

Utah State University

DigitalCommons@USU

All U.S. Government Documents (Utah Regional
Depository)

U.S. Government Documents (Utah Regional
Depository)

5-1996

Managed Care, Medicaid & the Elderly, An Overview of Five State Case Studies

Robert L. Mollica

Trish Riley

LTC Resource Center, University of Minnesota

Follow this and additional works at: <https://digitalcommons.usu.edu/govdocs>



Part of the [Insurance Commons](#), and the [Medicine and Health Sciences Commons](#)

Recommended Citation

Mollica, Robert L.; Riley, Trish; and LTC Resource Center, University of Minnesota, "Managed Care, Medicaid & the Elderly, An Overview of Five State Case Studies" (1996). *All U.S. Government Documents (Utah Regional Depository)*. Paper 170.

<https://digitalcommons.usu.edu/govdocs/170>

This Other is brought to you for free and open access by the U.S. Government Documents (Utah Regional Depository) at DigitalCommons@USU. It has been accepted for inclusion in All U.S. Government Documents (Utah Regional Depository) by an authorized administrator of DigitalCommons@USU. For more information, please contact digitalcommons@usu.edu.



2-24-97

HE 1.1002:M 31/6

MANAGED CARE, MEDICAID & THE ELDERLY

FIVE STATE CASE STUDIES

1996



A Partnership of

UNIVERSITY OF MINNESOTA
Institute for Health Services Research
School of Public Health
Minneapolis, Minnesota

NATIONAL ACADEMY FOR
STATE HEALTH POLICY
Portland, Maine

go
6447-A01

97-013694

Sponsored by the US Administration on Aging

MANAGED CARE, MEDICAID & THE ELDERLY

FIVE STATE CASE STUDIES

May
1996



A Partnership of

UNIVERSITY OF MINNESOTA
Institute for Health Services Research
School of Public Health
420 Delaware St., S.E., Box 197
Minneapolis, MN 55455
Phone [612] 624-5171

NATIONAL ACADEMY FOR
STATE HEALTH POLICY
50 Monument Square, Suite 502
Portland, Maine 04101
Phone [207] 874-6524

This project was supported by a grant from the US Department of Health and Human Services, Administration on Aging, number 90AM0698101. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view of opinions do not, therefore, necessarily represent Administration on Aging policy.

I

Preface

This publication contains a series of five state case studies of Medicaid managed care programs enrolling elderly Medicaid recipients. The case studies were prepared by University of Minnesota National Long Term Care Resource Center's two partners: the National Academy for State Health Policy (NASHP) in Portland, Maine and the Institute for Health Services Research, School of Public Health at the University of Minnesota in Minneapolis, Minnesota. These case studies have been conducted under the leadership of Trish Riley and Robert Mollica at NASHP.

The project was undertaken to examine the experience of elders in managed care, particularly managed care programs for low income, dually eligible elders, and the roles of the aging network in relation to managed care. The site visits were conducted from November to early March and changes may have occurred since the reports were written.

We wish to thank the many state Medicaid and Aging officials as well as representatives of managed care plans and community agencies who provided their valuable time and information which formed the basis of these reports. We could not have completed these reports without their assistance and contributions. We also want to thank the Administration on Aging and our project officer, James Steen, for their support.

Established in 1993, the University of Minnesota National Long Term Care Resource Center, funded by the Administration on Aging, is dedicated to facilitating responsive, inventive, and effective approaches to long term care. Its mission is to promote effective decision-making by persons seeking long term care and their families; long term care professional practitioners and program administrators, planners and policy makers.

For further information on these case studies, call or write to:

**University of Minnesota National LTC Resource Center
National Academy for State Health Policy
50 Monument Square, Suite 502
Portland, Maine 04101**

Phone (207) 874-6524

This dissemination of this product was supported, in part, by a grant, number 90AM0698101, from the Administration on Aging, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration on Aging policy.

Contents

Overview of Medicaid managed care programs serving elders	i
Minnesota	1
Arizona	33
Oregon	65
Utah	95
Florida	119

III

MANAGED CARE, MEDICAID & THE ELDERLY
AN OVERVIEW OF FIVE STATE CASE STUDIES

Prepared by
ROBERT L. MOLLIKA
TRISH RILEY

16

Contents

I. Introduction	v
II. Program Components	vi
Eligibility	vi
Enrollment	vii
Benefits	viii
Rate Setting	ix
Contracting	x
Linkages with long term care	xi
Quality improvement	xi
III. Discussion - the issue of dual eligibility	xii
Concerns and barriers	xiii
IV. Role of the aging network	xvii
Contracting options	xix
Future directions	xxi

17

I. Introduction

Increasingly, states are turning to managed care to deliver health services to Medicaid recipients. In a 1994 survey of states conducted by the National Academy for State Health Policy, 16 states reported that they enroll elders in Medicaid managed care programs. A few states (Arizona, Minnesota, Oregon, Tennessee, Utah) require mandatory enrollment and others allow elders to voluntarily select a managed care plan. Still other states plan to include mandatory enrollment of SSI recipients in a subsequent phase of their programs (e.g., Hawaii, Ohio, Oklahoma). In addition, states are in various stages of including long term care services as part of a benefit package available through managed care. A number of states have developed explicit managed care initiatives - Arizona, Florida, Minnesota, Wisconsin. Other states are planning similar initiatives for elders (e.g., Colorado, Connecticut, Oklahoma, Maine, Maryland, Massachusetts, Texas).

As part of its 1996 work plan, the Long Term Care Resource Center conducted case studies in five states (Arizona, Florida, Minnesota, Oregon and Utah) to examine managed care programs serving elderly Medicaid recipients. To better understand state experience serving elderly Medicaid recipients through managed care programs, the University of Minnesota Long Term Care Resource Center conducted case studies in five states - Arizona, Florida, Minnesota, Oregon and Utah. The five case studies represent different state approaches to enrolling elderly Medicaid recipients in managed care plans. This chapter compares the approaches in each state, and discusses the implications of managed care for the aging network. Each state is presented in subsequent sections of this report.

