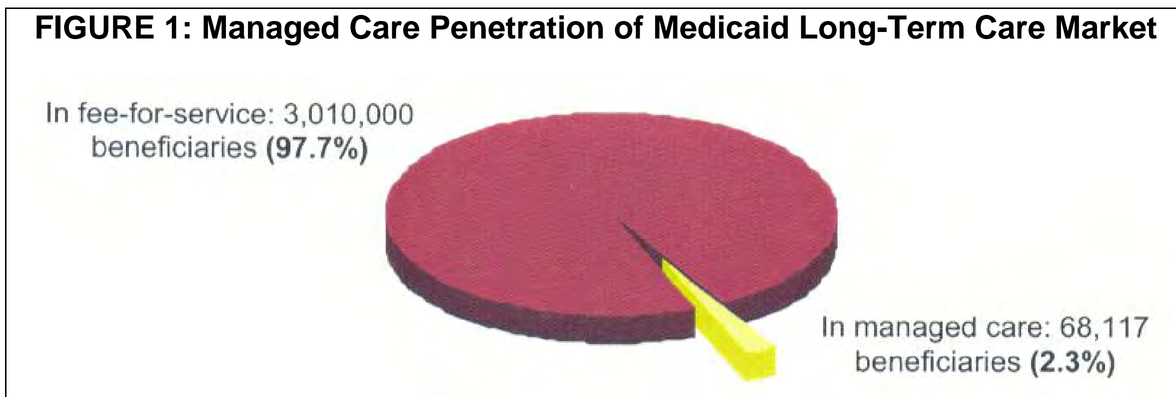
TABLE 2: Estimated Enrollment in Managed Long-Term Care Programs, 2004	
MLTC Program	**LTC Enrollment**
ALTCS	23,427
Texas Star Plus	10,671
NY MLTC	7,078[1]
PACE and “Pre-PACE”[2]	8,419
Wisconsin Family Care	6,998
MSHO	3,910
Florida Frail Elder Program	3,070
Florida Diversion	2,800
Wisconsin Partnership	1,644
Massachusetts SCO	<100
TOTAL	**68,117**

1. This number has been reduced by 2000 to avoid double-counting of New York PACE sites, which are included in national PACE totals. New York State includes PACE and non-PACE programs within its managed long-term care initiative.
2. Pre-PACE is an informal designation given to sites that are preparing to become PACE sites but are not yet operating under full dual capitation of Medicaid and Medicare.

Estimated enrollment only includes aged or disabled Medicaid beneficiaries receiving long-term care benefits. Does not include persons with developmental disabilities or severe mental illnesses.

As shown in Figure 1, we estimate that just under 70,000 of the approximately 3.1 million Medicaid beneficiaries receiving long-term care benefits were in risk-based managed long-term care programs in 2004.[4] This equals a managed care penetration rate of only 2.3%. Clearly, the managed long-term care market is still at a very early stage of development.

FIGURE 1: Managed Care Penetration of Medicaid Long-Term Care Market



[4] Note that there are additional aged and disabled long-term care beneficiaries enrolled in Medicaid acute managed care, but whose long-term care benefits are not included in the managed care benefit package.

2. STATE DEMAND FOR MANAGED LONG-TERM CARE

Between passage of the Balanced Budget Act of 1997 and the Medicare Modernization Act of 2003, demand for managed long-term care came from 9 state-developed programs in 7 states and 40 PACE or "pre-PACE" sites in 17 states.[5] Outside of PACE, program characteristics vary greatly, as summarized in Table 3.

Target populations vary. Several of the programs examined include older people and younger people with disabilities. The most population-inclusive of these is the Texas Star+Plus program, which includes all adults who qualify for Medicaid by virtue of SSI status (Aged, Blind or Disabled). Other programs enroll only older people (Massachusetts, Florida Diversion, MSHO, PACE).

Another important population distinction is functional need. All of the programs include persons with very high functional needs who are eligible for traditional home- and community-based services (HCBS) waiver programs. These are persons at the high end of community services and costs. Some programs (ALTCS, Wisconsin Partnership, New York, Florida Frail Elder and Diversion, PACE) include *only* such persons, while others (MSHO, MnDHO, Star+Plus, SCO) include persons with the entire range of needs, including those with no existing long-term care need. Wisconsin's Family Care program falls in between, serving persons who have a range of existing long-term care needs, including but not limited to those whose needs rise to the level of HCBS waiver programs.

Geographical scope varies, but the primary focus is on urban areas. With the exception of Arizona, none of the programs covers all areas of its state. Most are limited to a county or multiple counties with urban centers. Most state and plan officials consulted believe that managed long-term care needs an urban base to be viable. Plans want a sufficiently large target group to ensure adequate volume, particularly in voluntary programs. They also rely on an adequate supply of long-term care providers to establish networks. In Arizona, rural counties are generally limited to one ALTCS plan, and it is almost always operated by county government.

Breadth of managed care benefit package. With the exception of Wisconsin Family Care and the New York Managed Long Term Care Plans, programs capitate Medicaid-funded primary, acute and long-term care benefits for enrolled members. In Family Care and the New York plans, long-term care contractors are expected to coordinate with primary and acute providers but do not receive capitated payment for those services and are not responsible for them. Other service-specific variations exist. For example, Texas has a third party prescription drug vendor that it uses to reimburse all

[5] The National PACE Association reports that, as of 6/1/04, there were 32 fully capitated and certified PACE sites and 8 partially capitated "pre-PACE" sites.

Medicaid prescription drugs, so the benefit is carved out of Star+Plus and administered separately by that vendor.

TABLE 3: Characteristics of Selected Managed Long-Term Care Programs

Program	Implementation Date	Population Eligible	Voluntary/ Mandatory for Medicaid	Geographical Coverage	Medicaid Payments	Medicare Payments
PACE (includes "pre-PACE)	1983 (On Lok)	55+ with NF-level LTC needs	Voluntary	40 urban programs in 17 states	Capitated primary, acute and LTC; rate structure varies	Capitated
Florida Frail Elder Option	1987	Aged and disabled; NF-level LTC needs	Voluntary	2 urban counties in Southeast Florida	Capitated primary, acute and LTC; three rate cells	FFS
Arizona Long Term Care System (ALTCS)	1989	Aged and disabled; NF-level LTC needs	Mandatory	Statewide (urban and rural)	Capitated primary, acute and LTC; single blended rate	FFS[1]
Wisconsin Partnership Program	1995[2]	Aged and disabled; any LTC needs	Voluntary	6 counties (rural and urban)	Capitated primary, acute and LTC; multiple rate categories	Capitated
Minnesota Senior Health Options (MSHO)	1997	All aged	Voluntary	7 urban and 3 rural counties	Capitated primary, acute and LTC (NF limited to 6 mos.); multiple rate cells	Capitated
New York MLTC Plans	1997	Aged and disabled with NF-level LTC needs (aged/ disabled varies by plan)	Voluntary	Multiple counties (rural and urban, but mostly urban)	Capitated LTC only (primary and acute FFS); multiple rate cells	FFS
Texas Access Reform (Star) + Plus	1998	All aged and disabled	Mandatory	1 urban county; statewide urban expansion proposed	Capitated primary, acute and LT (NF limited to 1 mo.; Rx not in cap); multiple rate cells	FFS[1]
Florida Diversion	1998	Aged with NF-level LTC needs	Voluntary	25 urban and contiguous counties	Capitated primary, acute and LTC; single rate	FFS
Wisconsin Family Care	2000	Aged and disabled; NF-level LTC needs	Mandatory	5 counties (rural and urban)	Capitated LTC only (primary and acute FFS); two rate cells	FFS
MnDHO	2001	All physically disabled	Voluntary	4 urban counties	Capitated primary, acute and LTC (NF limited to 6 mos.); multiple rate cells	Capitated
Mass Health Senior Care Options (SCO)	2004	All aged	Voluntary	Nearly statewide (rural and urban)	Capitated primary, acute and LTC; multiple rate cells	Capitated

1. Some beneficiaries have opted to join companion capitated Medicare Advantage plans.
2. Wisconsin Partnership began operating in 1995 as a partially capitated Medicaid model. In 1999, it received the federal waivers needed to become a fully capitated Medicaid/Medicare model.

MSHO, Wisconsin Partnership, SCO and PACE programs include fully capitated Medicare benefits in addition to Medicaid benefits. These programs were designed to include comprehensive care coordination for dually eligible members, who typically comprise more than 90% of elderly Medicaid beneficiaries and as much as 50% of younger people with disabilities. Most state officials interviewed expressed interest in the more comprehensive approach but cited long development time as a significant obstacle. There are also significant differences among the fully capitated programs, particularly in how they relate to providers. MSHO relies on participating plans to

interact with and manage provider practice across extensive networks, while PACE more closely resembles a staff-model HMO, in which the key providers (members of the Interdisciplinary Team) are employees of the managed care contractor and are directly implementing the integrated care. The Wisconsin Partnership Program falls somewhere in between, with core team members on staff (like PACE) but including a network of independent practice physicians who must be oriented to the philosophy and practice of the program, and whose services must be integrated with those of long-term care providers via communication and education (as opposed to co-location).

Most programs are voluntary, but a large majority of members are in mandatory programs. Most of the programs studied are voluntary for Medicaid beneficiaries, meaning they can opt instead for the state's traditional long-term care services. Many factors impact a state's decision on this controversial issue, including:

- *Adequate enrollment levels*. A managed care organization's ability to manage risk depends in part on being able to spread risk across a large number of members. The three mandatory programs studied (Wisconsin Family Care, Texas and Arizona) are also the largest in terms of enrollment, ranging from 7,000 long-term care consumers in Wisconsin to over 23,000 in Arizona.[6] Also important is having a program of sufficient size to warrant the investments in state infrastructure that must be made to design, implement and monitor these programs.

- *Consumer and provider concerns*. Consumers and long-term care providers often argue for voluntary programs. Consumers of long-term services often have established relationships with providers and fear that mandatory programs would force them into new relationships. Providers fear losing their ability to bill the state directly for services and being required to build new business relationships with managed care plans.

- *Medicare*. As previously mentioned, PACE, MSHO, Wisconsin Partnership and SCO were all designed with the specific intent to integrate long-term care with acute services, making Medicare inclusion paramount. Freedom of choice may not be waived in Medicare, so programs including Medicare must be voluntary.

Some states protect traditional long-term care infrastructure. States also differ on how they treat traditional long-term care providers (including counties) under managed care. Most states expressed ambivalence on this question. A pure market approach would dictate an open and competitive procurement of managed care organizations and would give MCOs discretion to select and pay network providers as they see fit, allowing the state to focus more on outcomes and less on processes and structures. On the other hand, given the experience with Medicare HMO retrenchment in the late 1990s, states want to ensure that an adequate supply of long-term care providers will remain if managed care fails as a strategy. A few programs, like MSHO and the

[6] These enrollment figures for Wisconsin and Arizona exclude persons with developmental disabilities.

Wisconsin Partnership, have not provided any policy protection for long-term care providers. Texas, addressing early concerns of traditional long-term care providers, gave them three years of transitional protection. During that period, the Texas Star+Plus plans were required to contract with any willing provider that had been providing Medicaid long-term care services in the fee-for-service system. In Massachusetts, Senior Care Organizations are required to subcontract with at least one Aging Services Access Point (ASAP), the State's traditional portal for community long-term care services.

Another approach to protecting existing long-term care infrastructure is to ensure that traditional providers (including counties) can themselves become risk-bearing managed care organizations. ALTCS and Wisconsin Family Care both give counties, which had substantial stakes in those states' long-term care systems, first right of refusal to be MCOs. In Arizona, counties had been the primary funders and operators of long-term care services prior to implementation of ALTCS, and in Wisconsin, they had administered long-term care programs at the local level. In Florida and New York, certain long-term care providers were made eligible to become program contractors, giving them an opportunity to compete with HMOs and other managed care entities.

A seller's market to date. Variation in the processes used by purchasers to select plan contractors belies the assertion that nearly all states have found managed long-term care to be a seller's market. Some states issue RFPs and others do not, but in most states, substantial behind-the-scenes work has transpired to ensure that states get an adequate number of bidders. Many states have had concerns during the development phase that "no one would come to the party." Some states have structured interim rates (to minimize start-up risk), some have developed special insurance rules to reduce capitalization requirements, and others have explicitly or implicitly linked bids on managed long-term care to more popular and profitable TANF or SCHIP contracts. There are signs, also, that future procurement may be more competitive. Officials in two states with planned expansions report that several new organizations have expressed interest in bidding on future rounds.

Why so much program variation? The early managed long-term care experience reflects the variation found across state Medicaid programs generally. Despite sharing similar challenges in their long-term care systems, states are experimenting with several approaches. Several local factors appear to have influenced the policy and program designs of the ten programs studied.

When did planning for the program occur? In the early 1990s, the Minnesota Senior Health Options and Wisconsin Partnership initiatives attracted much attention and excitement from other states. Both states proposed models that would fully integrate acute and long-term care by combining Medicaid and Medicare financing streams, and both experienced protracted planning phases of more than five years, in part because of difficult negotiations with HCFA (now CMS) regarding Medicare payments, complicated by Office of Management and Budget (OMB) concerns that the proposed payments would not be cost neutral. By the time Wisconsin and Minnesota implemented their

programs in the late 1990s, states like Texas and Florida were considering alternatives to the fully integrated financing model that would allow them to implement programs in the short-term. By taking Medicare off the table and working with CMS to develop unprecedented approaches to HCBS waivers, these states were able to implement programs within a few years of beginning their planning. Rather than shutting the door on Medicare altogether, Texas included incentives for dually eligible consumers to join companion Medicare+Choice plans (now Medicare Advantage). About 3000 Star+Plus members are enrolled in the one companion Medicare plan that is currently offered by Evercare. Table 4 shows how states have moved from more complex demonstration waivers to more mainstream statutory authority over time.

TABLE 4: Legal Authority of Managed Long-Term Care Programs

Program	Medicaid Authority	Medicare Authority
PACE	State plan optional service under §1934 of Social Security Act (enacted in Balanced Budget Act of 1997)	§1894 (enacted in Balanced Budget Act of 1997)
Florida Frail Elder Option	Began as §1115 waiver-converted to 1915(a) and (c) in 1990	NA
Arizona Long Term Care System (ALTCS)	§1115 waiver	§1853*
Wisconsin Partnership Program	Began in 1995 as a prepaid health plan (no waiver) until §1115 waiver was awarded (1999)	§222 waiver (since 1999)
Minnesota Senior Health Options (MSHO)	Began as §1115 waiver-converted to 1915(a) and (c) in 2000	§222 waiver
New York MLTC Plans	§1915(a) and (c)	NA
Texas Access Reform (Star) + Plus	§1915(b) and (c)	§1853*
Florida Diversion	§1915(a) and (c)	NA
Wisconsin Family Care	§1915(b) and (c)	NA
MnDHO	§1915(a) and (c)	§222 waiver
Mass Health Senior Care Options (SCO)	§1915(a)	§222 waiver

* Some beneficiaries in Arizona and Texas have access to a companion Medicare+Choice (now Medicare Advantage) plan initially authorized under §1853 of the Social Security Act, but most receive Medicare services in the fee-for-service system.

What role has the aging network played? The impact of advocacy from the aging network is clearly visible in a few of the programs. In Wisconsin, Area Agencies on Aging and Councils on Aging are operated by counties, which also administer local eligibility systems for long-term care benefits. When the State Department of Health and Family Services released its plan for long-term care reform based on the Partnership model of fully integrated acute and long-term care, aging and disability advocates organized strong opposition at a series of public hearings. They were concerned that integrated plans would be dominated by medically-oriented HMOs, and the aging network would lose its role in the system. The Department withdrew its plan, and the Family Care program was developed instead, featuring a prominent role for counties and limiting the program to long-term care. In Massachusetts, a network of Aging Services Access Points (ASAPs) serves a number of roles. Several are designated

Area Agencies on Aging, and several are providers of care coordination, home care, and other long-term care services. Like the counties in Wisconsin, the ASAPs saw Massachusetts Senior Care Options program as a threat to their existing role and feared that it would be a medical model that would take long-term care in the wrong direction. The ASAPs appealed directly to the state legislature and emerged with a change to the program design that requires SCO contractors to subcontract with one or more ASAPs to provide community care coordination, in cooperation with the primary care team that will oversee members' care plans.

How active were long-term care providers? Long-term care providers have had varying levels of influence on the design of managed long-term care programs. Early in the implementation of Star+Plus, Texas nursing home providers successfully lobbied to have their payments removed from the managed care plans' capitation rates for long-term admissions (longer than 30 days). Other Texas providers (including adult day health and personal care providers) had expressed concerns that they would go out of business if the health plans chose not to contract with them, so the State required that plans contract for at least three years with all willing long-term care providers who had been participating in the State's Medicaid fee-for-service program. (Texas officials note that Star+Plus plans actually contract with more long-term care providers now than they did during the 3-year transition period.) In New York State, provider agencies were actively involved in developing the state's statutory framework authorizing managed long-term care, and all of the state's 15 managed long-term care plans are sponsored by provider organizations. In Florida, certain long-term care providers are statutorily eligible to become diversion program contractors by virtue of their state provider licensure status.

3. THE SUPPLY SIDE: WHAT HAS EMERGED IN THE MARKET?

While purchasers (states) may be showing growing interest in the use of managed care models to purchase Medicaid benefits for long-term care populations, the future success of the market also depends upon the development of organizations that can provide what purchasers want to buy. This section examines the supply side of the managed long-term care marketplace.

In developing managed long-term care programs, states are seeking business relationships with managed care entities with expertise in the clinical and social management of long-term care populations. Traditional health plans do not possess expertise in long-term care, nor do their existing networks include the range of long-term care providers needed to serve persons with long-term care needs. On the other hand, organizations with expertise in providing services to long-term care populations tend to have little or no experience in managed care. Therefore, successful development of the supply side of the market requires the merging of managed care expertise with experience in the management of long-term care populations.

Consequently, two kinds of managed long-term entities are emerging in the marketplace: (1) managed care companies that are expanding into the long-term business; and (2) long-term care companies that are expanding into the managed care business. To date, the marketplace is dominated by the latter and this has had important effects on the overall success of the market.