Because virtually all Medicaid elderly recipients receive Medicare, (and are therefore considered dual eligible), state activity must be viewed in the context of the Medicare environment. Nationally, 70% of the HMOs offer a product to Medicare beneficiaries. While enrollment of Medicare beneficiaries in HMOs grew 25% between 1993 and 1994, in April 1996, only 3.5 million of Medicare's 37 million beneficiaries had joined TEFRA risk plans while another 500,000 receive services from HMOs with a cost contract with HCFA or have formed a Prepaid Health Care Plan.¹ Enrollment is concentrated in eight states:

Arizona	192,000
California	1,351,000
Florida	500,000

¹ HMOs with cost contracts are reimbursed on a fee for service basis. Prepaid Health Care Plans are capitated for Part B services and Part A services are paid fee for service.

Massachusetts	105,000
New York	110,000
Oregon	120,700
Pennsylvania	232,000
Texas	175,000

While each of the five site visit states was reviewed along standard program components, the case studies reflect the diversity of states and their approaches to managed care for elderly Medicaid recipients. The studies in Arizona and Florida, for example, looked at the experience providing Medicaid acute and long term care through managed care networks. Oregon and Utah provide examples of states enrolling elderly recipients in managed care plans to receive their Medicaid acute care services while the Minnesota study examined both the acute care managed care program and a new program which will integrate acute and long term care for both Medicaid and Medicare.

II. Program Components

Eligibility

Oregon has expanded eligibility to 100% of the federal poverty level under a Section 1115 waiver. This means that elders who were previously covered as Qualified Medicare Beneficiaries (Medicare eligibles with income below 100% of the federal poverty level) are now eligible to receive full Medicaid benefits under the Oregon Health Plan.

The Arizona program has separate eligibility standards for the Arizona Health Care Cost Containment System (AHCCCS) and the Arizona Long Term Care Systems (ALTCS). AHCCCS provides acute care to state-funded medically needy members. ALTCS serves people with income up to 300% of the federal SSI benefit but does not include a spend down category. About 67% of ALTCS participants are eligible under the 300% rule and 33% are SSI recipients. In 1995, the income maximum was \$1,374 per month. Liquid resource limits are \$2,000 for SSI related beneficiaries (aged, blind and disabled) and \$1,000 for children who meet AFDC criteria.

Most SSI recipients in Florida must select a primary care case management provider, or, as an alternative, enroll in an HMO. However, dually eligible recipients, home and community based services waiver participants and other categories are exempt. Despite the exemption, 15,000 dual eligibles have joined an HMO to receive their Medicaid acute care services and 3,500 recipients who meet the nursing facility level of care criteria have enrolled in a frail/elderly option which provides Medicaid long term care services. Assessments are generally conducted by state employees from the nursing home preadmission screening program. An analysis of enrollment in

the frail/elderly option concluded that impairment level of participants was comparable to elderly Medicaid recipients in nursing homes and greater than the impairment levels of recipients in the Medicaid home and community based services waiver and other state funded home care programs.

Minnesota operates the Prepaid Medicaid Assistance Plan (PMAP), a mandatory managed care program, in 8 counties which serves about 26% of the total elderly Medicaid recipients in the state. In addition, by the fall of 1996, the state planned to implement a managed care program for dual eligibles that combines Medicaid and Medicare and acute and long term care services. The name of the program has been changed from the Long Term Care Options Program to the Senior Health Options (SHO). The SHO program is voluntary and operates in 7 metropolitan counties.

Utah expanded eligibility for aged, blind and disabled Medicaid recipients to 100% of the federal poverty level. While there was not a sizeable increase in the number of recipients, many aged recipients converted from spend down or Qualified Medicare Beneficiary categories to full eligibility. Recipients receiving institutional services are exempted from enrolling in a managed care plan.

Enrollment

In Arizona, outreach is conducted directly by the Arizona Health Care Cost Containment System (AHCCCS) staff. AHCCCS has a public information office which conducts presentations and provides brochures about ALTCS. There are two outreach workers - one with a minority focus and one who handles both acute and long term care. Additionally, outreach meetings are conducted and informational materials distributed by staff in the 15 ALTCS field offices. Most outreach focuses on organizations such as home health agencies, hospitals, nursing facilities and attorneys. Less outreach appears to be done with older people although the state regularly makes presentations to organizations representing or serving the elderly, like the Alzheimer's Association, and bi-monthly meetings are held with the Area Agencies on Aging.

Participation in managed care is mandatory in Arizona, Oregon and, by July 1996, in Utah. Enrollment is mandatory in Minnesota's PMAP (acute care program) and voluntary in the Senior Health Options program. Dual eligible recipients in Florida may voluntarily choose an HMO for Medicaid acute care services but, if they enroll, they may not join an HMO for Medicare. Enrollment in Florida's two frail/elderly option plans, which cover long term care services, is voluntary. In Arizona, 20,900 members participated in ALTCS as of December, 1995 and about half were elderly. Enrollment in Oregon has reached 65,000 and 18,000 elderly SSI recipients in Florida were served through HMOs, including 3,500 who had selected the two HMOs offering the

VIII

frail/elderly option.

Utah's program converted from a voluntary to mandatory program for SSI recipients effective July 1966. The program operates along the "Wasatch Front" which includes the major population centers in the states. Enrollment is conducted by Health Program Representatives who are employed by the Medicaid agency.

HMOs are available statewide in Arizona, Florida, Minnesota (PMAP) and Oregon. MCOs are available in selected counties in Utah.