We identified 67 different organizations providing long-term care services to aged and disabled Medicaid beneficiaries under risk contracts (Table 5). The vast majority are small private nonprofit plans with total enrollments under 1,000 members. This includes all of the PACE and "pre-PACE" sites, as well as the Prepaid Health Plans participating in the New York Managed Long Term Care Demonstration. Most serve both aged and disabled populations, and a high percentage of the members enrolled in the plans are dually eligible for Medicaid and Medicare. Table 5 also shows that most plans serve an enrolled population that largely resides in community-based setting, not in nursing homes. It is fair to say that the current managed long-term care market is concentrated on the management of long-term care beneficiaries in community-based settings, not on the management of people residing in nursing homes.

There are only two major for-profit players currently participating in the market--EverCare and Amerigroup. Evercare, an affiliate of UnitedHealth Group, is the dominant player in the managed long-term care marketplace. It is the one commercial company that has clearly made a long-range investment in this product line. Evercare focuses exclusively on products related to the care management of frail elders and persons of all ages with physical disabilities. Its business strategy reflects a firm belief that government purchasers (CMS and state Medicaid programs) will increasingly turn

to managed care purchasing strategies for providing integrated medical services and long-term care supports to frail elders, and Evercare's business strategy anticipates this trend. Evercare is aggressively pursuing new market opportunities in managed long-term care across the entire country, and is also working actively at the state and federal levels to increase market demand. Currently Evercare holds managed long-term care contracts (or subcontracts) in Arizona, Texas, Minnesota, Florida and Massachusetts, and is expected to bid on the upcoming expansions of Texas Star+Plus and the Florida Diversion Program.

TABLE 5: Managed Long-Term Care Supplier Characteristics		
	(N)	**Percent**
Type of Organization		
For-profit	(9)	13%
Not for-profit	(47)	70%
Local Government Agency	(10)	15%
State Government Agency	(1)	1%
TOTAL	**(67)**	**100%**
Geographic Coverage		
Multiple Counties	(32)	48%
One County	(35)	52%
TOTAL	**(67)**	**100%**
Enrollment		
<100	(4)	6%
101-1,000	(12)	18%
1,001-5,000	(32)	48%
5,001+	(2)	3%
Unknown	(17)	25%
TOTAL	**(67)**	**100%**
Percent in Nursing Homes		
51+%	(2)	3%
25-50%	(7)	10%
<25%	(38)	57%
Unknown	(20)	30%
TOTAL	**(67)**	**100%**
Percent Dually Eligible		
90+%	(34)	51%
50-89%	(19)	28%
<50%	(1)	1%
Unknown	(13)	19%
TOTAL	**(67)**	**100%**
Population Served		
Aged only	(16)	24%
Disabled only	(3)	4%
Both aged and disabled	(47)	70%
Other	(1)	1%
TOTAL	**(67)**	**100%**

On the for-profit side, Amerigroup has emerged as Evercare's primary competitor, with contracts in Texas Star+Plus and the Florida Diversion Program. Unlike Evercare, managed long-term care is not the core product line of Amerigroup. Rather, Amerigroup is a publicly traded company focused almost exclusively on the Medicaid market, with a total Medicaid membership of over 850,000 in 2003. Amerigroup's first

entry into the managed long-term care market occurred in 1997 with the award of one of the Texas Star+Plus contracts in Harris County, where Evercare and Amerigroup are the only two remaining contractors (a third contractor dropped out of the program). Amerigroup also has a small plan in the Florida Diversion Program, through acquisition. Thus, Amerigroup represents a Medicaid specialty plan with a core focus on the “moms and kids” Medicaid business, but which has expanded into the Medicaid SSI and managed long-term care markets, building off its basic Medicaid infrastructure. Many of the managed care tools employed by Amerigroup in its managed long-term care contracts are variants of the tools developed for its acute care Medicaid business.

Minnesota state law requires health plans to be non-profit, and accordingly all three MSHO plans--Medica Health Plans, Metropolitan Health Plan, and UCare Minnesota--are non-profit. (Evercare participates as a subcontractor, in part because its for-profit status precludes it from contracting directly with the state.) All are Minnesota-based plans, which do not appear interested in expanding their managed long-term care business beyond Minnesota’s borders. Medica is one of the largest health plans in the state, serving over 10,000 employers in Minnesota and bordering states. Metropolitan Health Plan and UCare Minnesota are smaller plans that are more focused on public programs, with Metropolitan being a spin off of Hennepin County government. While these three plans will probably continue to respond to future expansions of MSHO in Minnesota, they are not likely to seek contracts in other states.

Most organizations that have gotten into the managed long-term care business are provider-based organizations that have developed a managed care capacity. All 40 current PACE and “pre-PACE” providers are not-for-profit provider-sponsored organizations, generally integrated health care systems. All 15 plans participating in the New York Managed Long Term Care Program (5 of which are PACE or pre-PACE programs) are provider-sponsored plans, including hospitals, nursing homes, home health care agencies, and integrated health care systems. Similarly, the four plans in the Wisconsin Partnership Program are all community-based multiservice agencies that have decided to accept risk for the members they serve. Mercy Health Plan, one of three contractors in Maricopa County under the ALTCS program, also grew out of an integrated health care system, although it had some prior managed care experience.

A final group of plans participating in the managed long-term care market are publicly-owned plans. Pima Health System (Tucson) and Maricopa Long Term Care System (Phoenix) are the two largest contractors in the ALTCS program. Initially, these two plans were awarded exclusive contracts in their respective counties by legislative mandate. In October 2000, the Arizona legislature opened up Maricopa County to competitive bids, and now Maricopa Long Term Care System vies with two competing private sector plans (Mercy Health Plan and Evercare) for members. Three other county-based plans provide ALTCS services in six additional Arizona counties. In Wisconsin, all five Family Care program contractors are county-based plans.

It is interesting to note that two out of the three plans submitting bids on the recently-launched Senior Care Options program in Massachusetts are start-up organizations.

Senior Whole Health is a for-profit start-up company backed with venture capital, while Commonwealth Care Alliance is a start-up non-profit organization capitalized largely with charitable contributions. Both were incorporated for the specific purpose of bidding on the Massachusetts SCO contract.

In summary, the supply side of the managed care marketplace is still in the early stages of development. The market is dominated by one large commercial plan (Evercare) that is actively pursuing managed long-term care business on a national scale. Its primary commercial competitor--Amerigroup--builds off its core competency in Medicaid acute managed care, but tends to only compete in states where it has already established a large market presence on the “moms and kids” side of the market. Otherwise, the managed long-term care market is made up of a large number of relatively small provider-sponsored plans, as well as a number of public plans, largely county-based. There is no evidence that any of these small local plans, whether they are PACE providers or other provider-based organizations, have entrepreneurial ambitions to leverage their local expertise in other markets. On the other hand, the purchasers with the largest managed long-term care initiatives (Arizona, Texas, and Florida) tend to rely on for-profit plans to serve their markets.

4. WHAT VALUE DOES MANAGED LONG-TERM CARE OFFER?

Some observers have questioned whether managed long-term care offers value relative to traditional HCBS services. In traditional fee-for-service programs, long-term care is typically coordinated by a case manager who is involved in the development and management of a care plan. So what exactly does a managed care organization add to the equation? Information available from evaluations, studies and interviews with program officials remain inconclusive, but some important positive patterns are emerging. Most studies have found and officials report that managed long-term care programs reduce the use of institutional services and increase the use of home- and community-based services relative to fee-for-service programs, and that consumer satisfaction is high. Undesirable outcomes, such as higher death rates or preventable admissions, have not emerged as a concern. Cost findings are mixed and more difficult to summarize, though in general studies that examined the costs of Medicaid-only programs have found them to be cost-effective more consistently than studies looking at both Medicaid and Medicare costs for integrated programs. While a few state officials were confident that their programs produce savings, most were more circumspect, citing possible favorable selection (in voluntary programs), inability to capture savings through existing payment structures, and lack of adequate cost data as concerns.

Inconclusive results notwithstanding, state officials consulted for this study were largely positive about their experiences with managed long-term care and believe that it offers value.

Access

Less inpatient care. One clear outcome across several studies and interviews is that managed long-term care, like managed acute care, reduces the use of high cost services, including emergency rooms, hospitals and nursing homes. In an evaluation for CMS of the Minnesota Senior Health Options program, Kane et al. found that MSHO reduced preventable emergency room admissions, hospital length of stay and short-stay nursing home admissions.[7] Similarly, an Abt Associates evaluation of PACE found decreased inpatient hospital admissions and days, and decreased nursing home days.[8]

Similar findings emerge from Medicaid-only programs. The Wisconsin Family Care program includes only long-term care services; an independent assessor found in a

[7] Kane, R.L., and Homyak, P. Minnesota Senior Health Options Evaluation Focusing on Utilization, Costs, and Quality of Care. Minneapolis, MN: Division of Health Services Research and Policy, University of Minnesota School of Public Health. Final Version (Revised August 2003). Prepared under HCFA Contract No. 500-96-0008 Task Order 3.
[8] Chatterji, P., Burstein, N.R., Kidder, D., and White, A.J. The Impact of PACE on Participant Outcomes. Cambridge, MA: Abt Associates, 1998.

pre/post study that hospital length of stay significantly decreased following enrollment in Family Care (although no change in hospital admission rates).[9] A Texas Star+Plus study focusing on Medicaid-only SSI beneficiaries receiving Day Activity and Health Services or Personal Assistance Services found reduced hospital length of stay and fewer emergency room visits.[10]

Greater access to HCBS services. There is also evidence that managed long-term care increases access to HCBS waiver and other community services. The ALTCS program has progressively increased the use of HCBS services over time by adjusting its rates to assume diminishing nursing home use. The Wisconsin Family Care independent assessment found that waiting lists for long-term care in Family Care counties were eliminated while the waiting lists in comparison counties continued to increase. The Florida Legislature has chosen to expand funding for the Diversion program while cutting funds for Florida's traditional HCBS waiver programs, reportedly out of frustration that past increases to the traditional programs have not had a proportional impact on waiting lists. The Massachusetts SCO program will maintain benefits that have been cut from the FFS MassHealth program, including vision, dental, podiatry and hearing services. The MnDHO program has assisted 61 persons with physical disabilities leave nursing homes by providing alternative community services. In Star+Plus, plans are required to screen every new member and have as a result identified and addressed unmet LTC needs.

People enrolled in managed LTC programs are generally not subject to caps on the number of "slots" available for HCBS waiver services. Plans have the flexibility to provide LTC services to members who need them when they need them, and have incentives to do so when community services can prevent or reduce institutional use. In contrast, a recent national survey of 171 traditional HCBS waiver programs found that 69 of them had waiting lists. Among those reporting the length of wait, the average length was 10.6 months.[11]

More flexible services, including consumer-directed care. State officials report that capitated financing allows more flexibility in services than FFS. Examples include provision of pest extermination and air conditioners, items not generally covered in FFS systems. At least five programs (Wisconsin Family Care and Partnership, MSHO, MnDHO and Star+Plus) allow members to select and direct their own personal care attendants, creating a self-direction option within a managed care program without a need for additional waivers. In FFS, self-direction generally operates as a free-standing program that consumers must choose to the exclusion of other programs.

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[9] APS Healthcare, Inc. Family Care Independent Assessment: An Evaluation of Access, Quality and Cost Effectiveness For Calendar Year 2002. December 2003.
[10] Aydede, S.K. The Impact of Care Coordination on the Provision of Health Care Services to Disabled and Chronically Ill Medicaid Enrollees (Texas Star Plus Focus Study). University of Florida, Institute for Child Health Policy, November 2003.
[11] Reester, H., Missmar, R., and Tomlinson, A. Recent Growth in Medicaid Home and Community-Based Service Waivers. Prepared by the Health Strategies Consultancy for the Kaiser Commission on Medicaid and the Uninsured. April 2004.

Lower consumer costs. Until recently, savings to consumers have not been a widespread benefit of managed LTC, because many Medicaid programs offered full benefits without cost sharing in FFS. Recent fiscal challenges have made cost sharing more widespread and benefits less expansive in Medicaid. Minnesota and Massachusetts, for example, both enacted new cost sharing requirements in their FFS programs in 2003, but MSHO and SCO providers have agreed to maintain full access without charging co-payments. Another example is PACE, which does not require Medicaid beneficiaries to make co-payments, regardless of a state's fee-for-service cost sharing policy.

Streamlined access to care. The most commonly cited goal among state managed long-term care program administrators is ease of access. Long-term care consumers find the fee-for-service system difficult to understand and navigate. Managed long-term care generally includes a care coordination mechanism to assist consumers and families with the system. While this is generally also true in fee-for-service HCBS programs, HCBS programs generally are not responsible for consumers when an acute episode results in hospitalization, often the time when coordination is most important. Managed LTC contractors, on the other hand, usually have financial incentives to manage transition periods because of their ongoing risk. (The incentive is greatest in programs with the most comprehensive risk designs.)

Costs

Cost studies are inconclusive. In the first evaluation of ALTCS, McCall et al. found overall savings of 6% and 13% in 1990 and 1991, but nearly all of the savings were attributable to members with developmental disabilities, and the study was limited by its use of a different state (New Mexico) for the comparison group.[12] Weissert et al. took a different approach, developing a complex model that estimated nursing home savings resulting from the expansion of HCBS services in the ALTCS program and concluding that about 35% ($4.6 million) of estimated nursing home costs had been saved, net of added HCBS costs.[13] A recent analysis conducted for the Texas Health and Human Services Commission by The Lewin Group estimated substantial Star+Plus savings if the program were expanded to 51 counties in metro areas of the state. Higher savings (8.6%) were projected for SSI beneficiaries under 65 years of age than for older people (5%).[14] In the Wisconsin Family Care Program, savings were found in four out of five Family Care counties ($113 per member per month less than FFS comparison counties), but overall state savings disappeared when the fifth Family Care county (Milwaukee) was included in the analysis. In all three of these studies, only Medicaid

[12] McCall, N., Korb, J., Paringer, L., Balaban, D., Wrightson, C.W., Wilkin, J., Wade, A., and Watkins, M. Evaluation of Arizona's Health Care Cost Containment System Demonstration, Second Outcome Report. San Francisco, CA: Laguna Research Associates, 1992.

[13] Weissert, W.G., Lesnick, T., Musliner, M., and Foley, K.A. "Cost Savings from Home and Community-Based Services: Arizona's Capitated Medicaid Long-Term Care Program." *J. of Health Politics, Policy and Law*, 22(6) (December 1997): 1329-57.

[14] The Lewin Group. Actuarial Assessment of Medicaid Managed Care Expansion Options. Prepared for the Texas Health and Human Services Commission. January 21, 2004 (amended version).

costs are considered. Given the high proportion of dually eligible enrollees, it is possible that Medicaid savings derive from higher FFS Medicare costs.

Cost studies that include Medicare are more difficult to interpret and no more conclusive. The MSHO evaluation found that Medicare capitation payments were higher than FFS payments among comparison group members, but State officials have pointed out the study was conducted in the post-Balanced Budget Act period. The BBA effectively decoupled Medicare managed care rates from fee-for-service, allowing capitated payments to rise above average FFS expenditures. In the Abt PACE evaluation, combined Medicare and Medicaid payments to PACE were found to be comparable to the fee-for-service expenditures of the comparison group. Analyzed separately, Medicare payments were found to be lower for PACE enrollees than for the comparison group, and Medicaid payments were found to be higher. However, the cost analysis was limited to the first year of enrollment. A subsequent evaluation is analyzing costs over a longer period of time.

Payment systems are imperfect. Most of the state officials interviewed felt that they had not yet fully refined their payment systems. Texas has had concerns that plans within Star+Plus might experience adverse or favorable selection relative to one another. In 2003, the state implemented risk adjustment based on Adjusted Clinical Groups (ACGs), and in 2004 switched to the Chronic Disability Payment System. Florida reduced Diversion Program payment rates after determining that favorable selection resulted in overpayment, and has notified contractors that further reductions may be forthcoming. New York State believes that more study is needed to determine whether its managed long-term care programs are cost effective. Clearly, payment is an area of concern, but states believe that rates can be fine-tuned as better technology is developed. As long as utilization patterns move from higher-cost to lower-cost services (as they appear to be doing in most studies), the total costs of delivering care are probably declining. The challenge becomes one of appropriate pricing, in order to allow both purchasers and suppliers to share in the savings.

Budget predictability is a key attribute. As the baby boomers move into retirement, states are searching for ways to better manage a growing and uncertain liability for future LTC costs. Managed care models allow states to share the risk of budgetary cost increases with its managed care contractors. As the number of people in the long-term care FFS system increases over time, a state's aggregate risk increases.

Quality

Clinical indicators mixed. The ALTCS evaluation concluded that long-stay nursing home care was of lower quality in ALTCS than in the comparison group in New Mexico, based on incidence of decubitus ulcers, fevers and catheter insertions, though the authors note that the need to use another state for comparison was a serious limitation of the study. The MSHO evaluation found that quality indicators for nursing home residents were similar for MSHO and comparison groups, and that in general, MSHO

resulted in modest benefit for enrollees compared to control groups.[15] The Abt PACE evaluation was very positive, finding improved quality of life, satisfaction and functional status. The study also found that PACE enrollees lived longer and spent more days in the community than members of the comparison group.[16] It is important to note that of all the programs mentioned, PACE has the tightest managed care model, including both Medicare and Medicaid and using a staff model to deliver most services.

Satisfaction mostly high. Most of the programs have found consumer satisfaction levels to be high. MSHO, ALTCS and the New York Managed Long Term Care programs all report high overall levels of satisfaction.[17,18,19] Satisfaction levels in Texas Star+Plus have been slightly lower but still favorable overall, and Star+Plus satisfaction levels have been higher than those of other Texas mandatory managed care programs that do not include long-term care or care coordination.[20]

Enhanced accountability. State Medicaid officials value being able to hold plans accountable, and being able to work with plans in a systematic way on quality goals, something that is not possible in fee-for-service, where multiple providers are providing care, but none are responsible for overall quality outcomes. In managed long-term care, a negative quality indicator in one year can be turned into a focused quality improvement effort in the next. By comparison, little is known about quality outcomes in the traditional HCBS program.

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[15] Kane, R.L., Homyak, P., Bershadsky, B., Lum, Y., and Siadaty, M.S. "Outcomes of Managed Care of Dually Eligible Older Persons." *The Gerontologist* 43(2) (2003): 165-74.
[16] Chatterji, P., Burstein, N.R., Kidder, D., and White, A.J. The Impact of PACE on Participant Outcomes. Cambridge, MA: Abt Associates, 1998.
[17] Minnesota Health Data Institute. Minnesota Senior Health Options 2002 Consumer Assessment of Health Care: MSHO Nursing Home Population. August 2002. Accessed at http://www.dhs.state.mn.us/HealthCare/pdf/Final-Report-Appendices.pdf.
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[19] NYS Department of Health. New York State Managed Long-Term Care, Interim Report. Report to the Governor and Legislature. 2003.
[20] Texas Department of Health. Comparing Medicaid Managed Care Plans in Texas, 2000. Star+Plus Dually Eligible Consumer Study Technical Report. November 28, 2001. Accessed at http://www.hhsc.state.tx.us/medicaid/mc/about/reports/2000annrpts/2000consumersatsurvey/2000-09-15finalexecsummaryconsumersat.pdf.

5. THE FUTURE OF MANAGED LONG-TERM CARE

After a lull in managed long-term care development activities over the last 6-7 years, there appears to be renewed interest among states. The Texas Health and Human Services Commission proposed a large expansion of the Star+Plus program to seven additional metropolitan counties and a request for proposals for bidders was issued in 2004. However, as of April 2005, the Star+Plus expansion was still being debated by the Texas Legislature in the face of strong opposition from hospitals, which claim they will lose significant Medicaid revenue under the plan. If the Star+Plus expansion were to proceed, it alone could double the number of persons enrolled in managed long-term care nationally.

Florida has also received legislative authorization to increase enrollment in its Diversion Program by another 3,000 members in 2004. Minnesota will also be adding a long-term care benefit to its mandatory managed care program for the aged and disabled (PMAP), which will make PMAP similar to the specifications of the MSHO program, except it will not attempt to integrate Medicare. At the same time, Minnesota is considering expansions of the MSHO program into additional counties. The Massachusetts Senior Care Options Program began enrolling members late in 2004 and, as of March 2005 had just under 1000 members. The Maryland state legislature also recently passed legislation for the development of two managed long-term care pilots programs that are under development in 2005. Hawaii is seeking federal waivers to enroll all of its older beneficiaries and persons with physical disabilities into capitated managed care arrangements. Washington state is pursuing two programs that will include managed long-term care in the near future. Thus, we are seeing new states entering the market, as well as significant expansions in states that have successfully implemented managed long-term care programs on a demonstration basis.

Key Issues Affecting Growth

Issues for Purchasers

While there is renewed interest among states in managed long-term care expansions, they face important design decisions in shaping the structure of their managed long-term care programs. The question for states is not only *whether* to use managed care purchasing models for long-term care benefits, but also what kind of models work best. A number of these design questions are discussed below.

- *Complex policy and design questions.* The managed long-term care programs that *have* been implemented by states and PACE programs are highly diverse. Benefit packages, payment methodologies, target populations, types of managed care suppliers, degree of competition, whether enrollment is voluntary or

mandatory, and coordination with Medicare-covered benefits all vary from program to program. True to the nature of Medicaid in general, each state has developed its own model specifications based upon local exigencies. Given this diversity, states do not yet have the benefit of clear, replicable program models to consider. Arizona offers an excellent example. Despite having 15 years of experience managing and improving a statewide program, other states generally do not view the Arizona Long Term Care System (ALTCS) as a transferable model. Since Arizona never had a Medicaid-financed fee-for-service system prior to the implementation of ALTCS, it did not have to deal with the kinds of political issues that other states typically run into during managed long-term care program development. Furthermore, ALTCS still relies heavily on counties as suppliers, an infrastructure that does not exist in most states.

- *Legal authority.* Legal authority for managed long-term care programs has evolved in a positive direction from states' perspectives, but difficult issues will continue to complicate program development. Medicaid authority has largely been streamlined through the use of section 1915(a), (b), and (c) waiver authorities, which allow states to meet most of their program objectives without having to go through the far more rigorous requirements of section 1115 demonstration waivers. For states that want to integrate Medicare-covered benefits for dually eligible beneficiaries, negotiations with CMS over special Medicare payments may cease to be an issue if CMS implements the Medicare Frailty Factor for all Medicare Advantage plans in 2007 as has been stated as a goal by CMS. The Frailty Factor has recently been applied to Medicare payments in the PACE, MSHO, MnDHO, Wisconsin Partnership and Massachusetts SCO programs. (The Frailty Factor is not applied to populations under age 55.) Consensus appears to be emerging within these programs that the frailty factor works reasonably well for older beneficiaries with long-term care needs, and that it could become a mainstream alternative to negotiating Medicare rates program by program. However, less likely to be resolved is the issue of whether states can design programs that mandate managed care enrollment for both Medicare and Medicaid. Many states believe mandatory enrollment is necessary to ensure adequate volume and to attract suppliers. Although states can require mandatory enrollment for Medicaid-covered benefits, it is not permitted under current Medicare law.

- *Payment challenges.* Payment rates remain a controversial and technically challenging area. States with existing programs consistently identify this as an area in which they expect to make further refinements in the future. At issue is how a state can set a fair price in managed care when the model is expected to change utilization patterns, making the historical FFS data inadequate for setting price. If a supplier successfully provides care more cost-effectively but is paid based on FFS experience, the state may not capture the savings. Alternatively, if a state sets the price too low, it could jeopardize program viability. When Medicare is included, a similar dynamic exists between states and CMS, with each payer concerned that it pays more than its share in an integrated program.

One option is to create shared risk arrangements, in which states, CMS and suppliers all agree to share profits or losses in pre-established risk corridors. This issue is fundamentally about how risk should be distributed across purchasers and suppliers.

- *Constituent concerns.* Political resistance to managed long-term care from established constituencies in the fee-for-service system has been strong. Some in the aging network have expressed concerns that "private contracting" of the long-term care system will lead to reduced access to services and lower quality of care.

- *Infrastructure Issues.* Most states have not made the infrastructure investments needed to implement managed long-term care programs effectively. In managed care, it is particularly important for states to diligently monitor member outcomes, to ensure that managed care contractors are not cutting services and costs inappropriately. Unfortunately, managed care is often viewed by policymakers as a way of privatizing services and reducing state infrastructure. As one state administrator put it, "we are not going to take on a big new complicated program when we're losing staff and are under pressure to find immediate Medicaid savings." Managed long-term care may require states to *increase* administrative costs. For example, Arizona's AHCCCS program has higher administrative costs, but lower overall costs, than comparable fee-for-service Medicaid programs.

Supply Side Issues

Suppliers of managed long-term care have and will continue to be a diverse group. The type of supplier a state uses will continue to depend on program model, political factors, and availability in the local market.

- *Local provider-sponsored plans.* The majority of managed long-term care suppliers are small provider-affiliated plans that have decided to enter the market for local reasons. In the case of PACE, new programs are often initiated by the provider organizations themselves, not in response to state purchasing strategies. In some states, providers have applied political pressure directly to legislatures to ensure a role in a managed care program. In other states, the implementing agency deliberately creates a role for provider-based plans to ensure that traditional infrastructure does not evaporate, to attract an adequate supply or to take advantage of the long-term care expertise in those provider organizations. The challenge is to regulate entities that generally have very little experience managing risk and very little capital to establish reserves. Continued reliance on provider-sponsored plans may result in the market being dominated by many small plans with low enrollments.

- *Start-up plans.* There is evidence that venture capitalists are willing to invest in managed long-term care, but new capital will not flow to this market unless investors believe that the level of risk is acceptable, and there are reasonable opportunities for profitability. For this to happen, investors must develop confidence in states as reasonable business partners. Shared risk arrangements may be a useful strategy for attracting new capital to this market. Also, venture capitalists are more interested in developing managed long-term care products that can be more easily replicated across states. Managed long-term care programs that are so state-specific that they cannot be leveraged in other markets will not be as attractive to investors.

- *County plans.* The participation of county-based plans in the managed long-term care marketplace is not surprising, given the historical role of county governments in the administration of long-term care and social service programs in some states. The concept of "risk" in county-based models such as the Wisconsin Family Care Program is an odd one though, since it is presumably county taxpayers (or politicians) who are at risk if costs exceed revenues in those plans. While county-based plans appear to be viable suppliers in states with a history of county involvement, their further development remains local by definition and does not increase the number of suppliers who are active on the national market.

- *National firms.* Only two companies have entered this market on a national scale--Evercare and Amerigroup, with Evercare having a much larger market presence. Why aren't more managed care companies interested in this product line? First, entry into this market requires a strong commitment to learning the business of long-term care. Managing long-term care is a totally different business from managing general health care, and requires a considerable investment of resources to develop the kind of management expertise needed to be successful. Second, profitability in this market is, at present, fairly unpredictable, given uncertainties about payment rates and the abrupt Medicaid policy changes that can occur, especially during periods of state fiscal stress. Third, there is no assurance that this market will grow to a mature level, given its history to date. We are not likely to see more national companies venturing into this market until there is a significant increase in demand from states.

- *Medicare Advantage plans.* Many observers predicted that the managed long-term care market would grow primarily from Medicare managed care plans developing "wrap-around" agreements with states to serve dually eligible beneficiaries. While several Medicare plans have negotiated premium arrangements with states to cover primary and acute cost sharing, none has bid on managed long-term care products. The Medicare Modernization Act now offers a new opportunity in the form of "specialized plans," authorized under the Act to limit enrollment to dually eligible individuals (normal Medicare Advantage rules requires that plans be open to all Medicare beneficiaries.) This provision of

the Act provides new opportunities for states to integrate Medicaid and Medicare benefits for long-term care populations, without the extensive use of waivers.

Summary

After over 20 years of development, the Medicaid managed long-term market is still in a very early stage with less than 3% of the potential market enrolled in managed care. Although interest among states in managed long-term care purchasing strategies has been high, they have faced numerous barriers in efforts to implement managed long-term care programs, and many initiatives have been terminated during the development process. However, states which have been successful in implementing managed long-term care programs are pleased with the outcomes they have achieved, and are seeking further program expansions. After a recent lull in managed long-term care program development, it appears that there may be a significant expansion in the market over the next two years. The Medicare Modernization Act also provides states with new opportunities to more easily integrate Medicaid and Medicare-covered benefits for dually eligible populations.

On the supply side, the managed long-term care market is dominated by small provider-sponsored plans with small enrollments that have not, to date, demonstrated intent to expand beyond their current state borders. If the managed long-term care market is to expand to a mature level, it will have to attract more national companies that can operate in multiple states and manage programs with large enrollments.

APPENDIX 1: METHOD FOR DERIVING THE SIZE OF THE PUBLIC LONG-TERM CARE MARKET

(as presented in Table 1)

Estimates of the potential size of the Medicaid managed long-term care market in FY 2003 are presented in Table 1. The estimates are of the total number of aged and physically disabled Medicaid beneficiaries receiving long-term care services either in nursing homes or in community-based settings, as well as associated Medicaid and Medicare expenditures for these persons. The vast majority of this population is comprised of persons over the age of 65 who are dually eligible for Medicaid and Medicare.

We have excluded from these estimates persons under the age 21 receiving long-term care benefits, as well as persons with developmental disabilities or serious mental illness. About 90% of all Medicaid beneficiaries in nursing homes are over the age of 65. The age distribution of Medicaid beneficiaries receiving community-based HCBS waiver and personal care services is more difficult to estimate, but most likely includes a somewhat higher percentage of non-elderly persons.

In 2003, there were about 3.1 million aged and disabled beneficiaries of Medicaid-financed long-term care services. About 55% of this population received long-term care services in nursing homes, while 45% were receiving long-term care supports in community-based settings, either through the Medicaid home and community-based waiver services program or through the regular state Medicaid option personal care services benefit.

Table 1 also estimates total Medicaid and Medicare spending for these 3.1 million individuals. We estimate total Medicaid and Medicare spending of $86.5 billion for Medicaid beneficiaries in nursing homes in 2003, and $45.8 billion in total Medicaid and Medicare spending for Medicaid beneficiaries receiving community-based long-term care. These estimates each include three components: (1) the cost of Medicaid-financed long-term care services; (2) the cost of other Medicaid services for long-term care beneficiaries, such as prescription drugs, therapy services, and Medicare cost-sharing; and (3) the cost of Medicare-financed acute care services. While Medicaid accounts for about 74% of total spending for persons in nursing homes, Medicare accounts for about 57% of total spending for persons receiving community-based long-term care.

Thus, the total estimated size of the potential Medicaid managed long-term market was about $132.3 billion in 2003. This averages to about $42,955 per long-term care beneficiary per year--$50,882 per person per year for nursing home beneficiaries, and $33,188 per person per year for community-based long-term care beneficiaries.

If we assume that approximately 90% of this population is dually eligible for Medicaid and Medicare, this group comprised about 6% of the total Medicaid population in 2003, and about 32% of total Medicaid expenditures. On the Medicare side, they constitute about 7% of the Medicare population and 17% of total Medicare expenditures.

Appendix II

Questions Asked of the Managed Care Program Contractors and Nursing Home Providers

Questions for Program Contractors-Arizona

1. What elements are most important to program contractors in contract negotiations with nursing facilities which may result in favorable or unfavorable rate negotiation;

2. How much flexibility is there in rate negotiation? What percent do rates vary for providers in similar locations and for the same care level;

3. Are the rates paid for Medicare services in the nursing facility based upon the federal Medicare RUG level rates? If not, how are these rates set?

4. How has Medicaid managed care influenced care delivery and impacted patient outcomes; i.e., reduced hospitalizations; fewer emergency room visits; more frequent physician or nurse practitioner visits, earlier discharges? Do you have data you can share on this?

5. Can you share any information on Medicare average lengths of stay in nursing facilities for beneficiaries in your plan who have needed Medicare-covered nursing home care;

6. From your perspective, what impact has the ALTCS program had on the acuity and level of care of patients admitted to nursing homes? Do your beneficiaries that are admitted to NFs have greater medical, functional and psycho-social needs than in the past? Any data you might have on this would be helpful;

7. What outcome or quality measures/tools do you require providers to maintain and report as a result of their contracts with you? How are they used relative to incentive payments or future rate negotiation, if at all;

8. From your perspective, has there been good integration of services between Medicare and Medicaid? For dually-eligible patients, has the transition been fairly seamless as the patient progresses through the continuum or have there been problems as to coverage, duplication of services, poly-pharmacy, paperwork, etc.

9. As a result of the auto-enrollment of dual-eligibles into a Part D Plan, has the percentage of dual-eligibles in both the same plan for Medicare and Medicaid increased significantly? Can you provide percentages of the dual-eligibles in your Medicaid plan that are also enrolled with you for their Medicare services and to what extent that percentage has changed in the last year;

10. What elements of the contracting process have proven to be problematic with nursing home providers; i.e. rate negotiation, coverage, level of care; timeliness of payment; denials, etc.? What has been done to improve or streamline the processes?

11. Do you have contracts with NF providers to provide other services such as care and case management, assisted living, home-based personal care services, etc? Please describe.

Questions for Program Contractors-Minnesota

1. What elements are most important to program contractors in contract negotiations with nursing facilities which may result in favorable or unfavorable rate negotiation;

2. How much flexibility is there in rate negotiation? What percent do rates vary for providers in similar locations and for the same care level;

3. Are the rates paid for Medicare services in the nursing facility based upon the federal Medicare RUG level rates? If not, how are these rates set?

4. How has Medicaid managed care influenced care delivery and impacted patient outcomes; i.e., reduced hospitalizations; fewer emergency room visits; more frequent physician or nurse practitioner visits, earlier discharges? Do you have data you can share on this?

5. Can you share any information on Medicare average lengths of stay in nursing facilities for beneficiaries in your plan who have needed Medicare-covered nursing home care;

6. From your perspective, what impact has the MSHO program had on the acuity and level of care of patients admitted to nursing homes? Do your beneficiaries that are admitted to NFs have greater medical, functional and psycho-social needs than in the past? Any data you might have on this would be helpful;

7. What outcome or quality measures/tools do you require providers to maintain and report as a result of their contracts with you? How are they used relative to incentive payments or future rate negotiation, if at all;

8. From your perspective, has there been good integration of services between Medicare and Medicaid? For dually-eligible patients, has the transition been fairly seamless as the patient progresses through the continuum or have there been problems as to coverage, duplication of services, poly-pharmacy, paperwork, etc.

9. What elements of the contracting process have proven to be problematic with nursing home providers; i.e. rate negotiation, coverage, level of care; timeliness of payment; denials, etc.? What has been done to improve or streamline the processes?

10. Do you have contracts with NF providers to provide other services such as care and case management, assisted living, home-based personal care services, etc? Please describe

Questions for Providers-Arizona

1. What percent of your Medicare days are paid through managed care contracts?

2. What is the average length of stay for Medicare managed care v. traditional Medicare?

3. How do the rates compare under Medicare managed care v. traditional Medicare?

4. How do the rates compare under Medicaid managed care v. fee for service rates?

5. Has the ALTCS program impacted your nursing home occupancy? What has been the general trend in your occupancy over the last 3-4 years?

6. Has the program influenced care delivery and impacted patient outcomes; i.e., reduced hospitalizations; fewer emergency room visits; more frequent physician or nurse practitioner visits, earlier discharges? Please describe.

7. What impact has the managed care program had on patient acuity relative to Medicaid patients? Has your patient acuity scores increased and have your costs correspondingly increased?

8. What outcome or quality measures/tools do you maintain and report as a result of your managed care contracts?

9. Has there been good integration of services between Medicare and Medicaid through the program contractors? For dually-eligible patients, has the transition been fairly seamless as the patient progresses through the continuum or have there been problems as to coverage, duplication of services, poly-pharmacy, paperwork, etc.

10. What elements of contracting have proven to be problematic; i.e. rate negotiation, coverage, level of care; timeliness of payment; denials, etc.? If willing, please provide a copy of one or two contracts.

11. Do you provide other services under your contract other than NF? If so, please describe.

12. Are the rates for NF services and the services in number 11 adequate and allow the opportunity for a reasonable margin?

13. What other successes or problems have arisen with the program contractors?

Questions for Providers-Minnesota

1. What percent of your Medicare days are paid through managed care contracts?

2. What percent of your MA days are paid through managed care contracts?

3. What is the average length of stay for Medicare managed care v. traditional Medicare?

4. How do the rates compare under Medicare managed care v. traditional Medicare?

5. How do the rates compare under Medicaid managed care v. traditional Medicaid?

6. Has the MSHO program impacted your nursing home occupancy? What has been the general trend in your occupancy over the last 3-4 years?

7. Has the program influenced care delivery and impacted patient outcomes; i.e., reduced hospitalizations; fewer emergency room visits; more frequent physician or nurse practitioner visits, earlier discharges? Please describe.