Benefits

Benefits are limited to acute care services in all but two plans in Florida, and all plans in Minnesota's Prepaid Medical Assistance Plan, the Oregon Health Plan and in Utah. Arizona covers acute care services through AHCCCS for recipients who do not need long term care. Both acute and long term care services are provided through ALTCS for recipients who meet the nursing home level of care criteria. ALTCS services include case management, institutional care including nursing facilities and ICF-MR, home and community based services (HCBS), hospice, acute medical care services, and behavioral health services. The HCBS package includes adult day health care, home health agency services, personal care, attendant care, homemaker services, home delivered meals, hospice, individual habilitation type services, respite care (short term or intermittent) and transportation. Environmental modifications are also covered when they are determined to be cost effective.

Utah's benefit package includes personal care. However, one HMO in Utah has used its capitation payment flexibly to pay for services that maintain or promote independence and a strict application of "medical necessity" has not been adopted. Acute care benefits for dually eligible recipients are limited to services that are not covered by Medicare as well as the cost sharing component of services provided through Medicare.

Minnesota's SHO program will cover home and community based services and 180 days of nursing facility care. Nursing facility services beyond 180 days are reimbursed fee for service.

Two of Florida's 22 plans participate in the frail/elderly option which covers acute and long term care for SSI recipients. In addition to acute care, the frail/elderly plans offer coordination of services, adult day health care, homemaker/personal care, adaptive equipment, and supplies. Other services deemed necessary by a multi-disciplinary team must also be covered such as emergency alert response services, identity bracelets, expanded home health, financial education, respite, caregiver training and pharmaceutical management.

X

Coverage for aged, blind and disabled recipients under the Oregon Health Plan was excluded during Phase I because of concerns about the impact of the priority list.² A subcommittee on coverage for aged, blind and disabled recipients was implemented that included advocates, consumers and providers with a special interest and training in these areas to review the appropriateness of the priority list for these populations. The committee held public hearings, solicited comments through a targeted telephone survey and community forums. Flyers were mailed to aged, blind and disabled recipients announcing the forums and inviting written statement from people who could not attend. The major issues cited were the need for drug coverage, transportation and the cost of health care.

As a result of the committee's report, changes were made covering ancillary services, dental and transportation services. Examples of the use of assisted communication devices and case management were added to the list to explain the coverage of ancillary services. Five dysfunction lines to cover symptoms caused by chronic conditions were added that address the impact of neurological conditions on breathing, eating, swallowing, bowel and/or bladder caused by chronic conditions (eg., g-tubes, j-tubes, respirators, tracheostomy, urological procedures); posture and movement caused by chronic conditions (eg., durable medical equipment and orthopedic procedures); in loss of ability to maximize level of independence in self-directed care caused by chronic conditions (eg., short term rehab with defined goals); communication caused by chronic conditions. The Priority List has expanded benefits for elders and people with disabilities by emphasizing preventive services and broadening coverage for adult dental care and vision care which had been reduced under the fee for service system.

Services authorized by MCOs must be "medically appropriate" which is defined as "services and medical supplies which are required for prevention, diagnosis or treatment of a health condition or injury.

Rate Setting

States have generally based their rates on 95% of the comparable Medicaid fee for service experience in a base year with adjustments for Medicaid inflation. States advise that recipient eligibility files must be accurate when developing expenditure profiles or rates may be skewed due to erroneous classification of recipients in rate cells. Arizona's ALTCS rate includes an incentive for plans to use home and community based services rather than nursing homes. Since the program only serves recipients who meet the nursing home level of care criteria, creating a weighted rate

² Oregon's Medicaid benefits are tied to a priority list which ranks conditions and treatments in terms of their effectiveness and outcomes.

was necessary to avoid overpaying contractors. The rate takes into consideration a HCFA waiver requirement that no more than 40% of the members served will reside in community settings. The community participation cap has been raised each year from its original 5% to 40% in 1995. Contractors that serve higher numbers of members in institutions will exceed the capitation payment.

Minnesota will use several adjusters for recipients enrolling in SHO. Separate rate cells are used for nursing home residents, community recipients who meet the nursing home level of care criteria and reside in the community, recipients who have lived in a nursing home for more than six months who move to the community, and other recipients living in the community.

Florida's frail/elderly rates were constructed early in the program and adjusted periodically for inflation. The state is reviewing its methodology and is seeking to identify a comparable population upon which to develop rates that officials feel will be more appropriate to the population served.

Developing a Medicaid rate for dual eligibles who join an HMO to receive their Medicare services is complicated in counties with a very high adjusted average per capita cost (AAPCC). As a result of expanded benefits and zero premiums in many of its HMOs, Florida, and several other states, has not yet developed a rate that would avoid duplicate Medicaid payments for services covered through a TEFRA HMO when the frail/elderly option was implemented in the late 1980s. As access to better Medicare utilization data and more sophisticated Medicaid rate systems are developed, an adjusted rate will be devised that allows dual eligibles to enroll in an HMO for both Medicaid and Medicare.

Utah found that sharing risk with plans made it easier for plans without any previous experience in serving Medicaid recipients to agree to participate and to accept the rate developed by Medicaid. Over time, as plans gain experience, plans have assumed full risk.

Contracting

Contracting under the ALTCS program is limited to one contractor per county and, by statute, the state's two largest counties are required to operate the program. Two private HMOs operate the program in 10 of the 15 counties. HMO participation has been high in other states which offers Medicaid recipients a choice of plans and provider networks. Five plans are available to recipients in Utah and all the area hospitals and most primary care physicians have joined one or more networks. As a result, recipients are very likely to retain the physicians and hospitals of their choice. However, participation of home health agencies and durable medical equipment providers is not as widespread and recipients receiving services may have to change

providers.

Florida's contracts for the frail/elderly option are limited by design to two HMOs. A specialized program to integrate acute and long term care for dual eligibles is being prepared to test the concept in other pilot areas. Florida has signed contracts with 22 HMOs across the state to serve its Medicaid population. The state contracts with licensed HMOs that meet the terms and conditions of the contract.

Utah also contracts with HMOs that meet the conditions of the contract. Five HMOs are available and nearly all primary care physicians and all the major hospitals in the service area are part of one or more of the HMO networks. Recipients therefore by and large are not required to choose a new physician or hospital to receive care. However, many of the home health agencies and durable medical equipment providers do not have contracts with the HMOs and changing providers may be required. Federally Qualified Health Centers in Utah have negotiated agreements to participate in HMO networks. They are interested in forming their own licensed HMO.

Health plans in Arizona, Oregon and Utah have made arrangements with nursing homes which are not part of their networks to accommodate participants who enter a hospital from a nursing home and return to the home following discharge.

Linkages with long term care

The states studied represent different approaches to serving elderly Medicaid recipients through managed care and as a result the linkages with long term care vary considerably. Two states, Arizona and Minnesota, cover long term care services in the benefit package. Florida has continued its pilot program in two HMOs that includes long term care. Since 1989, Arizona has operated the ALTCS program and Minnesota is building on its managed care experience to launch Senior Health Options in the fall of 1996. Oregon has demonstrated the clearest ties to the aging network and the long term care system by requiring that MCOs create the position of Exceptional Needs Care Coordinator to coordinate health services within MCO networks and to coordinate with the home and community based services system for members who are receiving long term care services. While formal linkages have not been developed in Utah, at least one HMO has taken a broader view of the purpose of the benefit package and authorizes services which are likely to maintain independence and functional capacity even the services may not be "medically" necessary.

Quality Improvement

The states reviewed require common quality improvement safeguards that include HMO grievance procedures, an internal quality improvement mechanism, focus studies and access to the Medicaid appeals procedure. Oregon has created a

managed care ombudsman program. The data from each state indicated that relatively few formal grievances are filed and most complaints are resolved either by the plans or through the intervention of state staff on behalf of recipients.

Arizona has an added advantage in that the initial assessment is performed by ALTCS staff who can compare utilization data to the assessment and determine whether the expenditures are in keeping with the assessment. In Florida's two Frail/Elderly programs, assessment data is also available to state agencies through the CARES preadmission screening process which provides a tool to monitor care plans and spending.

III. Discussion - the issue of dual eligibility

Government leaders have turned to managed care to achieve four broad goals. First, managed care is designed to deliver only the amount and level of care that is needed and to improve continuity of care as a person moves from primary care to acute, post acute and, in fully integrated systems, long term care. Second, managed care creates a structure for integrating services and funding for acute and long term care. Third, managed care may reduce incentives for providers to shift costs to other funding streams and can reduce costs and facilitate budget predictions. Finally, because of the capitation payment, MCOs have the flexibility to provide services that are outside the benefit if they substitute appropriately for covered services or achieve outcomes intended by the benefit.

Because of the complexities of payer sources (Medicare and Medicaid) and the type of benefits (acute and long term care), a number of complex arrangements are possible. Older persons may join an MCO to receive their Medicare covered services but remain in the fee for service system for their Medicaid acute care and long term care services. Second, elderly Medicaid recipients may have joined an MCO for their Medicaid acute care benefits while receiving Medicare benefits and Medicaid long term care from the fee for service system. Adding to the complexity, an older person could join one MCO for Medicaid acute care (wrap around) services and another, separate MCO for Medicare benefits while receiving Medicaid long term care from the fee for service system. A person could also select the same MCO for both Medicare

Potential Enrollment Patterns		
	Medicare	Medicaid
Acute Care	FFS or MCO	FFS or MCO
Long Term Care	NA	FFS or MCO

and Medicaid services while long term care is paid fee for service. Finally, under a fully integrated model, the person could receive all services, acute and long term care, from both Medicare and Medicaid from one MCO.

Concerns and barriers

These patterns affect the delivery of care. Arizona officials have noted problems receiving timely notification of Medicare enrollment and lack of interest among some HMOs in coordinating transportation, surgery, physician services and out of area services. Some nursing homes have been reluctant to admit dual eligibles who have joined a Medicare HMO if the facility is not in the HMO's network. Conflicts over attending physicians used by the HMO and the nursing facility can also occur.

Lack of integration in a single HMO also contribute to fragmentation such as the maintenance of duplicate medical records, selection of two primary care physicians and varying benefit packages and prescription drug formularies.

Integration has the potential to minimize cost shifting between programs. Under fee-for-service, services which substitute for hospital and nursing home care are often covered by Medicaid. To reduce hospital and Medicare covered nursing home admissions, states would have to finance additional home care and physician visits and other services to residents in nursing homes. States do not have the financial incentive to increase Medicaid spending since the savings are reaped by Medicare.

As federal and state policy makers move ahead to capitate and integrate services, several issues must be addressed. First, how many plans will potential members have to choose from and what process will be used to help people understand what managed care is and how plans can be compared? Many aging network agencies offer counseling for Medicare supplemental policies, Medicare managed care options and private long term care insurance. Extending that role to perform counseling and enrollment activities for elders builds on that experience.

Perhaps the most hotly contested issue among aging advocates is the potential "medicalization" of long term care services. The Aging network has developed an impressive system for meeting the supportive needs of older people with impairments in activities of daily living (bathing, dressing, eating, toileting, ambulation). HCBS systems provide personal care, respite care, home delivered meals, homemaker services, transportation, home repair for people in their home or apartment. States have also added day and residential options such as family or foster care and assisted living. The system has many characteristics of a managed care network. Many aging agencies operate through a combination of fixed budgets that are determined by state or federal policies, and sometimes per person limits on care plans. The limits can be

set based as a percentage of the cost of care in a nursing facility or the "budget neutrality" formula in Medicaid HCBS waiver and Section 1115 Waiver Demonstration programs. MCOs assume partial or full risk for managing services within the capitation payment. Aging agencies receive budgets or reimbursement arrangements that are also fixed and spending that exceeds that budgeted amount must be addressed by the aging agency. Agencies are not entitled to reimbursement beyond that which is budgeted or contracted. However, aging agencies may reduce service plans or stop accepting new applicants while MCOs must accept all who enroll.³

The aging network conducts comprehensive assessments of the functional, cognitive, health, environment, social and family dimensions and is often the "gatekeeper" for admission to a nursing facility. While many aging agencies have registered nurses on staff or contract to address the health issues of elders, the system operates as a social model without extensive involvement or management from physicians or registered nurses from the acute care system.