8. What impact has the managed care program had on patient acuity relative to Medicaid patients? Has your acuity scores increased and have your costs correspondingly increased?

9. What outcome or quality measures/tools do you maintain and report as a result of your managed care contracts?

10. Has there been good integration of services between Medicare and Medicaid through the MCOs? For dually-eligible patients, has the transition been fairly seamless as the patient progresses through the continuum or have there been problems as to coverage, duplication of services, poly-pharmacy, paperwork, etc.

11. What elements of the contracting have proven to be problematic; i.e. rate negotiation, coverage, level of care; timeliness of payment; denials, etc.? If willing, please provide a copy of one or two contracts.

12. Do you provide other services under your contract other than NF? If so, please describe.

13. Are the rates for NF services and the services in number 12 adequate and allow the opportunity for a reasonable margin?

14. What other successes or problems have arisen through contracting with the MCOs?

Appendix III

ALTCS Program Summary

CHAPTER 3

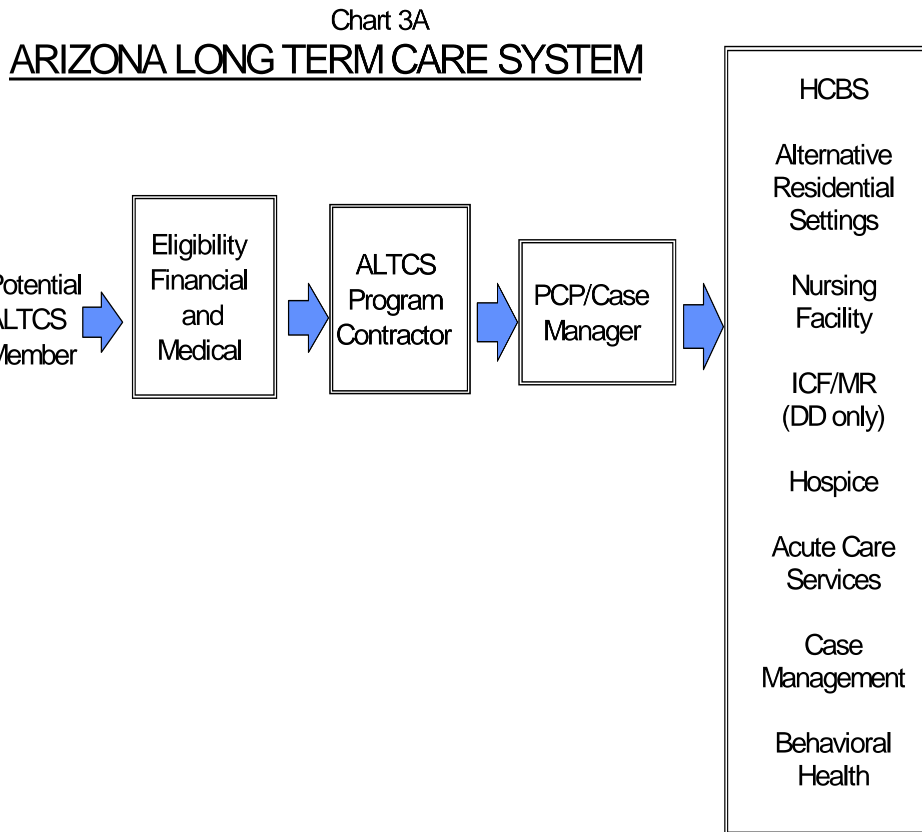
ARIZONA LONG TERM CARE SYSTEM

In 1987, Arizona passed legislation to establish the Arizona Long Term Care System (ALTCS) for the delivery of long term care services. ALTCS was implemented on December 19, 1988, for the developmentally disabled (DD) population. The long term care program for the elderly or physically disabled (EPD) population was implemented on January 1, 1989. As of October 1, 2005, the ALTCS program served 41,634 members; 17,092 were persons who are DD and 24,542 were persons who are EPD.

ALTCS offers a complete array of acute medical care services, institutional services, behavioral health services, home-and-community-based services (HCBS) and case management services for all eligible persons. A listing of the services and the approved settings is provided in Appendix III.

ALTCS is unique in that all covered services are integrated into a single delivery package, coordinated and managed by the Program Contractors listed in Exhibit 3.1. Program Contractors provide services for ALTCS members in the same way that Health Plans provide acute care services to AHCCCS enrolled members. Until October 1, 2000, only one Program Contractor operated in each county, and members were enrolled with the Program Contractor in their county of residence. On June 1, 2000, AHCCCS awarded contracts to three Contractors to in order to offer choice to elderly and physically disabled ALTCS members residing in Maricopa County. This allowed a choice of ALTCS Program Contractors beginning October 1, 2000. This measure was initiated in 1997 by lawmakers who sought a wider choice of providers for Medicaid members.

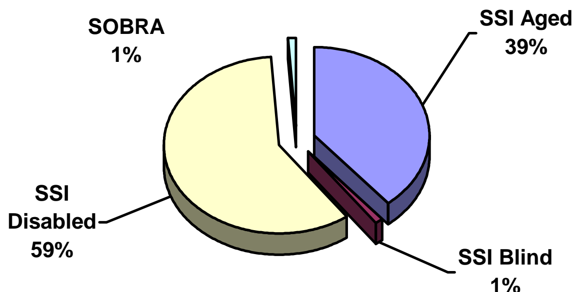
Once enrolled, the member has a choice of available primary care providers who coordinate care and act as gatekeepers. Chart 3A displays the main components of the ALTCS program. Exhibit 3.2 shows the Program Contractor for each county and the ALTCS member enrollment for each contractor as of September 30, 2005.



ELIGIBILITY

Financial Eligibility

Individuals must be financially eligible for ALTCS. The Legislature established ALTCS financial eligibility at 300 percent of the Federal Benefit Rate (FBR), which is used by the Social Security Administration to determine eligibility for Supplemental Security Income (SSI). Effective January 1, 2005, an individual may have up to $1,737. An eligible individual may have no more than $2,000 in resources.



Nearly all ALTCS members meet financial eligibility requirements based on the established SSI methodology. A small number of individuals are determined eligible based on SOBRA criteria (see Chart 3B). ALTCS members are required to contribute a share of the cost for their institutional care, which is calculated by taking an individual's income and subtracting certain allowable deductions. Appendix I contains specific ALTCS eligibility criteria.

Medical Eligibility

Once financial eligibility has been established, a Pre-Admission Screening (PAS) is conducted by a registered nurse or social worker to determine if the individual is at immediate risk of institutionalization in either a nursing facility or an ICF/MR. If deemed necessary, the registered nurse or social worker may refer the case to a physician for a final determination. AHCCCS has developed five standardized PAS instruments: one is used to screen persons who are elderly and/or physically disabled and the others are age-specific for DD.

The PAS instruments use weighted scores to provide information on the functional, medical, nursing, and social needs of an individual, which are the basis for determining medical eligibility for ALTCS services. Targeted groups are reassessed on an annual basis and others are reassessed when a change occurs.

On September 1, 1995, AHCCCS implemented a new ALTCS Transitional Program, which allows AHCCCS to complete a second scoring of the PAS for members who are enrolled in ALTCS, but fail to be at “immediate risk of institutionalization” based on the PAS conducted at the time of the redetermination. If determined eligible, AHCCCS transfers the member to the ALTCS Transitional Program which limits institutional services to 90 days per admission and provides the member with medically necessary acute care services, HCBS, behavioral health services and case management services. On October 1, 2005, there were 3,733 eligible members in the ALTCS Transitional Program; 1,996 members who are DD and 1,737 members who are EPD.

SERVICES

Acute Medical Care

ALTCS members receive the same acute services listed in Appendix III. The Program Contractor assigns a case manager to each ALTCS member. The case manager coordinates care with the primary care provider and is responsible for identifying, planning, obtaining and monitoring appropriate services that meet the member's needs.

Home and Community-Based Services (HCBS)

ALTCS provides a comprehensive HCBS package in settings that may include a member's home, as identified in Appendix III.

Prior to October 1, 1999, there was a federal restriction on the number of HCBS slots available to the EPD population enrolled in ALTCS. AHCCCS believed that there should be no limit on the number of members receiving HCBS and each year negotiated with CMS to increase the limit from an initial five percent, which was based on the total ALTCS budget in 1989, to 50 percent, which is based on the total elderly and physically disabled population in 1998. CMS notified AHCCCS of the elimination of the HCBS cap effective October 1, 1999. As of September 30, 2005, approximately 63 percent of the EPD population was served within the community. CMS never imposed a similar cap for the DD population and almost all of this population is served within the community rather than through more restrictive and costly institutional settings.

Alternative Residential Settings under HCBS

ALTCS approved HCBS settings for EPD members include the member's home, adult foster care, assisted living homes, assisted living centers, level II and level III behavioral health facilities, hospices, group homes for traumatic brain injured members, and rural substance abuse transitional agencies. Since August 2001, members who are elderly and/or physically disabled (EPD) may also use DD alternative residential settings as appropriate.

The ALTCS program has expanded alternative residential settings to meet the needs of the members. Initially, an ALTCS member could only receive HCBS in their own home or an adult foster care home. In 1993, the Arizona Legislature established a Supportive Residential Living (SRL) three-year pilot program in Maricopa County to expand the ALTCS members' options for community based services. In 1996, alternative residential settings were expanded to adult care homes, also as a pilot program. In 1996, the Arizona Legislature established SRLs as permanent, statewide settings available to ALTCS members. In 1998, the Arizona Legislature consolidated the licensure of adult care homes (ACH), adult foster care homes, SRLs, supervisory care homes and unclassified residential care institutions under the single licensure classification of assisted living facilities. On October 31, 1998, when the new assisted living facility license was implemented, ACHs ceased being a pilot program and became a permanent alternative setting available to ALTCS members.

The ALTCS program has expanded alternative residential settings...

Effective October 1, 1999, AHCCCS implemented a three-year Alzheimer's Treatment Assisted Living Facility pilot project in a limited number of facilities. The purpose of the pilot was to determine if a new type of Alzheimer's housing facility that was less restrictive than a nursing facility, could provide cost effective quality care.

By providing a variety of alternative settings with differing levels of care, ALTCS members are able to delay institutionalization or, in some cases, transfer from nursing home care into an HCBS setting. More important than the savings experienced by using HCBS, this alternative to institutionalization provides members with a degree of independence and control not available in an institutional setting.

Institutional Care

ALTCS provides institutional care in either a Medicare/Medicaid approved nursing facility, hospice, ICF/MR, inpatient psychiatric hospital, Level I behavioral health residential treatment center, or a Level I behavioral health sub-acute facility if the member requires the level of care in these facilities.

Chart 3C: Program Contractor Placement Comparison to Statewide Percentages as of September 30, 2005

Setting	Statewide %	CHS	ES	MLTC	MC LTC	PHS	P/G LTC	YLTC
Nursing Facility	36.61%	40.38%	39.33%	40.02%	27.73%	38.79%	35.37%	43.01%
HCBS Community	16.53%	7.15%	22.68%	18.91%	13.11%	16.78%	9.41%	11.36%
HCBS Home	44.47%	51.21%	35.95%	38.86%	55.46%	42.40%	53.86%	43.98%
Acute Services Only	1.26%	.74%	.93%	1.45%	1.67%	1.15%	.80%	.87%
Not placed	1.13%	.53%	1.11%	.75%	2.03%	.88%	.56%	.78%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

NOTE: Report is based on the number of members enrolled with a Program Contractor on the last day of the reporting period. Enrollment does not include members who are ventilator dependent.

SERVICE DELIVERY

Elderly and Physically Disabled

Currently, there are six Program Contractors that serve elderly and physically disabled members. In 2006, AHCCCS will be issuing a Request for Proposals (RFP) for the ALTCS Program. New contracts will be effective in the contract year beginning on October 1, 2006. These ALTCS contracts are awarded using the same GSA system as the acute care program.

Developmentally Disabled (DD)

ALTCS services for persons with developmental disabilities are managed by the Arizona Department of Economic Security/Division of Developmental Disabilities (ADES/DDD) under a capitation arrangement with AHCCCS. Through a non-competitive contract, ADES/DDD, a Managed Care Organization, is required to comply with the same requirements as other Program Contractors. Once enrolled, a DDD member chooses a primary care provider who coordinates the member's care in coordination with the member's case manager. ADES/DDD provides or contracts with individuals and agencies for services and support for members with developmental disabilities. Services are provided to members based on the person's identified needs. ADES/DDD also administers a one hundred percent state-funded program for persons with developmental disabilities who are not eligible for ALTCS.

Tribal Elderly and Physically Disabled

Seven tribal governments have signed intergovernmental agreements for the delivery of long term care case management services under the ALTCS program. The seven tribes are Gila River Indian Community, Hopi Tribe, Navajo Nation, Pascua Yaqui Tribe, San Carlos Apache Tribe, White Mountain Apache Tribe, and Tohono O'Odham Nation. In addition, AHCCCS has a contract with the Native American Community Health Center (NACHC), first signed in April of 1997, to provide case management services to on-reservation tribal ALTCS members whose tribes do not have an agreement with AHCCCS. As of October 1, 2005, there were 1,778 Native Americans receiving case management through a tribal agreement or through NACHC.

Native Americans also have a choice as to how they access their long term care services. Native Americans living on reservations are enrolled with a Tribal Program Contractor or with the Native American Community Health Center (NACHC), a Phoenix-based urban Indian health provider for case management services. Tribal ALTCS programs are paid a monthly case-management capitation rate for each ALTCS member enrolled in their respective programs. These members receive all of their services on a FFS basis.

ALTCS Native American members who live off reservation are managed by an ALTCS Program Contractor that serves the geographic service area where the member resides. IHS and tribal facilities function as the acute care providers for tribal ALTCS members. These members may also receive acute care services from private sector providers on a FFS basis. The ALTCS administration at AHCCCS provides administrative oversight, technical assistance and training for tribal case managers.

CAPITATION

Similar to the acute care program, AHCCCS pays Program Contractors prospectively on a capitated, per member, per month basis. ALTCS capitation rates are blended rates, which include nursing facility costs, HCBS, acute medical care services, behavioral health services, case management services and administrative costs. Beginning October 1, 2005, the weighted average statewide capitation rate paid to Program Contractors for covered services provided to the elderly or physically disabled population is $3,171 per member per month. The weighted average for the DD population beginning July 1, 2005, is $3,004 per member per month. The rates are based on AHCCCS FFS rates, Program Contractor financial statements, service utilization data and historical trends. In a contract year, this information is used to determine the capitation rate ranges; in renewal years, this information is used to adjust rates.

PROGRAM FUNDING

ALTCS is funded by federal, state and county monies as reflected in Appendix IV. Historically, the county contribution was established by the Legislature and the counties paid most of the State share for the ALTCS program. In November 1997, the State Legislature froze the county contributions at SFY 1997/1998 levels and required the State and counties to each pay 50 percent of any increase effective through SFY 2000/2001. In December 2001, the State Legislature created a revised funding model effective with SFY 2001/2002 and forward where increases are funded at a percent determined the Legislature. The State match for the DD population is provided to AHCCCS by ADES/DDD and then deposited into an intergovernmental fund with AHCCCS having sole disbursement authority.

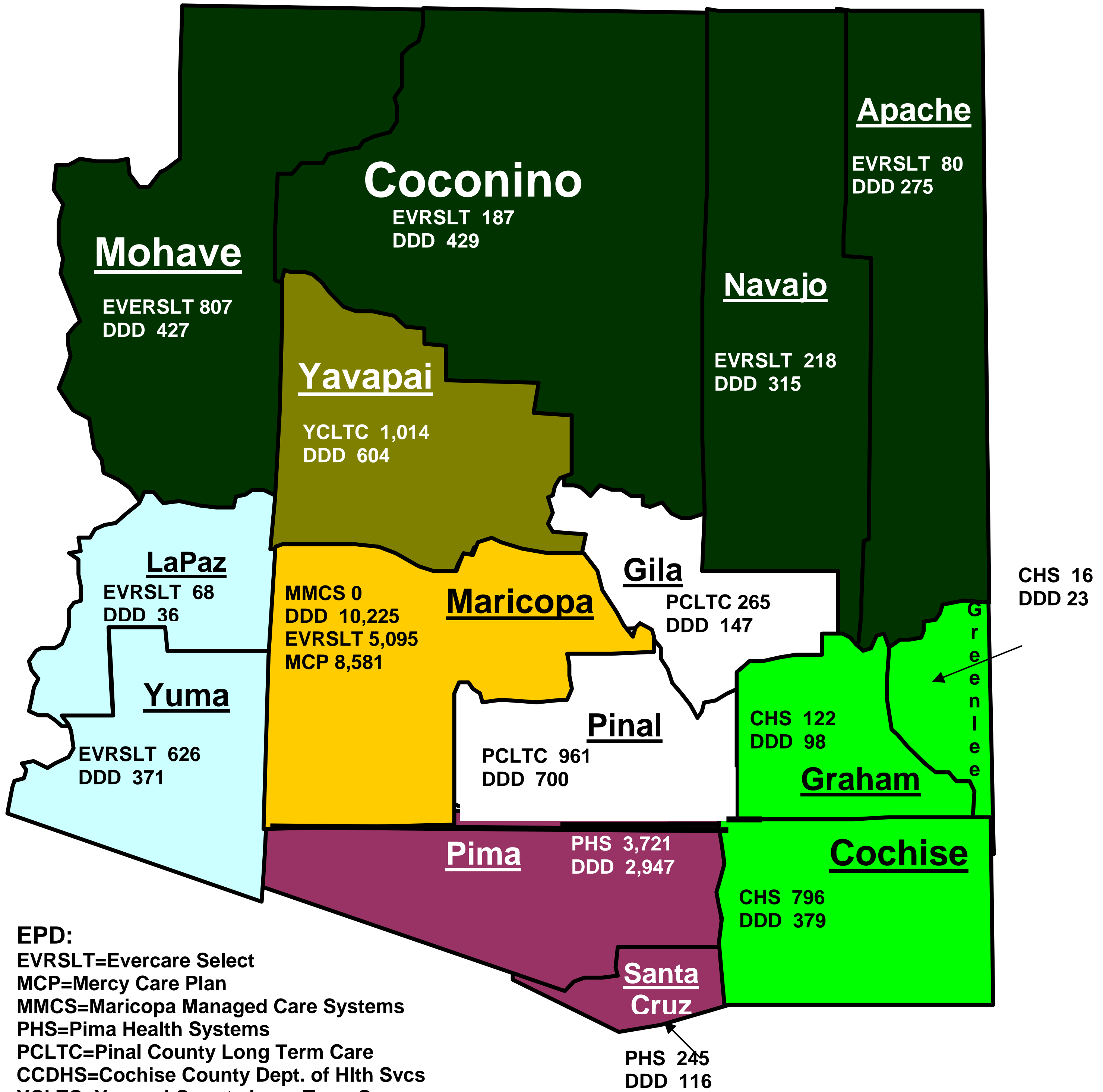
Exhibit 3.1
ALTCS PROGRAM CONTRACTORS
(As of October 1, 2005)

NAME	OWNER/OPERATOR	CORPORATE STRUCTURE	DATE OPERATIONS COMMENCED	COUNTIES OF OPERATION	ENROLL-MENT	SERVICE MODEL
Cochise Health Systems	Cochise County Government	Government Not for profit	11/1/93	Cochise, Graham, Greenlee	934	IPA
Department of Economic Security/Division of Developmental Disabilities	State of Arizona	Government Not for profit	12/19/88	All Counties	17,092	Contracts with AHCCCS Health Plans for acute care services
Evercare Select	Managed Care Solutions, Inc.	Corporation For profit	1/1/89	Apache, Coconino, Maricopa, Mohave, Navajo, Yavapai,Yuma	7,081	IPA
Maricopa Long Term Care Plan	Maricopa County Government	Government Not for profit	1/1/89 Ended Contract 9/30/05	Maricopa	0	Mixed
Mercy Care Plan	Mercy Healthcare Arizona	Corporation Not for profit	10/1/00	Maricopa	8,581	IPA
Pima Long Term Care	Pima County Government	Government Not for profit	1/1/89	Pima, Santa Cruz	3,966	Mixed
Pinal/Gila County Long Term Care	Pinal County Government	Government Not for profit	10/1/90	Pinal, Gila	1,226	IPA
Yavapai County Long Term Care	Yavapai County Government	Government Not for profit	10/1/93	Yavapai	1,014	IPA

Note:

This exhibit shows the program contractor for each county and the ALTCS member enrollment for each contractor as of October 1, 2005.

Exhibit 3.2
ALTCS ENROLLMENT BY COUNTY
As of October 1, 2005



EPD:
EVRSLT=Evercare Select
MCP=Mercy Care Plan
MMCS=Maricopa Managed Care Systems
PHS=Pima Health Systems
PCLTC=Pinal County Long Term Care
CCDHS=Cochise County Dept. of Hlth Svcs
YCLTC=Yavapai County Long Term Care
DDD: Division of Developmental Disabilities/DES
FFS=0
*American Indian Contractors=1,682 (included in total)
DDD-17, 092 EPD=22,805 & **NACH=76
**Native American Community Health Care
Source: ALTCS Enrollment Summary Report **TOTAL 41,655****

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Appendix III

KIDSCARE COVERED SERVICES

KidsCare members are eligible for the same services covered for members under the Acute Title XIX program.

ALTCS SERVICES

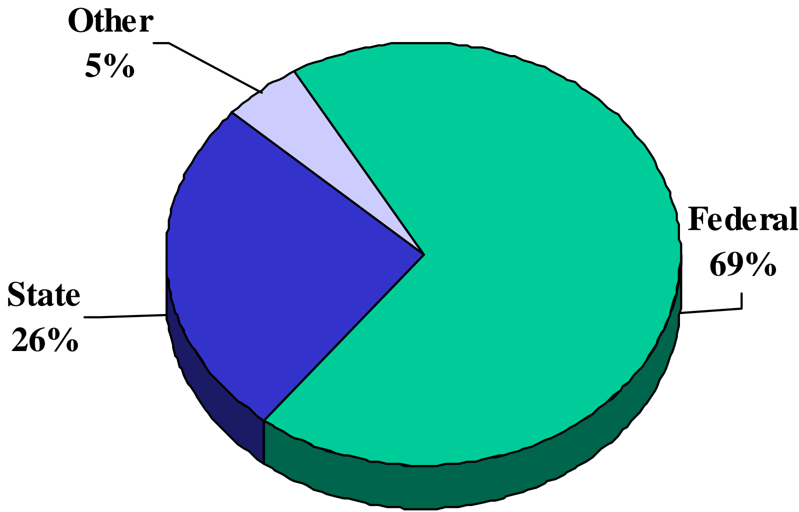
Covered ALTCS services include all the acute care services and the following services:

- Nursing facility services
- Case management
- Speech, physical, occupational, respiratory and audiology therapies
- Services provided in Christian Science Sanitoria
- Hospice
- Adult Day Health (EPD only)
- Intermediate Care Facility for Mentally Retarded (DD only)
- Developmentally Disabled Day Care (DD only)
- Home Delivered Meals (EPD only)
- Home Health Agency services, including intermittent nursing services and home health aid
- Homemaker
- Personal Care
- Respite Care
- Habilitation including Supported Employment
- Group Respite services as an alternative to Adult Day Health (EPD only)
- Attendant care services
- In home private duty nursing services
- Home Modifications
- Emergency Alert System
- Other services, if approved by CMS and the Director of AHCCCS
- Services provided in the following settings:
  - Adult Foster Care Home

APPENDIX IV

Title XIX Expenditures by Funding Source

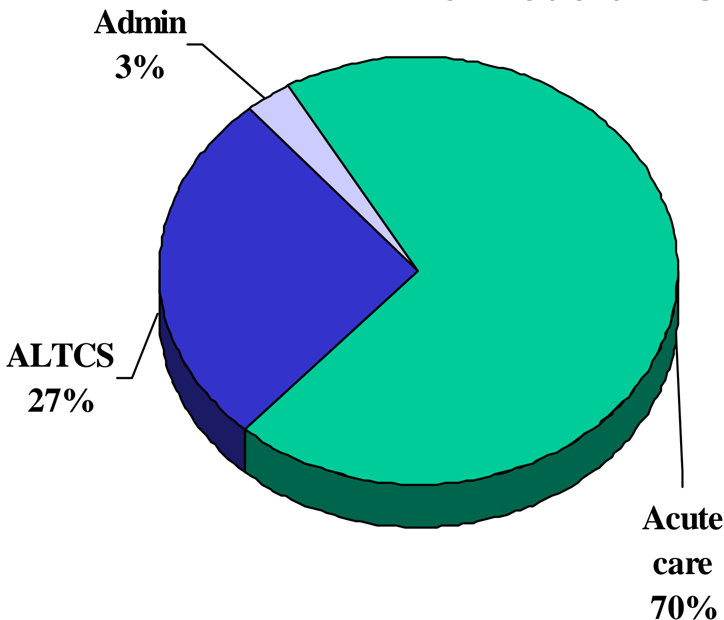
for Federal Fiscal Year 2005



Funding Source	Amount
Federal	$4,057,940,384
State	1,545,828,365
Other	305,604,207
Total	$5,909,372,956

Title XIX Expenditures by Program Type

for Federal Fiscal Year 2005

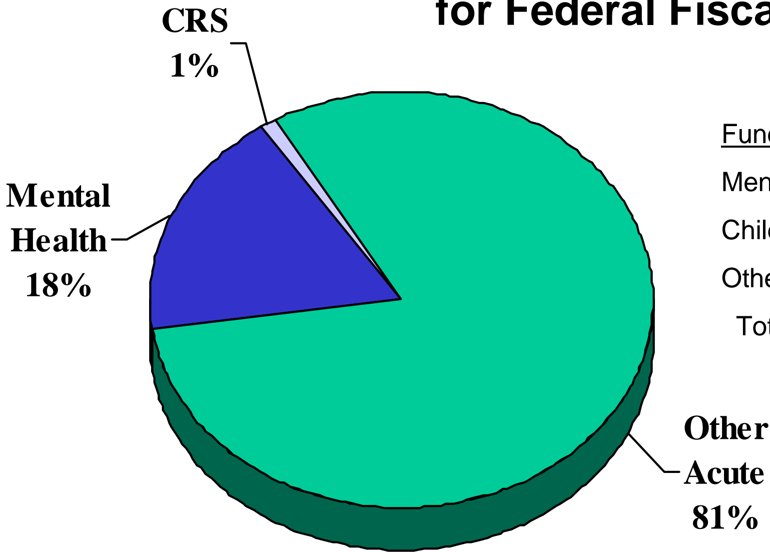


Program Type	Amount
Acute care	$4,140,047,119
ALTCS	1,585,872,443
Administrative	183,453,394
Total	$5,909,372,956

APPENDIX IV

Title XIX Acute Care Expenditures by Type

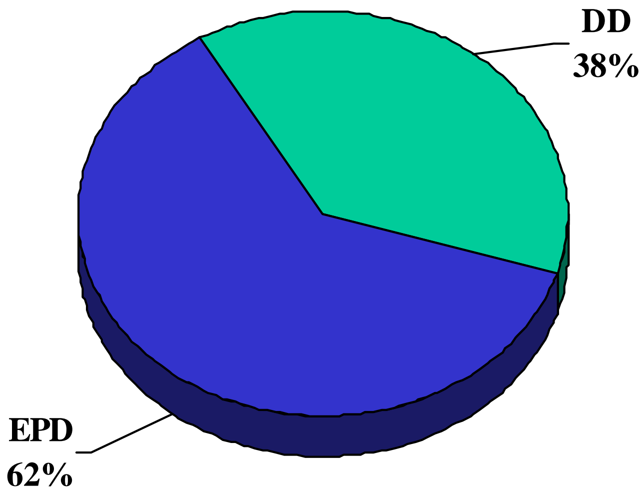
for Federal Fiscal Year 2005



Funding Source	Amount
Mental Health	$736,680,772
Children's Rehabilitative Services (CRS)	47,474,726
Other Acute	3,355,891,621
Total	$4,140,047,119

Title XIX ALTCS Expenditures by Type

for Federal Fiscal Year 2005

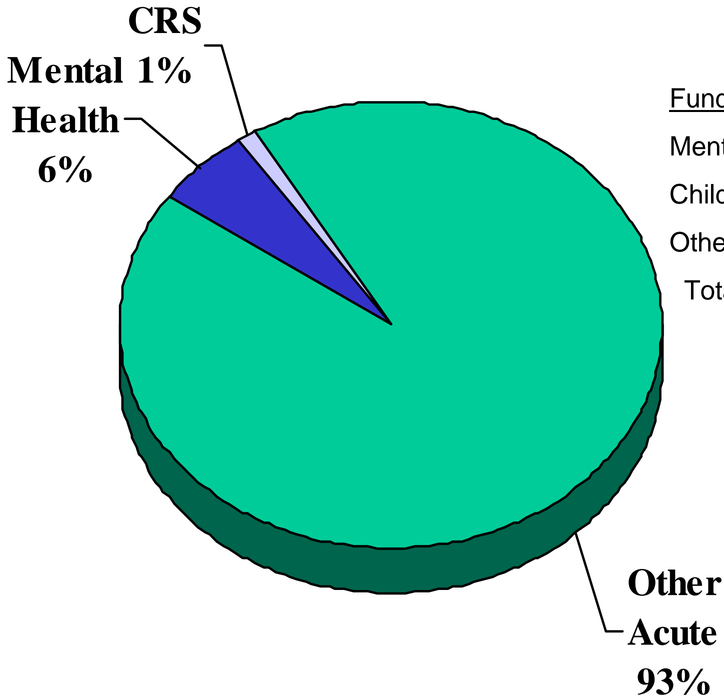


Program Type	Amount
Developmentally Disabled	$604,341,864
Elderly/Physically Disabled	981,530,579
Total	$1,585,872,443

APPENDIX IV

Title XXI Acute Care Expenditures by Type

for Federal Fiscal Year 2005

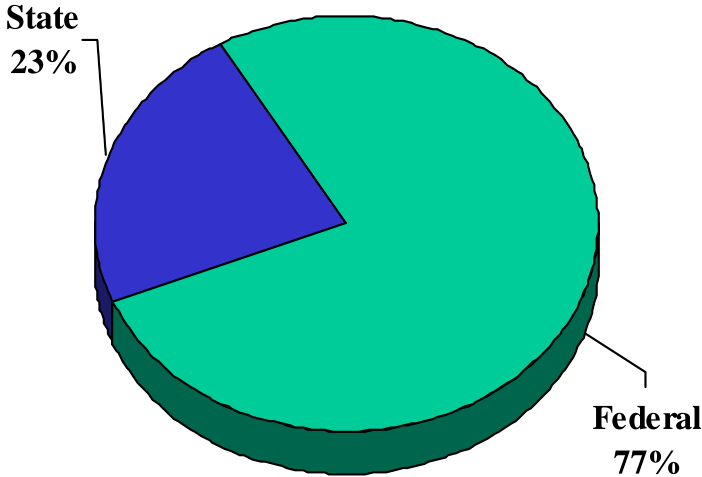


Funding Source	Amount
Mental Health	$14,433,164
Children's Rehabilitative Services (CRS)	3,184,595
Other Acute	238,826,498
Total	$256,444,257

APPENDIX IV

Title XXI Expenditures by Funding Source

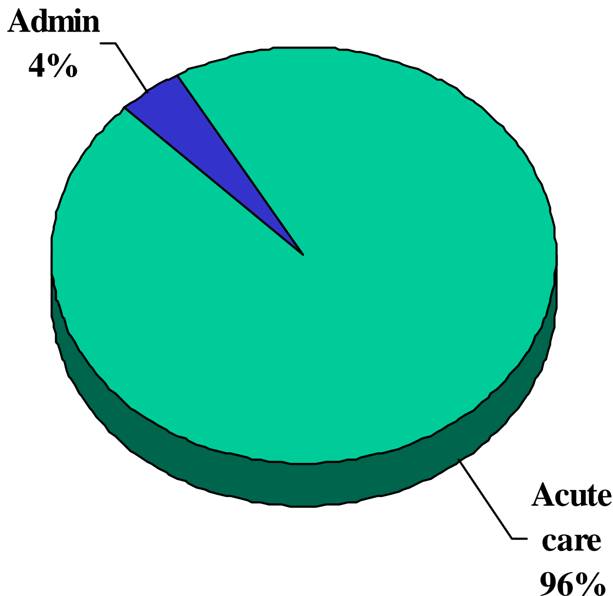
for Federal Fiscal Year 2005



Funding Source	Amount
Federal	$198,024,238
State	58,420,019
Total	$256,444,257

Title XXI Expenditures by Program Type

for Federal Fiscal Year 2005



Program Type	Amount
Acute care	$245,627,157
Administrative	10,817,100
Total	$256,444,257

Appendix IV

MSHO Program Summary

Bulletin 5-26-06

#06-21-05

Bulletin

May 26, 2006

Minnesota Department of Human Services P.O. Box 64941 St. Paul, MN 55164-0941

OF INTEREST TO

- County Directors
- Financial Services Supervisors
- Social Services Supervisors and Staff
- County Public Health Nursing Services
- Waiver managers and case managers
- County managed care staff
- Health Plans

ACTION/DUE DATE

Implement Immediately.

EXPIRATION DATE

The policies in this bulletin are ineffective as of December 31, 2007.

Minnesota Senior Health Options Expansion Update

TOPIC

Update on the Minnesota Senior Health Options program for expansion.

PURPOSE

Update information and replace bulletin number #03-21-02..

CONTACT

Sue Kvendru, Project Coordinator
Minnesota Senior Health Options
Minnesota Department of Human Services
Phone: (651) 431-2517

SIGNED

BRIAN J. OSBERG
Assistant Commissioner
Health Care

Background of MSHO

The Minnesota Senior Health Options (MSHO) is a managed health care program that combines Medicare and Medicaid financing and services for seniors age 65 and over who are eligible for Medical Assistance (MA), with or without Medicare. MSHO offers all medically necessary MA state plan services, all Medicare services including prescription drugs covered by the Medicare Prescription Drug Program (Part D), Elderly Waiver services, and any alternative services the health plan may choose to offer. The health plan also pays for the first 180 days of nursing facility care for enrollees who enter a nursing facility after enrollment. Enrollment into MSHO is voluntary.

MSHO enrollment began in 1997 with three health plans (Medica, Metropolitan Health Plan (MHP) and UCare Minnesota) serving the seven-county Metro area. In 2001, MSHO expanded to Mille Lacs, Sherburne and Wright counties.

In August 2004, the Minnesota Department Human Services (DHS) issued a Request for Proposals to expand MSHO statewide and add additional health plans in anticipation of the Medicare Prescription Drug program. Through this process, MSHO is now available in 83 counties being served by nine MSHO health plans. (See Attachment 1 for map). The MSHO health plans are Blue Plus, First Plan Blue, HealthPartners, Itasca Medical Care(IMCare), Medica, MHP, PrimeWest, South County Health Alliance, and UCare Minnesota.

A key feature of MSHO is the care coordinator (a nurse, nurse practitioner, or social worker), who is the enrollee's contact person for help in navigating the health care system and in getting needed services across all settings of care.

MSHO is a demonstration program operating with special permission from the federal Centers for Medicare and Medicaid Services (CMS), which waived certain Medicare and Medicaid regulations to allow DHS to have special financing arrangements and other policies for the program. MSHO plans are Special Needs Plans (SNPs), which is a special designation from CMS that allows health plans to serve specific populations, in MSHO's case dual eligibles. In addition to a contract with DHS, each MSHO health plan also contracts directly with CMS for all Medicare services including Part D.

Passive Enrollment

In order to facilitate enrollment of Medicaid recipients into Medicare Part D, CMS announced in mid-2005 that Medicare SNPs who were also contractors for Medicaid managed care could submit proposals to CMS to "passively enroll" the dually eligible members of their Medicaid plans into their Medicare SNP plan. This was a one-time option related to the start up for Part D coverage of prescription drugs under Medicare effective January 1, 2006 and only applied to the Medicare SNP plans. All MSHO plans sent CMS proposals and were approved to some extent for passive enrollment. Recipients eligible for passive enrollment were not to be auto-assigned into a national or regional stand-alone prescription drug plan on January 1, 2006. In August

2005, a list of dual eligibles to be passively enrolled was submitted to CMS. In order to be considered for passive enrollment, a recipient had to be on PMAP in August, not be enrolled in a Medicare Advantage or Medicare cost plan and their PMAP plan had to have a corresponding MSHO plan available in their county of residence.