As long term care is added to the benefit structure of an MCO, aging advocates are concerned that the principles, philosophy and cost effectiveness of the social model will be lost and MCOs will over-medicalize the delivery of long term care. The philosophy of the social model would provide whatever services are appropriate to assist the person to remain as independent as possible for as long as possible. However, many aging leaders also recognize that elders have a combination of health and social or supportive needs that are currently addressed through a fragmented system of care. Progress toward serving elders does not mean a choice between a social or medical model but a blending of the two to best address the full range of needs of older people.

Managed care also changes the financial incentives in the delivery of health care services. The fee for service system encourages over-utilization of services since providers are reimbursed for each unit of service delivered. Critics charge that the managed care system has an incentive to underserve members since plans are paid a fixed amount regardless of what services are utilized. Others note that the incentive is diminished since lack of access is likely to generate higher utilization if health conditions are not treated promptly and correctly.

Beyond the financial incentive lies conflict between the social and medical models. MCOs generally authorize services based on medical necessity rather than functional or social need. Under the fee for service system, health services may be

³ In some state Medicaid managed care programs, enrollment in specific MCOs can be limited based on the capacity (number of providers) of the MCO to serve members.

delivered to meet supportive needs. Some health services are provided for both acute and long term needs such as nursing home care, skilled nursing and home health aides. The fee for service system allows home health visits for extended periods and the financial incentives encourage their delivery after the acute care needs have been met. As a long term care benefit, home health may be provided because it has historically been funded by Medicare and Medicaid and MCOs have existing agency contracts or providers that can be accessed easier than creating new procedures to provide personal care services. As responsibility shifts from the fee for service to the managed care system, interpretations of medical necessity are used to authorize services.

Policy makers have a choice as they develop Medicaid managed care systems. They can include the full range of acute and long term care and eliminate or at least minimize the medical necessity determination, or they can broaden access to skilled nursing, home health and personal care as needs change. MCOs can then authorize services on a basis that is not limited to strict interpretations of medical necessity.

Other barriers to developing fully integrated managed care systems are found in conflicts between Medicaid and Medicare statutes. Medicare does not allow for member lock in. That is, Medicare beneficiaries are allowed to change MCOs on a monthly basis. Medicaid, on the other hand, allows waivers that require a person to remain in the MCO of their choice for 6 or 12 months, except for cause.

Membership in an MCO for Medicare is voluntary and beneficiaries always have the choice of joining an MCO or remaining in the fee for service system. Medicaid waivers often require mandatory enrollment in an MCO. Medicare rules only allow contracts with MCOs whose membership is at least 50% private or commercial. Medicare enrollment cannot exceed 50% of total enrollment. MCOs contracting with Medicaid and Medicare must limit enrollment under these programs to 75% of total membership. However, Medicaid waivers can be obtained to increase the percentage of Medicaid members but the Medicare limits cannot be waived.

Serving dual eligibles lies at the core of concerns raised by state policy makers developing managed care programs for elderly Medicaid recipients. Medicaid and Medicare have evolved with inherent conflicts that must be resolved if services are to be integrated. Some may ask why services must be integrated and many contend that a number of states already operate managed long term care programs through their case managed, home care systems. However, as described above, dual systems lead to fragmented care and cost shifting. While state case management systems have reduced fragmentation in the delivery of long term care services, they have not addressed integration of acute and long term care.

Since its inception, Medicare has received broad support as a social insurance

model without means testing. However, the premium and cost sharing requirements have, over time, imposed a difficult burden on low income Medicare beneficiaries. To address these barriers, Congress tapped Medicaid to cover the premium and coinsurance liabilities for Medicare beneficiaries with incomes below 100% of the federal poverty level and coinsurance for beneficiaries with incomes between 100% and 125% of poverty. Medicaid allows Medicare to remain a non-means tested program.

In a managed care environment, freedom of choice and means testing conflict. The conflicts pit the roles and responsibilities of states and HCFA against one another. While states have the authority to determine what services will be covered and through which delivery system or providers, in managed care, decisions made by Medicare providers have an impact on Medicaid. For example, dual eligibles in a state with mandatory Medicaid managed care may remain in the Medicare fee for service system. A physician outside the Medicaid managed care plan may schedule an appointment which requires transportation services funded by Medicaid and prescribes medication that is covered by Medicaid. As a result, the Medicare system controls the services and providers state Medicaid programs must cover even though recipients may be required to join a Medicaid managed care network.

States could serve dual eligibles by piggy backing on Medicare managed care plans. In areas with a high Average Adjusted Per Capita Cost (AAPCC), these plans may in fact generate savings for state Medicaid programs because of expanded benefits and zero premiums. In addition, the plans may facilitate continuity of care for members who enroll prior to becoming Medicaid recipients. However, relying solely on TEFRA plans has its disadvantages.

1. Because of low AAPCCs in many states, plans may not be available in a state.
2. Statewide coverage may not be possible in states with higher AAPCCs because of variations among counties within a state. Plans are not required to contract with Medicare in all counties and only recipients in covered counties could participate.
3. The MCO base may be unstable with plans entering and leaving the Medicare market. States would not have options to continue a contract for Medicaid services if the Medicare plan were terminated.
4. The 50% commercial/50% Medicare membership limitation eliminates smaller MCOs with good track records serving Medicaid recipients.
5. AAPCCs may drop over time in mature HMO markets as practice patterns

change and the effects of increased managed care penetration take hold. Lower AAPCCs could force HMOs to raise premiums and eliminate added benefits. However, in some markets, if HMOs attract healthier members, the remaining fee for service base will include sicker beneficiaries which could increase the AAPCC and increase, rather than decrease, costs to Medicare.

6. States have to adjust their Medicaid rates to reflect the added benefits available from most Medicare HMOs. However, copayments and benefits may change from plan to plan in an area which adds to the state burden as rates must be set for each plan.

7. Medicare and Medicaid rules require duplicate administrative procedures covering enrollment and disenrollment, external quality review organization reviews, grievance procedures, quality assurance requirements and general oversight responsibilities.

8. Because of their limited enrollment share, states may not be able to require adequate utilization information from HMOs. Medicare risk plans are not required to provide states with financial or utilization information which therefore makes it difficult to determine whether costs have been shifted to Medicaid.

9. Plans may refuse to accept risk for long term care benefits.

10. States will still have to address management of services for dual eligibles who do not join a Medicare managed care plan.

But as more and more Medicare beneficiaries enroll in managed care and as HCFA's CHOICES Demonstrations unfold, these disincentives to build on TEFRA HMOs may diminish. The full impact of these barriers, concerns and opportunities have been described as states developed and implemented Medicaid managed care programs for dual eligibles. Despite the limitations, states are proceeding within the context of existing law, waiver authority and federal policy.

IV. Role of the aging network

The role of the aging network varies among the five case study states. The Oregon Health Plan has devised the most prominent role for aging agencies among the five states studied. Area Agencies on Aging and the Senior and Disabled Services Division field offices are responsible for outreach, counseling and enrollment functions. Intake staff and case managers meet with aged and disabled Medicaid recipients to review the managed care program, explain options among competing plans and enroll the recipient in the plan of choice. Aging agencies in Oregon and Arizona also play an advocacy role. Recipients often contact the aging system when they have questions or

complaints about managed care.

Except in Oregon, the aging network was not an active part of the process that developed managed care projects. AAAs in Arizona develop their own working relationships with contractors and in Maricopa County, the AAA contracts with the ALTCS program contractor to provide case management and other services managed by the aging network. Working relationships between plans and AAAs in Utah are expected to emerge as enrollment converts from a voluntary to a mandatory program. The "lead agency," or single entry agency designated by the AAA in areas served by the Florida frail/elderly plans, subcontracts with the plans to deliver home health services. The lead agency manages parallel programs but does not provide case management for the home and community services covered by the HMOs.

The expanded enrollment of elders in managed care plans has implications for the functions of aging network agencies. The extent of the impact depends upon the role of state units on aging and area agencies on aging (AAAs). In general, there are two types of AAAs. One group manages the traditional Older Americans Act (OAA) services - senior centers, home delivered and congregate meals, and in-home services. Case management is contracted to other community based organizations and is not provided by the AAA. In addition to the traditional OAA services, the second group manages the OAA in home services and provides case management directly. Further, the AAA also manages Medicaid home and community based services (HCBS) waiver programs and HCBS programs funded through state general revenues. The extent of integration and the role of the aging network frames the scope of the potential impact of managed care.

Aging agencies have a number of potential roles in an evolving managed care system: benefits counseling, enrollment, case management and monitoring quality of care. Benefits counseling activities funded through Medicare and state general revenues are now provided in a number of states by aging agencies. These activities involve helping elders understand their Medicare benefits, choosing among Medicare supplemental health insurance plans, understanding and comparing managed care plans and dealing with private long term care insurance.

The aging network also can perform the enrollment functions for state Medicaid agencies. Medicaid managed care programs in several states do not allow MCOs to perform the marketing and enrollment functions because of concerns about biased selection or "skimming" and unfair marketing activities. An impartial agency is selected to provide information to older Medicaid recipients, to answer questions about the options and enroll the person in the plan of their choice. In the event that a person fails to select a plan, the enrollment agency can "auto assign" and enroll the person in an MCO.

Quality assurance is an important component of state policy and managed care. Well defined roles for the aging network have not been determined in this area, however, case managers in several states are playing an informal quality assurance and advocacy role for their clients. During home visits, case managers note care needs that are referred to MCOs and clients often contact their case manager for information when they first select an MCO and as access issues arise. Building on the aging network's nursing home ombudsman experience, a similar function could be performed in managed care programs, however, the array of existing quality assurance mechanisms used by states would have to be examined to determine how this additional component might be included (see section on quality assurance).

Case management tasks are an important function in aging agencies in many states, particularly states with single entry systems such as Colorado, Connecticut, Indiana, Massachusetts, Oregon, Pennsylvania and Illinois. The prospective role for aging agencies in these states depends upon the scope of the benefit delivered through MCOs. MCOs signing contracts with Medicare and/or Medicaid to provide acute care services have fewer incentives to organize and coordinate the long term care services available from Medicaid, state general revenues and the OAA. While MCOs generally do not receive funding for long term care services in their capitation rate, many MCOs are concerned about the impact of chronic conditions on the member's health status and acute care needs. Linkages between AAAs and MCOs are important to coordinate transitions between the acute and long term care systems and simultaneous utilization of services from both systems.

If funding for all acute and long term care services is combined in a capitation payment to an MCO, MCOs will need to provide case management directly or to contract with other organizations to do so. While full integration is more likely, though very difficult, for Medicare and Medicaid, adding state general revenue HCBS and OAA long term care can also be considered.

Contracting options

Aging agencies have several options for providing case management for long term care services in an integrated system. First, policy makers could carve out community benefits from the acute care benefit and require that aging agencies and MCOs develop formalized procedures for coordinating and authorizing services. Two capitated payments would be made, one to the MCO for acute care services and a second to the aging network for long term care services, including nursing home care beyond the post acute benefit. In such an example, states might build on existing 1915(c) programs and pay AAAs a capitation. Questions arise concerning the ability of the AAA to assume risk, the implications a carve out may have for continuity of care and whether carve outs increase administrative costs by funding two organizations.