Recipients on the passive enrollment lists were sent letters in early October indicating that they would be automatically enrolled in MSHO but were given the option of opting out. CMS indicated that recipients who chose to opt out of MSHO would be auto-assigned to a stand alone prescription drug plan for January 1, 2006 unless the recipient chose to enroll in a plan on their own.

The purpose of passive enrollment was to ensure as smooth of a transition as possible to drug coverage under Medicare Part D. Passive enrollment allowed enrollees to get Medicare drugs without having to change health plans, pharmacies and formularies. These enrollees were also able to avoid having to deal with CMS's auto-assignment process. Some recipients chose to opt out of passive enrollment for several reasons. Recipients on EW may have wanted to stay with their county case manager or a medical provider may have chosen to not participate with MSHO.

In Minnesota, passive enrollment had a significant impact because most seniors are enrolled in Medicaid managed care and all of the current nine Medicaid managed care plans are also participating in MSHO as Medicare SNPs. Health plans wanted to be able to keep care for their current Medicaid enrollees intact and integrated rather than having them auto-assigned to a separate and perhaps out-of-state entity for Medicare Part D. There are no provisions for Medicaid managed care plans to receive information from or to coordinate with these free standing Part D plans so care management, communications and drug access might be difficult for those who were auto-assigned to separate drug plans.

CMS experienced significant systems problems with the implementation of Part D on January 1, 2006. These systems problems resulted in some recipients experiencing enrollment problems including those who were passively enrolled into MSHO. DHS and MSHO health plans continue to work with CMS to correct enrollment problems related to MSHO enrollment.

Health Plans and Sub-contractors

DHS contracts with the nine MSHO health plans, which subcontract with providers, care systems and counties to provide health care services to MSHO enrollees.

Each MSHO enrollee is matched with a "care coordinator" to assist with care planning and service access. Care coordination and clinical models differ among the health plans and care systems, but must meet basic criteria under DHS's contract with the health plans. Depending on each health plan's care coordination model, some care coordinators work for the clinics, some for the care systems, some for counties and some directly for the health plans.

MSHO Eligibility Criteria

Who is eligible?

Seniors can enroll if they:

- are 65 years of age or older, and
- are MA-eligible, with or without Medicare. If they have Medicare, they must have both Medicare Parts A and B in order to be eligible for MSHO;
- reside in one of the 83 counties where MSHO is available. The only four counties that **do not** have MSHO available are Beltrami, Clearwater, Hubbard, and Lake of the Woods. (See attachment A – MSHO Service Area Map)

Clients who have elected hospice or who have End Stage Renal Disease are eligible to enroll in MSHO.

Clients who are on waiver programs including EW, CADI, TBI and MR/RC are also eligible to enroll. (See section on waiver services for additional information on the provision of services)

Seniors with waiver obligations and institutional spenddowns may also enroll in MSHO.

MSHO does have the authority to enroll persons with Medical spenddowns but DHS currently has a moratorium on the enrollment of persons with Medical spenddowns until further notice. Persons enrolled in MSHO and who had medical spenddowns prior to July 1, 2005 were allowed to stay on MSHO. If an enrollee acquires a medical spenddown after being enrolled in MSHO, the enrollee can choose to stay enrolled in MSHO. **Persons with Medical Spenddown and not currently enrolled in MSHO are not eligible for MSHO enrollment.**

Excluded Populations

The following recipients are currently **excluded** from participation in the MSHO program:

- Individuals who have Medicare but are not eligible for MA
- Individuals who have MA but have either Medicare Part A or Part B but not both
- Recipients eligible for the Refugee Assistance Program
- Residents of State Regional Treatment Centers, unless the health plan approves placement
- Individuals who are Qualified Medicare Beneficiaries (QMB), as defined in 42 CFR Part 400.202 and who are not otherwise eligible for MA
- Individuals who are Specified Low-Income Medicare Beneficiaries (SLMB), as defined in United States Code, Title 42, section 1396 a(a)(10)(E)(iii) and who are not otherwise eligible for MA
- Individuals who have Medicare coverage through United Mine Workers

As noted above, persons with medical spenddowns prior to MSHO enrollment are not currently enrolled into MSHO.

Questions about MSHO Eligibility

If counties have any questions about whether a client is eligible to enroll in MSHO, they should contact their county managed care unit or the DHS enrollment coordinator assigned to their county. See Attachment B for enrollment coordinator assignments.

Enrollment Process

Enrollment into MSHO is voluntary and may occur through the county or through MSHO health plans and care systems. MSHO enrollments through the county are primarily for clients who have just become eligible for Medicaid, while the health plans and care systems normally handle enrollments for clients already enrolled in managed care (PMAP now also called Minnesota Senior Care (MSC)/Minnesota Senior Care + (MSC+)for seniors). The enrollment process varies somewhat depending on which entity is processing the enrollment.

Enrollment via Health Plans or Care Systems

The health plans and care systems process most MSHO enrollments. The state's MSHO contract allows MSHO health plans to market to any managed care enrollee, including managed care enrollees in other health plans. Care systems, however, may market only to those enrollees already enrolled in the PMAP or MSHO product of the care system's health plan partner. Care system involvement in enrollments is usually for clients in nursing facilities. Health plan and care system marketing activities must follow Medicare and Medicaid marketing regulations, and all marketing materials are reviewed and approved in advance by DHS and CMS. Health plans and care systems use health plan-specific enrollment forms based on a model developed by DHS and approved by CMS. The health plan/care system is required to review and verify the information on the enrollment form including verifying Medicare eligibilty before faxing the enrollment form to DHS. The health plan retains the original form for its records.

Starting in June 2006, health plans will be able to enter enrollments into a batch file that will update MMIS. Training will be provided to health plans choosing this option. All other changes to enrollment and disenrollments will continue to be submitted to DHS for keying.

When filling out the MSHO enrollment form, clients (or their authorized representatives) are required to initial statements to demonstrate that they are making an informed choice about their health care coverage. For example, the current MSHO enrollment form states that clients understand that if they are enrolled in another Medicare health plan, they will be disenrolled from that health plan when they enroll in MSHO. Another statement indicates that enrollees may no longer have a county case manager for home- and community-based services when they enroll in MSHO unless the MSHO health plan contracts with the county for care coordination.

Enrollment via Counties

The county human services agency/managed care unit mails information about managed care options to clients who have just been determined as MA-eligible. Recipients may also choose to attend a presentation on managed care options held by county managed care personnel. Recipients receive each health plan's Primary Care Network Listing (PCNL), a document

describing the health plan's network (hospitals, clinics, etc). DHS-4106B is available for counties to include in enrollment packets to explain MSHO to potential enrollees.

In the county enrollment process, the MSHO enrollment form is similar to the PMAP form, which is provided by the State. MA recipients (or their authorized representative) indicate their choice of health plan either in person or by mail by completing and signing a Health Plan Enrollment Form. If the client wants to enroll in that health plan's MSHO plan, they must check the MSHO statement indicating that is their choice. Recipients may complete the forms on site at the county managed care unit or mail the forms to the county within 30 days. For clients selecting MSHO, the county must fax the enrollment form to the State. The county retains the original copy.

Unlike PMAP enrollments and disenrollments which county staff enter in the Medicaid Management Information System (MMIS), MSHO enrollments and disenrollments received from the counties are entered in MMIS by DHS staff only. This arrangement is due to the need for handling by staff familiar with MSHO's unique Medicare marketing and enrollment procedures.

After receiving an MSHO enrollment form from the county, MSHO staff at DHS (1) review forms for completeness and for enrollee or authorized representative signature (2) verify MSHO eligibility criteria using MMIS (for MA eligibility) and CMS systems for Medicare eligibility. Following this verification process, MSHO staff enters MSHO enrollment into MMIS.

Enrollee Notification of Enrollment

For all MA managed care programs including MSHO, after enrollment into a specific health plan/product is entered in MMIS, the system produces a notice to recipients confirming their enrollment in a specific health plan and the enrollment effective date. New MSHO enrollees also receive a membership packet from the MSHO health plan within 15 calendar days after the health plan receives readable enrollment data from the State.

Effective Date of Enrollment - Enrollment Guidelines

Medicaid managed care enrollment, including MSHO, occurs on a monthly basis. The effective coverage date for MSHO enrollees is as follows:

- When enrollment occurs and has been entered on the State MMIS System on or before the cut-off date, coverage will begin at midnight on the first day of the month following the month of enrollment
- When enrollment occurs and has been entered on the State MMIS System after the cut-off date, coverage will begin at midnight on the first day of the second month following the month in which the recipient enrolls in the health plan
- For MSHO enrollees who are hospitalized in an acute care facility on the first effective date of coverage, hospital costs for the stay begun before enrollment shall not be the responsibility of the health plan

Disenrolling from MSHO – Effect on PMAP enrollment

Enrollment in MSHO is voluntary, and MSHO enrollees may disenroll on a monthly basis. MSHO enrollees may also change to another MSHO plan on a monthly basis. Enrollees who choose to disenroll from MSHO altogether are automatically enrolled in the PMAP product offered by the health plan with which they were enrolled in MSHO. Or, if they were enrolled in another health plan's PMAP product immediately before enrolling in MSHO, they may request that they be enrolled in that health plan's PMAP product upon disenrolling from MSHO. Enrollees are not permitted to choose any other health plan for Medicaid services unless they meet PMAP change guidelines (See Prepaid Minnesota Health Plan Programs Manual, Chapter 3). As noted below, if the enrollee is exercising the one-time change option within the first year of Medicaid managed care enrollment or it is open enrollment, the enrollee may move to any health plan's PMAP product. Additionally, enrollees who meet a PMAP exclusions such as medical spenddowns are disenrolled to MA fee-for-service. SIS-EW/SPMI/licensed HMO voluntary exclusions may apply along with medical spenddowns

The enrollee must request the disenrollment in writing. The enrollee does not need to provide a reason for the request or use a special form. The written request must be signed by the enrollee or authorized representative.

Disenrollment from MSHO is processed according to the following guidelines:

- When disenrollment occurs and is entered in MMIS on or before the enrollment cut-off date, coverage ends at midnight on the first day of the month following the month of disenrollment.
- When disenrollment occurs and has been entered in MMIS after the enrollment cut-off date, coverage ends at midnight on the first day of the second month following the month on disenrollment.
- If an enrollee is terminated due to ineligibility for MA, and the enrollee is hospitalized in an acute care facility on the effective date of ineligibility, coverage will end at midnight on the first day following discharge from the hospital.
- MSHO enrollees may not be disenrolled involuntarily unless they become ineligible for Medical Assistance or their county of residence is no longer in the MSHO service area.

Effect of MSHO Enrollee Enrolling in a Different Part D/Medicare Plan

If an MSHO enrollee voluntarily chooses to enroll into a different health plan for Medicare coverage including a different MSHO health plan, they will be automatically disenrolled from their current MSHO health plan on CMS's system. DHS will disenroll recipients on MMIS to match CMS's system when recipients select a different Medicare plan including a different MSHO health plan.

Effect of MSHO Disenrollment on Medicare Part D Coverage

For those MSHO enrollees with Medicare, MSHO is providing their Medicare Part D Prescription Drug coverage. If voluntarily disenrolling from MSHO, the client must choose another Part D plan in order to have coverage for Medicare Part D prescription drugs. If the client does not choose a Medicare Part D plan, CMS may auto-assign them to a Part D plan. CMS's process for auto-assigning may result in delay or gaps in prescription drug coverage. Any clients disenrolling from one Part D plan including MSHO, is encouraged to actively chose another Part D plan in order to prevent a delay or gap in coverage. Clients disenrolling from MSHO can find additional information on Medicare Part D plans at http://www.medicare.gov or call 1-800-Medicare (1-800-633-4227). In Minnesota, the Linkage Line is available to assist persons in enrolling in Part D plans at 1-800-333-2433.

Loss of Medical Assistance Eligibility

For Special Needs Plans, CMS requires that elderly recipients who lose eligibility under the Medicaid (MA) program continue to receive Medicare benefits including Medicare Part D covered drugs for 30 days to 6 months. The time period is chosen by the SNP. All MSHO health plans have chosen to continue Medicare benefits through their Special Needs Plan for up to 3 months after MA eligibility ended. MMIS will show the person disenrolled from MSHO but the enrollee will have Medicare coverage on the CMS system for up to three months or until the enrollee chooses a new Part D plan. If the enrollee's Medicaid eligibility is reinstated, MMIS will reflect MSHO once again. See re-enrollment below. For this reason, providers are encouraged to use CMS's system of coverage verification for Medicare and Part D benefits. EVS and MN-ITS may show MSHO as closed for MA benefits, while CMS's system would show the enrollee active for Medicare benefits.

Notification to Counties of MSHO Enrollment

Several InfoPac reports are available for counties to review.

PWMW185L-R0504 PPHP Current Enrollment Report for Worker
PWMW1850-R0506 PPHP Potential Enrollee Report
PWMW185I-R0507 MSHO and MnDHO New Enrollee Report
PWMW 186D-R0510 Pre-Capitation Error/Recipient Capitation Error
PWMW185J-R0535 PPHP County Elderly Disenrollment Report

Breaks in MSHO Enrollment

Reinstatement

A client whose termination from the MSHO health plan has been entered into MMIS by the monthly cut-off date may be reinstated for the following month with no lapse in coverage if the client re-establishes MA eligibility and the eligibility is entered into MMIS by the last business day of the month.

When reinstating MSHO enrollees, county workers should simply update the RELG screen in MMIS, save (PF9), and exit. This will automatically update the MSHO enrollment span on RPPH. Counties cannot update MSHO enrollment spans directly on RPPH. Counties should contact their DHS enrollment coordinator if there are problems with reinstating MSHO enrollees.

Re-enrollment

Clients who experience a break in their MA eligibility for up to 90 days because of delays in submitting and processing their eligibility re-certification may be re-enrolled in the MSHO health plan they were previously enrolled in without completing a new enrollment form. If the break in eligibility is for longer than 90 days, then the client must fill out a new enrollment form.

DHS staff monitor a report of MSHO enrollees who have lost MA eligibility. If MA is reopended within 90 days, DHS enrollment staff will re-enroll the client back to the date MSHO was closed so no break in MSHO eligibility exists. DHS notifies the MSHO health plan to open the client up on the health plan's system. If fee-for-service claims including Elderly Waiver (EW) services were paid prior to the MSHO adjustment, DHS will recover claims paid to providers. Providers must rebill the MSHO health plan.

Collection of Waiver Obligations, Medical Spenddowns and Institutional Spenddowns

Waiver Obligations

MA-eligible seniors who have services provided through the EW and have waiver obligations can enroll in MSHO. Prior to June 2005, clients enrolled in MSHO were required to pay their full obligation directly to DHS on a monthly basis. This limited MSHO enrollment to only those clients who met their full waiver obligation on a monthly basis.

The process for the collection of waiver obligations is now a similar process used by DHS for fee-for-service claims. MSHO enrollees with waiver obligations are required to pay their waiver obligations to their providers and the waiver obligation cannot exceed the cost of waiver services received that month. Providers will bill the MSHO health plan for EW covered services. MSHO health plans pay the provider after deducting the waiver obligation. Enrollees cannot be involuntarily disenrolled for non-payment of their waiver obligation. Health plans may assist enrollees in designating providers to receive the waiver obligation in the health plans' payment system.

Medical Spenddowns

Clients who were on MSHO prior to July 2005 with automated monthly medical (AMM) spenddowns or who acquire automated monthly medical (AMM) spenddowns after being enrolled into MSHO may continue enrollment in MSHO. MSHO clients with medical spenddowns are required to pay the full amount of their spenddown to DHS each month.

Therefore, MSHO clients with medical spenddowns should stay enrolled in MSHO only if their monthly MA-covered medical expenses are routinely more than the amount of their medical spenddown. While enrolled in MSHO, these clients are required to pay their full spenddown directly to DHS on a monthly basis. DHS's Special Recovery Unit bills these spenddowns to the client on a monthly basis.

Institutional Spenddowns

See "MSHO Nursing Facility Policies" on page 12.

Provision of Waiver Services and Screenings

Elderly Waiver (EW)

Recipients eligible for EW receive waiver services from the MSHO health plan. Providers providing EW services to MSHO enrollees must bill the MSHO health plan for payment. The MSHO health plan is responsible for entry of screenings into MMIS to open and close EW waiver spans as required by EW policy. The manual that contains instructions for completing and entering LTCC screening documents into MMIS is found on the DHS website at http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4669-ENG
The health plan may sub-contract with clinics, care systems or counties for this function. Attachment C – LTC Functions Under County and MSHO Management outlines screening processes.

CADI, MR/RC and TBI

Recipients age 65 and older and meet other MSHO eligibility criteria and are eligible for CADI, MR/RC, and TBI waivers may enroll into MSHO. These recipients will continue to receive their waiver services through fee-for-service and will continue to be managed by the county. Providers will continue to bill DHS for payment of CADI, MR/RC and TBI services. All other services including state plan home care services must continue to be billed through the MSHO health plan. Counties continue to enter required waiver screens for these waiver clients. MSHO health plans do not enter screens into MMIS for MSHO enrollees on the CADI, MR/RC and TBI waivers. The county waiver case manager and the MSHO care coordinator work together to coordinate services for MSHO enrollees on these three waivers.

Telephone Screens

MSHO health plans are responsible for conducting and entering telephone screens for their enrollees according to bulletins issued by DHS. These are listed on Attachment D. Counties do not conduct or enter telephone screens for MSHO enrollees unless the county is acting as a subcontractor of an MSHO health plan. Attachment C outlines LTC screening policy including MSHO.

DHS as Third Party Administrator for EW

Three MSHO health plans, Blue Plus, South Country Health Alliance and UCare Minnesota have contracted with DHS to be their third party administrator (TPA) for payment of EW services in some counties. Health plans may contract with counties for the entry of service

agreements into MMIS for these services. Providers may be instructed by these health plans to continue to bill DHS for EW services provided to MSHO enrollees. See Provider Update MCO-05-01. Questions regarding billing of EW services for MSHO enrollees should be directed to the MSHO health plan.

Tribal EW
DHS has a contract in place with White Earth that allows for tribal management of EW services. MSHO enrollees who live on the White Earth reservation can choose to have their EW managed by the tribe. If the enrollee chooses this option, the MSHO enrollee will have two case managers: one from the tribe for EW services and one through the MSHO health plan to coordinate all other medical services.