Second, policy makers could designate aging agencies that are providing case management and managing single entry systems as an "essential provider" and encourage or require MCOs to contract with them for case management and long term care. The MCO would receive the full capitation for all acute and long term care and the aging agency would be paid either on a fee for service or subcapitation basis. Aging agencies under both options could possibly assume partial or full risk for the services authorized. However, states would still have to determine the AAA's ability to accept risk. In addition, entities bearing risk are usually required to be licensed as a health insurer or HMO. Either AAAs would have to be licensed or a new category of risk bearing provider entity would have to be created. Questions concerning the HMOs legal ability to delegate functions to a AAA would have to be researched.

Third, a provider model is also possible. Aging agencies could also join an MCO or create a subsidiary organization for the case management and long term care services component which joins with health systems or providers to form a new MCO entity.

Aging agencies could seek to contract with MCOs to provide case management and service authorization of long term care services. Forming or contracting with an MCO pose conflicts for an aging agency depending upon the range of choices of MCOs for consumers. If only one MCO serves an area, the aging agency can create a relationship with the MCO and continue to serve all of its clients. If, however, consumers have multiple MCOs to choose from, aging agencies may not find all MCOs in the area willing to contract with them. Further, the geographic areas for which an MCO is licensed may not coincide with the service area of the aging agency and two or more agencies may be involved. Aging agencies in adjoining services areas may or may not have the same interest in contracting, or capacity to contract, with an MCO. While an aging agency may contract to provide services to an MCO outside its normal service area, this practice would run counter to the tradition of defined planning and service areas and might require creation of a separate entity to do so.

Many MCOs resist the notion of subcontracting case management, noting that the MCO bears financial risk and a responsibility to members that makes subcontracting case management unattractive. However, MCOs do subcontract for the delivery of direct services.

Contracting with MCOs challenges traditional AAA roles to serve all elders in a community. Contracting directly with some but not all MCOs also conflicts with the counseling and enrollment functions since the aging agency develops a financial interest in the decision of the consumer. Observers also question whether an AAA compromises its advocacy function on behalf of elders if it enters a contractual relationship with an MCO. However, contracting with an MCO has many similarities to

contracting with the State Unit on Aging or Medicaid to provide case management, preadmission screening and home and community based services. The financial relationship is similar in some respects. AAAs authorize services in relation to a fixed budget or a maximum cap per person served. The challenge resides less in the contractual relationship with an MCO than the type of services being purchased. MCOs may expect to receive priority for acceptance of referrals whose care will be financed from state general revenues, medicaid waiver or OAA funds. Limited funding and waiting lists have traditionally hindered the ability of community based programs to gain credibility with hospital discharge planners and this situation is likely to continue with MCOs who receive a capitation for acute care either from Medicare or Medicaid and make referrals to AAAs for long term care services. If MCOs are also capitated to provide long term care services, the conflict can be avoided more easily since the MCO may contract with the AAA to provide the community services included under the capitation payment.

Future directions

State experience enrolling elderly Medicaid recipients in managed care plans has been varied, new and limited. The case studies reflect a wide range of initiatives from which states can draw valuable lessons in shaping their own in initiatives. The experiences highlight the challenges and conflicts that must be resolved if the promise of integration of Medicaid and Medicare services is to be achieved. Managed care has drawn attention to the limitations in measuring quality of care in the managed care, fee for service and acute and long term care arenas. Further work will be needed in these broad and complex areas.

As state Medicaid managed care programs evolve, the impact on aging network agencies will be complex and far reaching. Traditional roles will have to be examined closely and the development of options will vary based on the current roles, mission and directions adopted in each state agency and perhaps by agencies within a given state. The current trends suggest that aging agencies have much to contribute to the successful implementation of integrated managed care systems that provide a full range of acute and long term care and shaping a role in this emerging area will be varied and complex.

State Managed Care Programs								
State	Arizona		Florida		Minnesota		Oregon	Utah
Name	AHCCCS	ALTCS	Prepaid Health Plan	Frail/Elderly option	PMAP	Senior Health Options	OHP	
Status	Operating (1115)	Operating (1115)	Operating	Operating	Operating	9/96 start (1115)	Operating (1115)	Operating
Populations	Medicaid non-NF	NF eligible < 300% of SSI	SSI (spend down exempt)	SSI NF eligible	Medicaid	Medicaid NF	All Medicaid	All Medicaid
Benefits	Acute	Acute & long term care	Acute	Medicaid Acute & long term care	Acute	Acute & long term care Medicaid and Medicare	Acute	Acute
Type	Mandatory	Mandatory	Voluntary	Voluntary	Voluntary	Voluntary	Mandatory	Mandatory
Who performs								
Eligibility	AHCCCS staff	ALTCS staff	AHCA	AHCA (financial), CARES assessment (functional)	County	Plan with county review (functional)	AAAs/SDSD	Medicaid
Marketing	AHCCCS	ALTCS	Plans	Plans	Counties	Counties	Medicaid	Medicaid
Counseling	AHCCCS	NA	NA	NA	Counties	Counties	AAAs/SDSD field offices	Medicaid
Enrollment	AHCCCS	ALTCS	Plans	Plans	Counties	Counties	AAAs/SDSD field offices	Medicaid
Out of network coverage	No	No	No	Yes	No	No	No	Yes*

* Wavier request to deny Medicaid coverage for out of network utilization is pending.

X X / / /

MANAGED CARE, MEDICAID & THE ELDERLY

THE MINNESOTA EXPERIENCE

Prepared by
ROSALIE A. KANE
LOUISE STARR

XXIV

PREFACE

This report is the fourth in a series of state-specific studies on managed care for the elderly that were prepared by the University of Minnesota's National Long-Term Care Resource Center. With leadership from Robert Mollica and Trish Riley at the Academy for State Health Policy and involvement of personnel at both of the Resource Center's offices, these case studies were undertaken to examine the experience of seniors in managed care, particularly managed care programs for low-income seniors dually eligible for Medicaid as well as Medicare, and roles of the aging network in relation to managed care for seniors. Some of the individual case studies are being released in their present form as interim products to help guide the deliberations at the Administration on Aging's Conference: *Emerging Trends in Managed Care: Opportunities for the Aging Network*, convened by Assistant Secretary Fernando M. Torres-Gil in Washington, DC February 28-March 1, 1996. (The Resource Center has served as planner for that conference.) In the spring of 1996, we intend to release a series of at least 5 case studies, along with a document synthesizing and deriving lessons from the cumulative experience of these states. This package will be available for purchase from our office at the National Academy for State Health Policy.