Transitions
If an enrollee chooses MSHO and is currently on EW, the county should contact the MSHO health plan to transition the provision of services to the health plan. If an MSHO enrollee is on EW and chooses to disenroll from MSHO, the MSHO care coordinator should contact the county to transition the provision of services to the county. In neither case should the EW span be closed on MMIS. The county or the health plan who is receiving the new enrollee may choose to do a reassessment at the time of transition but a screening document would not be due until the reassessment date in MMIS. The county should enter service agreements into MMIS based on the services identified by the health plan and the needs indicated on the screening document.

MSHO Eligibility for the Elderly Waiver Maintenance Needs Allowance

RPPR and RWVR Screens on MMIS

In the past, MSHO enollees eligible for EW did not have open waivers spans. Since June 2005, MSHO enrollees eligible for Elderly Waiver services also have open waiver spans on the RWVR screen in MMIS. **EW spans on RWVR for clients who transition from receiving EW services through the county to receiving them through the MSHO health plan should remain open.** When clients receiving EW services through MSHO disenroll from MSHO, the EW span will also remain open.

1. In MMIS
- Verify enrollment in MSHO, Product ID “MA02” on RPPH
- Verify enrollee has an open waiver on RWVR.

2. In MAXIS:

On STAT/DISA:
- For “Elderly Waiver Begin Dt”, use waiver begin date.
- For “Health Care Disability Status,” use “23” {MA Waiver}
- For “Ver” (Verification), use “8” {LTC Consult Services}
- Enter “Home and Community Based Waiver” type K (diversion)

In HC ELIG: Set up the budget (SIS-EW Budget or SBUD) and waiver obligation (Elderly Waiver or "EWWO") on MAXIS per usual procedures

3. In MMIS:

- On RELG, a "Y" should be coded for the spenddown indicator
- On RSPD, enter a waiver obligation using A – W – M (automated, waiver obligation, monthly) and enter the Waiver Obligation in appropriate field

Worker Messages
If an MSHO enrollee has an RCC-B but the SIS-EW has not been applied, the following worker message is generated: "MSHO WITH EW WVR ELIG EXISTS, BUT SPDN METHOD IS NOT W"

MMIS Edits Related to MSHO, RSPD and Eligibility for SIS-EW

When an MSHO enrollee's rate cell category changes, and the client is no longer eligible for EW, the following warning edit appears in MMIS.

EDIT: WARNING: CHANGE IN WAIVER OBLIGATION ELIG, CONTACT COUNTY CASE MGR

In these cases, DHS notifies the financial worker of change in waiver eligibility

If a financial worker tries to set up a waiver obligation for an MSHO enrollee who is not eligible for SIS-EW, they will get the following edit:

EDIT: MSHO RECIPIENT DOES NOT HAVE ELDERLY WAIVER ELIGIBILITY

Designated Providers for MSHO enrollees

Because MSHO health plans pay for EW services, designated providers should not be set up in MMIS during MSHO enrollment periods. The MSHO enrollee should be referred to their MSHO health plan to see if a designated provider can be set up in the health plan's claims payment system.

If an MSHO care coordinator exits an MSHO enrollee from EW, the MSHO care coordinator is instructed to contact the county financial worker to report this change.

MSHO Nursing Facility Policies

1503 Form

Medicaid-certified nursing facilities are required to send DHS Form 1503 to county financial workers whenever any MA-eligible client is admitted to the facility. Form 1503 serves as

notification to the county that the enrollee has been institutionalized for a short or long-term stay. The county financial worker uses this information to adjust the client's eligibility for MA and calculates institutional spenddowns as needed. This information is also used by CMS to set the Medicare Part D co-pay levels for dually eligible institutional enrollees so it is very important that this information is reported and updated as soon as possible.

County financial workers need to update MAXIS/MMIS with nursing facility admissions information regardless of whether a health plan may be responsible for some of the days. MMIS will track responsibility for payment.

Collection of Institutional Spenddowns During Health Plan Liability

For MSHO enrollees with institutional spenddowns, the Nursing Facility (NF) collects the institutional spenddown (also known as "recipient resource") from the enrollee just as it does for other Medicaid recipients. In cases where the MSHO health plan has responsibility for the 180-day nursing facility benefit, nursing facilities bill the full charges for 180 days of Medicare skilled nursing facility and Medicaid room and board days directly to the health plan, and the health plan pays 100 percent of the negotiated rate. During the months when the plan is responsible for NF services, DHS deducts the institutional spenddown amount from the payment it sends the NF.

Example:
For a NF placement for 30 days at a daily charge of $100/day:

Health Plan payment to NF:	$3,000
NF collects recipient resource:	+$ 200
Total NF receipts - preliminary:	$3,200
DHS debits recipient resource on the Remittance Advice (RA):	- $200
Total NF receipts - final:	$3,000

If, for a given month, the total MA-covered room and board charges incurred for an enrollee is less than the amount of the enrollee's institutional spenddown that was deducted for that month by DHS (including cases where no MA-covered room and board charges were incurred), the NF should contact DHS to arrange for an adjustment.

MSHO, MnDHO, PMAP and Hospice

The hospice policy for MSHO is similar to the policy for other Minnesota Health Care Programs (MHCP) managed care products such as PMAP and MnDHO. MSHO enrollees who elect hospice do not need to disenroll from MSHO. Policies regarding EW and hospice services apply for MSHO as they do for FFS. When an MSHO enrollee elects hospice and resides in a nursing facility, DHS pays room and board directly to the hospice provider, which, in turn, pays the NF. This is true even if the health plan has liability for NF services. If the NF has already collected the institutional spenddown, then the hospice reduces its payment to the NF for room and board by that amount.

During hospice election periods, the hospice and the NF negotiate the payment the hospice makes to the NF for the room and board. Regardless of what the hospice agrees to pay the NF, DHS pays the hospice provider 95% of what MA would have paid the NF if the person had not elected hospice.

See Poli/Temp TE02.07.081 for updating MMIS spenddown information for hospice cases.

180-day Nursing Facility Benefit

If an enrollee who resided in the community at the time of enrollment in MSHO enters a NF sometime after enrollment, the health plan is financially responsible for NF services for the first 180 days. The 180-day period begins at the time of the Enrollee's date of admission to a Skilled Nursing Facility (SNF) or Nursing Facility (NF). Both MA- and Medicare-covered days are counted toward the 180-day benefit period. The 180 days are counted cumulatively. After the 180 days, the NF services are paid by MA on a fee-for-service basis. Nursing facility days during hospice do not count toward the health plan's 180-day obligation.

Transition from PMAP to MSHO

Upon the transition from PMAP to MSHO, the PMAP health plan liability for recipients already in a 90-day NF stay is cancelled and payment responsibility reverts to fee-for-service through DHS on the first of the month of MSHO enrollment.

Appeals and Grievances

Enrollees in the MSHO program have the same appeal and complaint rights as enrollees in other Medicaid managed care programs with the exception of Medicare Part D covered prescription drugs for which CMS requires a different process. For all other covered services, enrollee's have the right to file complaints with their health plan, to contact the State Managed Care Ombudsman's Office, and to file an appeal with the state. MSHO enrollees who have Medicare also have an additional right to file an appeal with a federal administrative law judge if the issue involved is solely a Medicare issue and the enrollee has gone through the state's appeal process. For information on the appeals and grievance process for Medicare Part D covered prescription drugs, enrollees should review their Certificate of Coverage provided by their MSHO health plan or contact their MSHO health plan directly.

Website

For more information about MSHO, check out the website:
http://www.dhs.state.mn.us/healthcare/msho

Legal References

Section 402(a)(1) of the Social Security Act, Public Law No. 90-248, also United States Code 1395b-1, as amended by Section 222(b)(1), Public Law 92-603(42 United States Code, 1395b-1).

Medicaid State Plan Option, Section 1915(a), Social Security Act

Minnesota Statutes, section 256B.69, subdivision 23.

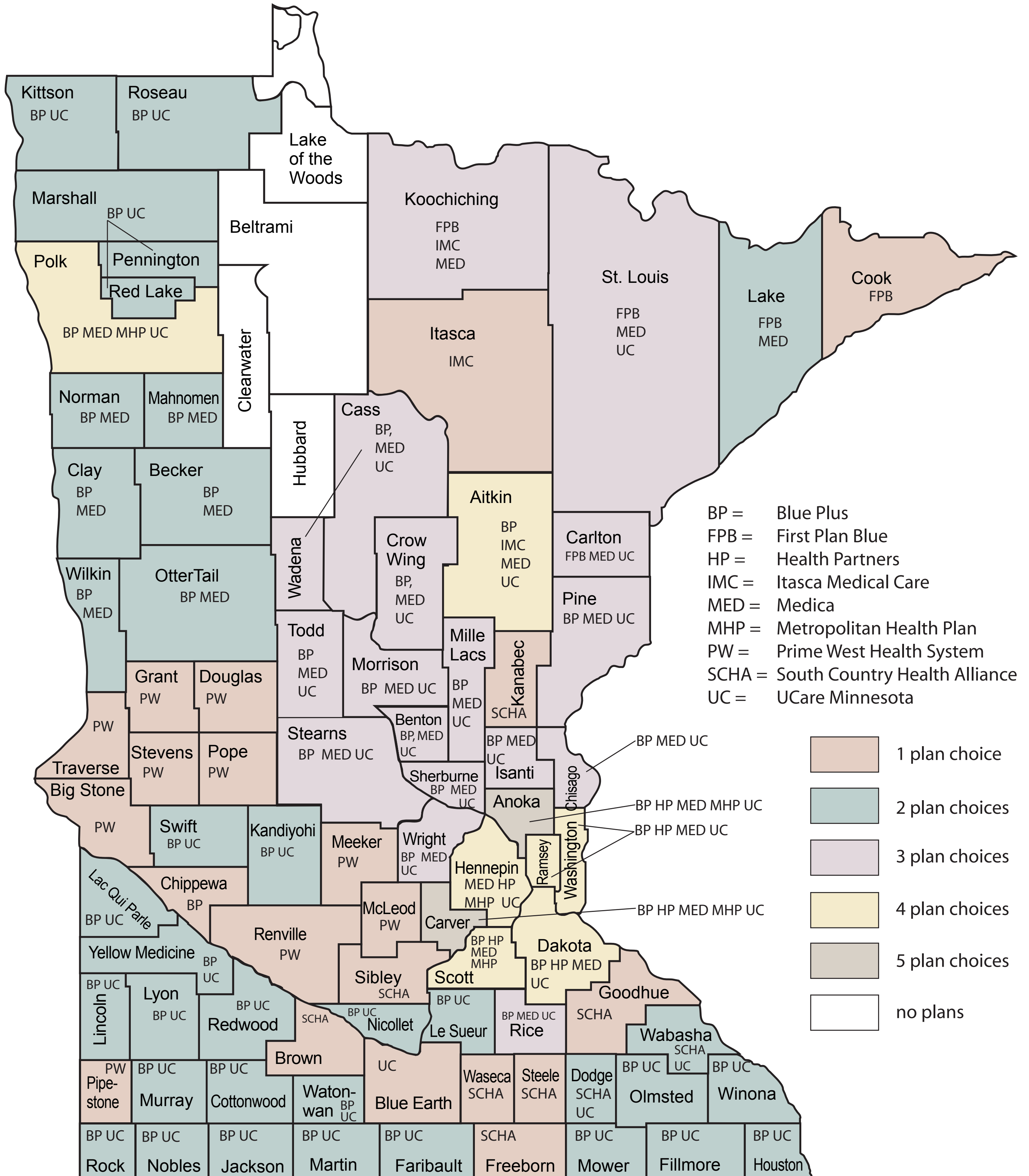
Attachments

Attachment A – MSHO Service Area Map
Attachment B – DHS enrollment coordinators contact list
Attachment C – LTC Functions Under County and MSHO Management
Attachment D – List of Elderly Waiver Instructional Bulletin and Resources.

Special Needs
This information is available in other forms to people with disabilities by contacting us at 651-431-2478 (voice) or through the Minnesota Relay Service at 1-800-627-3529 (TDD), 7-1-1 or 1-877-627-3848 (speech to speech relay service).

Health Plan Service Areas for Minnesota Senior Health Options (MSHO)

effective January 1, 2006



Minnesota Department of Human Services

www.dhs.state.mn.us/msho/

SERVICE IMPLEMENTATION SECTION
Jeanine Heller, Supervisor (651) 431-2513
Chris Gibson, Lead (651) 431-2529

11/21/2005

PMAP Maintenance Enrollment Coordinators

Jo Ann Jones (651) 431-2524 Maxis email HXC Back-up: Mary	Susan Kennedy (651) 431-2528 Maxis email HJS Back-up: Rotates	Shelly Nelson (651) 431-2542 Maxis email JVG Back-up: Carla	Mary Timm (651) 431-2527 Maxis email WI Back-up:Jo Ann
Anoka (02)	Aitkin (01)	Blue Earth (07)	Becker (03)
Big Stone (06)	Carver (10)	Brown (08)	Cass (11)
Chippewa (12)	Chisago (13)	Cottonwood (17)	Clay (14)
Dakota (19)	Isanti (30)	Dodge (20)	Crow Wing (18)
Douglas (21)	Le Sueur (40)	Faribault (22)	Hennepin (27)
Grant (26)	Mille Lacs (48)	Fillmore (23)	Kittson (35)
Kandiyohi (34)	Nicollet (52)	Freeborn (24)	Mahnomen (44)
LacQuiParle (37)	Pine (58)	Goodhue (25)	Marshall (45)
Lincoln (41)	Rice (66)	Houston (28)	Morrison (49)
Lyon (42)	Scott (70)	Jackson (32)	Norman (54)
McLeod (43)	Sherburne (71)	Kanabec (33)	Otter Tail (56)
Meeker (47)		Martin (46)	Pennington (57)
Murray (51)		Mower (50)	Polk (60)
Nobles (53)		Olmsted (55)	Red Lake (63)
Pipestone (59)		Redwood (64)	Roseau (68)
Pope (61)		Sibley (72)	Todd (77)
Renville (65)		Steele (74)	Wadena (80)
Rock (67)		Wabasha (79)	Wilkin (84)
Stearns (73)		Waseca (81)	
Stevens (75)		Washington (82)	
Swift (76)		Watonwan (83)	
Traverse (78)		Winona (85)	
Yellow Medicine (87)		Wright (86)	

Health Plan Enrollment Coordinators

Jo Ann Jones	Susan Kennedy	Shelly Nelson	Mary Timm
PrimeWest Health System	HealthPartners	South Country Health Alliance	Medica
UCare Minnesota	Metropolitan Health Plan		

Addresses

Physical:
Elmer L. Anderson Human Services Building
540 Cedar Street
St. Paul, MN 55155

Mailing:
Department of Human Se
PO Box 64984
St. Paul, MN 55164-098

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11/21/2005

Other Initiatives

	POLICY
Chris Gibson	MAXIS e-mail - HGX
	Appeals - All Programs
Mary Timm	MAXIS e-mail - WI
	PMAP/CBP Expansion and Education Materials
Jo Ann Jones	MAXIS e-mail - HXC
	All MANUALS
Chris Gibson	MAXIS e-mail - HGX
	MinnesotaCare
Carla Turnbom	MAXIS e-mail - CA
	MSHO/MnDHO
Susan Kennedy	MAXIS e-mail - HJS
Chris Gibson (backup)	MAXIS e-mail - HGX
	NF Liability
Shelly Nelson	MAXIS e-mail - JVG
	Open Enrollment
Mary Timm	MAXIS e-mail - WI

Adjustments: Send requests on MAXIS to 'MADJ'
FAX NUMBERS: Managed Care 651/431-7426 MSHO Only 651/431-7426

Contracting

Health Plan	Contract Manager
Blue Plus	Doris Wong
First Plan	Pam Olson
HealthPartners	Doris Wong
Itasca Medical Care	Mary Freeberg
Medica	Deb Bachrach
Metropolitan Health Plan	Lill Tallaksen
PrimeWest Health System	Lill Tallaksen
South Country Health Alliance	Mary Freeberg
UCare Minnesota	Nancy Paulsen

11/21/2005

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Carla Turnbom (651) 431-2525 Maxis email CA Back-up: Shelly
Benton (05)
Carlton (09)
Cook (16)
Itasca (31)
Koochiching (36)
Lake (38)
Ramsey (62)
St. Louis (69)
Mille Lacs Tribal TANF (88)
MinnesotaCare (MCR)

Carla Turnbom
Blue Plus
First Plan Blue
Itasca Medical Care

ervices

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11/21/2005

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(651) 431-2542
(651) 431-2527

Phone Number
(651) 431-2519
(651) 431-2526
(651) 431-2519
(651) 431-2521
(651) 431-2518
(651) 431-2522
(651) 431-2522
(651) 431-2521
(651) 431-2520

- Long Term Care Functions: Preadmission Screening (PAS) Under LTCC and Minnesota Senior Health Options **Attachment C**

Purpose of PAS Service	People Served	Who Provides the Service	Statutory Timelines & Process Requirements	Forms Used
Preadmission Screening (PAS) ▪ Determine need for NF level of care ▪ Screen for mental illness or mental retardation ▪ Ensure specialized services are provided in the NF for people with MI or MR who are admitted Under state provisions: ▪ Required interventions to avoid . is required for all persons age 20 and under before admission to a nursing facility or certified board and care. See Bulletins 01-25-05 and 01-56-20. ▪ DHS must approve admission and length of stay for people with developmental disabilities of any age. See Bulletin 95-60-1. **PAS**: See **MN Statute Section 256B.0911**, subdivisions 4a – 4d for further information about PAS, exemptions, emergency admissions and screening options.	Required under federal law for *all* persons entering a certified NF or certified boarding care facility, including "swing" beds, regardless of payment source for NF care. **Funding Available** County LTCC allocation Health plan capitations Health plan contract payments to county or other agencies performing PAS duties for the HMO Fee-for-service for face to face assessment for all persons under 65 regardless of public programs eligibility or participation.	***County LTCC staff*****:** SW, PHN or both. The county agency may elect to contract "in" staff who function as county employee. Responsible LTCC County: where the hospital is located, or where the person is located for all other admission sources. ***Managed care screeners*****:** Under statute and contract, health plans participating in Minnesota Health Care Programs can make the determination of need for NF services and complete Level I screening for their enrolled members participating in Minnesota Health Care Programs. Some plans subcontract with county agencies to do PAS.	***Admission from an acute hospital:*** Before admission for all admissions with a projected length of NF stay of more than 30 days. By the 40th day of admission for a person admitted under a 30 day exemption from an acute hospital who has remained in the facility longer than 30 days. OBRA LEVEL I and LEVEL II are required to be completed within the 40 days as well as the PAS. ***Before any admission from an RTC***. ***Emergency admissions:*** First working day after an emergency admit, or non-exempt hospital transfer on county non-working day. ***Admission from the community:*** Before admission for all admissions from the community. Typically requires a face-to-face visit. A telephone screening is only permitted when a health care professional (physician or clinic nurse, e.g.) is seeking admission and contacts the county LTCC staff or HMO care coordinator directly and can provide the LTCC/screener with enough information to determine the need for NF level of care. ***NF Level of Care Waiver or AC participants*****:** PAS is not required to admit a person who has been receiving services in the community that "substitute" for NF level of care. However, OBRA Level I must be completed for all persons. OBRA Level II requirements must be met for all admissions. See Bulletins 97-6-5 and 95-60-1 for Level II information. ***All People Under Age 65:*** Face-to-face visit within 40 working days of admission for persons age 21-64 if phone screening was used to admit. ***All People with Developmental Disabilities:*** See Bulletin 97-6-5 and 95-60-1 for policy and process requirements. DHS *always* must approve admission and length of stay.	***DHS Form 3361***: NF Level of Care Criteria ***DHS Form 3426***: Level I Screening Form County LTCC staff or HMO staff enters a Telephone Screening Document ***DHS Form 3427T*** for all PAS completed by phone. This form documents PAS was completed. This form will be required in MMIS in order for FFS payments to be made for NF services provided to people participating in MA who are not in prepaid health plans This information is also required to be present in MMIS in order for FFS payments to be made to an NF for services provided to a person enrolled in MSHO and who accumulates more than 180 days of NF service (the HMO benefit maximum). The LTC Screening Document ***DHS 3427*** is entered into MMIS for admissions approved during a face-to-face visit. **OBRA LEVEL II NOTE:** OBRA Level 1 is completed for all admissions. OBRA Level II will be coded as "Y" if a referral for completion of Level II activity is made OR if the person is known to have a current completed Level II evaluation.

Long Term Care Functions: Assessment and Support Planning Activity
I. "Early Intervention" Activity
Under LTCC and Minnesota Senior Health Options

Purpose of Early Intervention Service	People Served	Who Provides the Service	Timelines & Process Requirements	Forms Used
MSHO "Risk Assessment" for Community Members Early detection of health needs. Referral for EW or other community services. See Section 6.1.3.A.1 and 6.1.3.A.4 of the managed care contract with DHS.	***All MSHO enrollees living in the community.*** Funded under the HMO capitation. Health plan may subcontract with county or other agencies to perform these duties.	***Managed care screeners*:** Screeners/consultants either employed by or under contract with the HMO. Some plans subcontract with county agencies to perform these initial assessments.	***Within 30 days of enrollment*** for new HMO enrollees. ***Annually*** thereafter. ***Contract requirements*** outline what domains of health and welfare must be addressed in the risk assessment.	Health plans can create their own risk assessment forms. The health plan can opt to perform or contract for these initial and annual member risk assessments by telephone, by mail survey, or in person. Some plans have opted to use DHS 3428 (LTCC Assessment Tool) or 3427 (LTC Screening Document) and have requested that county contracted staff use these tools. A modified LTC Screening Document 3427 is entered into MMIS. See manual "Instructions for Entering the LTC Screening Document in MMIS: MSHO" at http://edocs.dhs.state.mn.us, select DHS 4669-ENG.
MSHO NF Resident Care Plan Assessment Health assessment, evaluation of NF care plan, and relocation intervention. See Section 6.1.3.A.1 and 6.1.3.A.4 of the DHS/managed care contract.	***All MSHO enrollees living in a NF*** Funded under the capitation. Health plan may subcontract with county or other agencies to perform these duties.	***HMO care coordinators*** either employed by or under contract with the HMO. Some plans subcontract with county agencies to perform these activities. Minimum requirement is participation in routine care plan reviews as required in certified NFs.	***Within 30 days of enrollment.*** ***"Routinely"*** according to schedule required in certified NF. ***Contract requirements*** and NF certification requirements outline what domains of health and welfare must be addressed in the NF resident care plan evaluation and assessment.	Health plans can create their own NF resident assessment forms and perform or contract for more frequent or more extensive work with NF residents. No LTC Screening Document is entered into MMIS to record this activity.
LTCC Early Intervention Visit Provides all citizens who have long term care needs access to decision-making support about LTC needs and options. MN Statute 256B.0911	***Any person requesting an LTCC visit at home or in an institution.*** Funded under the county LTCC allocation.	***County LTCC staff where the person is located.***	Within 10 working days of request for visit or referral.	When this activity is carried out under the LTCC program requirements, "Early Intervention" is a type of activity coded in MMIS for any visit that **did not** result in **complete** assessment and support plan development. DHS Form 3427 is used to record this kind of visit, with Screening Document edits reflecting the assumption that assessment was not fully completed.

Types of Assessment and Support Planning Activity
II. Ensuring HCBS Access
Under LTCC and Minnesota Senior Health Options

Purpose of Service	People Served	Who Provides the Service	Timelines & Process Requirements	Forms Used
Community Assessment Level of care determination Identify consumer's needs Identify risks to health and safety Identify consumer goals and preferences Identify plan implications Determine service eligibility for Elderly (and other) Waiver (need for service, LOC)	***Any citizen with long term care needs*** who requests or is referred for assessment, support planning or waiver eligibility determination as provided for under the LTCC program. ***MSHO enrollees*** living in the community who request community-based services. ***MSHO enrollees referred*** for LTCC/EW assessment through the risk assessment process or other referral for community-based service.	***County LTCC***: PHN or SW or both. County may contract "in" additional staff to perform these activities under LTCC. Funded with county LTCC allocation, and, for all persons under age 65, FFS payment for face-to-face assessment and support planning. ***HMO care coordinators*****:** Screeners/consultants either employed by or under contract with the HMO. Some plans subcontract with county or other agencies to perform these assessments. Funded under the capitation.	***County LTCC:*** Within 10 working days of referral or request as outlined in MN Statute, section 256B.0911. This process ***HMO:*** Within 30 days of referral resulting from risk assessment, or within 30 days of request by enrollee.	***County LTCC***: **DHS Form 3428 or 3428A**. Can create their own forms but must contain all of the same elements. Must conduct the assessment in person. **DHS Form 3361** is used for level of care determination. Under ***MSHO*** contract with the Department, health plans must also use **DHS Form 3428 or 3428A**. Can create their own forms but must contain all of the same elements. Must conduct the assessment in person. **DHS Form 3361** is used for level of care determination. **LTC Screening Document 3427** is entered into MMIS for all community assessments for both HMO enrollees referred for assessment and persons served under the LTCC program or FFS waiver programs. HMO staff, county or tribal LTCC staff, or HMO contract staff enter this document. See manual "Instructions for Entering the LTC Screening Document in MMIS: MSHO" at http://edocs.dhs.state.mn.us, select DHS 4669-ENG.
Support Plan Development Identify goods and services to meet needs. Consumer choice and decision-making in planning. Choice between institutional and HCBS. Reasonable assurance of health and safety. Personal risk management	***All persons noted above.***	***County LTCC staff: PHN or SW or both.*** Funded with county LTCC allocation, FFS payment for under 65 face-to-face assessment and support planning. ***HMO care coordinators/case managers*** either employed by or under contract with the HMO. Some plans subcontract with county agencies to perform these activities. Funded under capitation. Higher capitation for persons enrolled in EW program.	For support plans developed under the ***LTCC*** requirements, the practice guideline has been within 30 days of referral. ***FFS county or tribal-managed HCBS waiver programs:*** Within 30 days of request or referral for HCBS per the waiver plan for some programs; for EW, within 30 days is the practice guideline. ***HMOs: Same as EW*** practice guidelines. Community support plans developed by county, tribe or HMO must meet all requirements in federal and state law.	Both HMOs and counties/tribes must use **DHS Form 2925 or 4166** (Community Support Plan) or their own version of a support or care plan that contains all required elements. **Section G of the LTC Screening Document (DHS 3427)** must reflect the complete support plan, including informal and quasi-formal services. This information is entered into MMIS by HMO and county or tribal staff.

Supports caregivers.				

Types of Assessment and Support Planning
III. Moving People Out of Institutions
Under LTCC and Minnesota Senior Health Options

Purpose of Service	People Served	Who Provides the Service	Timelines & Process Requirements	Forms Used
Discharge Planning Preparation of discharge summary that includes: ▪ Recapitulation of resident's stay ▪ A final summary of resident's status using the Resident Assessment Instrument (RAI) ▪ Post-discharge plan of care developed with the resident, resident's family which will assist the resident to adjust to his or her new living environment. See CFR section 483.20 for NF staff responsibility, and DHS MSHO contract with HMOs section 6.1.3 for a description of all care coordination and case management requirements.	**All residents of certified NFs** **Funding:** NF rates support NF staff HMO capitation TCM and DD case management payments	***NF Social Worker and RN:*** Discharge planning is a primary responsibility of these NF staff. ***HMO Care Coordinators*** for MSHO enrollees. Participation in discharge planning is a key role of care coordinators. Care coordinators may be employees of the HMO or county or other agency contracted staff.	Follows MDH guidelines, CMS certification and Medicare payment guidelines for review of needs for NF service. For MSHO enrollees, annual review of need for facility residents.	**RAI** **HMOs** may develop their own discharge planning or summary forms for use in transitioning people out of facilities.
Transition Assistance Assessment and development of broad community support plan needed for return to community. Referrals for services	**All residents of certified NFs.** Transition assistance is available to all persons in institutions, regardless of public programs participation. **Funding:** HMO capitation, county LTCC allocation	***County or tribal LTCC staff*** as provided for under Minnesota Statute section 256B.0911. ***HMO Care Coordinators*** for MSHO enrollees.	For LTCC visits: within 10 working days of request or referral For MSHO referral for EW assessment, within 30 days of referral	For people served under the Long Term Care Consultation Program: ▪ LTC Screening Document **DHS Form 3427** ▪ LTC Assessment Tool **DHS Form 3428 or 3428A** or lead agency facsimile version ▪ Community Support Plan **DHS Form 2925 or 4166** or lead agency facsimile version **HMOs** may develop their own discharge planning or summary forms for use in transitioning people out of facilities. HMOs must use the same forms listed above to move a person from an institution into EW services in the community.

Relocation Service Active assistance to relocate people from institutions. Goes beyond transition assistance available under LTCC program as described in MN Statute 256B.0911. Examples of activities completed by an RSC include but are not limited to: ▪ Refine the community support plan, including person-centered planning activity. ▪ Locate housing. ▪ Implement the support plan developed to return to community life. ▪ Broker services See Minnesota Statutes, section 256B.0625, subd. 43-43b and 43d-43h and Bulletin #01-56-23 for more complete information about Relocation Services Coordination.	**MA participants of all ages***:* For any individual participating in Medical Assistance, regardless of the need for or funding source of community supports that will comprise the relocation plan. **Persons receiving other types of targeted case management** Funding**:** various depending on service and person served.	***Relocation Service Coordinators: See Bulletin 01-56-23and MN Statute section 256B.0621 for description of qualifications.*** ***MSHO case managers***/care coordinators both under case manager responsibility for EW enrollees admitted as well as care coordination responsibility for all members. *Requirement to coordinate with Relocation targeted case managers in contract section 6.1.3.* ***Alternative Care Conversion Case Managers:*** For people aged 65 and over who are eligible for Alternative Care. ***Targeted Mental Health Case Manager*** for people with SPMI and ***DD Case Managers*** for people with developmental disability or related conditions can be Relocation Services Coordinators.	Within 20 working days of a request for Relocation Services Coordination.	**For Relocation Services Coordination provided under FFS***:* DHS Form 3427, DHS Assessment Form 3428 or 3428A or lead agency facsimile. **DD Screening Document** for people with development disabilities.

Minnesota Department of **Human Services**

Memo

Attachemnt D

DATE: May 1, 2006

FROM: Libby Rossett-Brown, Elderly Waiver Program Administrator
651-431-2569
Libby.Rossett-Brown@state.mn.us

SUBJECT: Elderly Waiver Program - RESOURCES

RESOURCES:

- Minnesota Statute: 256B.0915 www.leg.state.mn.us
- Federal Medicaid Waiver approved by Centers for Medicaid and Medicare Services (CMS) –Under 1915(c) of the Social Security Act
- Provider call center – 800 366-5411 or 651 282-5545 – Provides Technical Assistance to all Medical Assistance enrolled providers
- Resource Center County Help Desk 651 296 -4488 or 888 968-8453 – Provides technical assistance to counter waiver staff on MMIS long term care and developmental disability screening documents and service agreements

DHS Manuals: www.dhs.state.mn.us/infocenter/docs

- Disability Services Program Manual
- Health Care Programs Manual
- Health Care Programs Provider Manual
- LTC Screening Document and Service Agreement into MMIS – manual
- MMIS User Manual
- Social Services Manual

Other Resources:

- www.minnesotahelp.info – MinnesotaHelp.info Web site – Online directory of services designed to help people in Minnesota identify resources.
- Minnesota Board on Aging - www.mnaging.org/
- Minnesota Area Agencies on Aging – www.minnesota-aaa.org/
- Aging and Adult Services Web page – www.dhs.state.mn.us/main/groups/aging/documents/pub/DHS_id_030550.hcsp
- List Serv mail group – to get on this information mail group email Lynn Glockner lynn.glockner@state.mn.us
- DHS forms http://edocs.dhs.state.mn.us/index.htm
- Older Minnesotans – Know your Rights about services – DHS 4134 publication available on E-Docs
- Sr Linkage Line -800-333-2433
- Office of Ombudsman for Older Minnesotans 800-657-3591

INSTRUCTIONAL BULLETINS - www.dhs.state.mn.us/fmo/legalmgt/bulletins/default

99-16-2 Special Income Standard Allows Eligibility Expansion of the Elderly Waiver Program
99-25-08 Client Service Cost Limits for AC/EW and Rate Limits for Assisted Living and Residential Care Services for AC/EW for FY 2000
99-25-19 New MDH rule changes home care licensing options for housing with services establishments
00-25-04C Counties may contract directly with Class A Home Care Agency for “Assisted Living Plus” Service delivered in registered Housing with Services Establishments
00-25-04 “Assisted Living Plus” service available for qualified Housing with Services

establishments and “Assisted Living” service Name expands to additional settings
00-56-26 “PCA Choice:” A new Option for FPCA Services
Instructional Bulletins:

00-56-30 DHS clarifies policy on leave days used by persons on HCBS waivers and AC
01-25-08 Approval of Waiver Amendments and Statutory Changes affect services funded by Elderly Waiver Program and the Alternative Care Program
02-25-03 DHS Answers Frequently Asked Questions about Assisted Living Services for Persons 65+ 0n The Alternative Care Program and Elderly Waiver Program
02-25-05 Waiver Amendment changes to services funded by Elderly Waiver and Alternative Care Programs and the FY02 SIS/EW income standards are announced
02-25-11 Clarification of PCA Services for Older Minnesotan
02-25-12 DHS Answers Frequently Asked Questions (FAQ) about Home Care, Elderly Waiver and Alternative Care Program recipients
02-56-13 Hospice Policy Update
02-56-20 PCA Consumer Guide and Changes to the PCA Choice Option
03-21-02 Minnesota Senior Health Options Serves Seniors
03-25-06 Policy Clarification for Caregiver Services and other Respite Options for Families of Older Persons
04-25-04 Elderly Waiver is renewed - Two Additional Services are approved
04-25-05 DHS issues rate limits, monthly service caps and National Procedure Codes for Home and Community Based Services
04-25-06 DHS issues rate limits, monthly service caps and National Procedure Codes for MA and Community Based Services -update

04-25-10 Service Description changes for new National Codes
04-25-11 MMIS changes to Support Consumer Directed Community Supports for AC and Elderly Waiver
04-56-07 Implementation of Consumer Directed Community Supports Across all Waivers, MSHO and MnDHO
04-56-08 Conversion to National HIPPA Procedure Codes for Home Care, Waiver and AC programs.
04-56-09 Implementation of 2003 Legislative Changes to Group Residential Housing Rates and Waiver Services
05-25-03 Changes to LTC Screening Document DHS- 3427 and Telephone screening document form DHS-3427T
05-25-04 Recent MMIS changes to Support Consumer Directed Community Supports for EW and AC Programs
05-24-01 Changes to the County Based Purchasing Model of Managed Care for Minnesota Seniors
05-25-08 Annual Increase for Maintenance Needs Allowance
05-25-09 Legislative Action Increases Alternative Care and Elderly Waiver Program Service Rates and Case Mix Caps
05-56-05 Legislature Provides Increases to Home Care and other Home and Community Based Services
05-56-05C Legislature Provides Increases to Home Care and other Home and Community Based Services

DHS REPORTS AVAILABLE ON INFOPAC

PWMW185L-R0504 PPHP Current Enrollment Report for Worker

This report is generated after capitation and reports data for the next month. It is sorted by financial worker service location and financial worker ID. The data it identifies are: health plan,

product ID, and enrollment period.It can be used to identify people in the servicing county who are enrolled in managed care.

PWMW18500RR0506 - PPHP Potential Enrollee Report

This report is generated after capitation and reports data for the next month. It is sorted by financial worker service location and financial worker ID. It identifies those people in the financial worker's caseload who need to go through the managed care education process who are not currently enrolled in managed care.

PWMW185I-RP507 MSHO AND MnDHO New Enrollee Report

This report is generated after capitation and identifies people who enrolled in managed care that month. It is sorted by county of service and then by health plan. It contatins a lot of information including if the person is on a waiver program , the waiver span and the rate cell.

PWMW185J-R0535 PPHPCounty Elderly Disenrollment Report

This report is generated after capitation and reports data for the next month. It is sorted by financial worker service location and financial worker ID. Some of the data it identifies are: health plan, product ID, and enrollment period. It can be used to identify members who have disenrolled from managed care and the reason.

PWMW9061-R2216 Elderly Waiver Utilization Master List

This report is run nightly and is sorted by county of Financial Responsibility - contains each client on Elderly Waiver, the reassessment date and the processing date for the current waiver year. The Y indicates that the client will be taken off the master list at the beginning of the new waiver year. All other clients have open waiver spans and are open to elderly waiver. If a person is on this report and they are not open to the waiver - a screening document needs to be entered into the system in order to close them properly.