States selected for case studies thus far have all had some experience with enrolling low-income seniors in managed care under the state's Medicaid program. The method included on-site visits, on-site and telephone interviews with state Medicaid and State Unit on Aging (SUA) officials, Area Agency on Aging (AAA) officials, and managed care providers, among others, and review of existing materials. Although we asked our informants to review the material and comment on our facts and interpretations, the authors take responsibility for any errors or omissions in the final products. We also caution this is a fast-changing field, and changes could have occurred since these reports were prepared.

We are appreciative of all those who provided us with information for the case study and to the Administration on Aging (AoA) and our project officer James Steen for their support. However, the final product does not necessarily reflect the views of the AoA or any of its staff.

XXV

TABLE OF CONTENTS

SUMMARY	1
BACKGROUND	2
Acute Care	2
Long-Term Care	3
THE PREPAID MEDICAL ASSISTANCE PROGRAM (PMAP)	5
Eligibility	5
Enrollment	6
Benefit Package	7
Rate Setting and Capitation	7
Grievance Process	8
Evaluation	10
PMAP Providers	11
Special Problems of the Dually Eligible	12
THE LONG-TERM CARE OPTIONS PROJECT (LTCOP):	
INTEGRATING ACUTE AND LTC	14
Eligibility	14
Enrollment	15
Benefit Package	16
Rate Setting and Capitation	16
Quality Improvement	19
Grievance Process	20
Evaluation	21
County Responses	21
Provider Responses	22
AGING NETWORK INVOLVEMENT	22
Planning	22
Advocacy	23
AAA Efforts with Managed Care	27
Aging Network Concerns	29
CONCLUSIONS	29
INFORMATION AND RESOURCES	30

SUMMARY

The state of Minnesota began its involvement in managed care with the advent of the Prepaid Medical Assistance Program (PMAP) in 1983. PMAP provides primary and acute care services to certain Medicaid-eligible residents¹ in the program's demonstration counties. Older PMAP enrollees are composed primarily but not exclusively, of persons who are dually eligible for Medicare and Medicaid. Coverage for the dually eligible under PMAP includes all Medicare co-payments and deductibles, and some services such as out-patient pharmacy and home care benefits expanded beyond usual Medicare coverage. A §1115(a)(1) waiver and state legislative authority established PMAP, which began operations in 1985, starting with three counties and now serving 16 counties. Waivers covering PMAP will continue through 1997. Enrollment in the program is mandatory, except for some exempted categories.² The most noteworthy exclusion pertains to people in Medicare risk contracts; Medicaid will cover this group's deductibles and coinsurance and medical assistance benefits on a fee-for-service basis. As of September, 1995, PMAP enrolled 141,521 people in the program (from the eight counties participating at the time), with 13,919 elderly people among them.

Long-term care for dually eligible older adults may (if consumers so choose) be provided through a managed care system in the summer of 1996, when the Long-Term Care Options Project (LTCOP) begins enrolling people in the seven-county demonstration area including and surrounding the twin cities of Minneapolis and Saint Paul. LTCOP is a §1115 demonstration waiver that builds on the foundation provided by PMAP, and will enroll only dually-eligible persons. The project expects to serve approximately 4000 people through the three-year demonstration period. LTCOP is the first program of its kind operating under several federal waivers combining capitations received from Medicare and Medicaid to create a seamless system of care covering primary, acute, post-acute and long-term care services for older adults. The project will be contracting with health systems that, by working with LTC organizations under special agreements, will provide the complete continuum of care and services for enrollees.

The Minnesota experience illustrates the importance of integrating acute care and LTC at the funding and operational level. After more than a decade of experience with trying to use PMAP to manage Medicaid acute-care expenditures for the elderly without any ability to control Medicare expenditures, the state pursued its new waiver for the LTCOP program precisely so that

¹Medicaid-eligible enrollees in PMAP include all adults and children enrolled in Medical Assistance through Aid to Families with Dependent Children (AFDC), the aged and those enrolled through the state General Assistance Medical Care (GAMC) in the demonstration counties, including older adults dually eligible for both Medicaid and Medicare.

²See PMAP section on enrollment for further explanation of reasons for exclusion from the program.

it could have greater accountability and effectiveness as a purchaser. In summary, Minnesota's proposed programs create a laboratory for the nation to examine the effects on both costs and quality of increased integration under a model where the capitation goes to ISNs responsible for both acute care and LTC and where the State keeps channels for accountability for both cost and quality (some other states are considering models with separate capitations for acute care and for LTC, which would create a contrasting experience). Of particular interest as the LTCOP program unfolds are the following:

- What is the actual cost experience for LTCOP? Is the greatly increased capitation rate for nursing-home-certifiable community residents justifiable?
- How interested are ISNs in participating in LTCOP, and how do they modify existing processes to develop those programs. In particular, how flexible and user-friendly are the LTC programs provided by the ISNs?
- What kind of case management capacity do the LTCOP contractors develop, and what will be the balance between case management internal to the ISN and case management from home- and community-based providers?
- How do LTC providers (e.g., nursing homes, adult foster homes, assisted living facilities, home care providers) adjust and realign themselves in the light of the new purchasing power and changed incentives that come with the creation of ISNs with responsibility for LTC?
- How, if at all, will voluntary and community grass-roots services change as a result of LTCOP?
- To what extent will consumers elect to use LTCOP?

BACKGROUND

Acute Care

Minnesota, particularly the Twin Cities area, has a history of involvement in managed care. Group Health Inc., a staff model health maintenance organization (HMO), began operations in Minneapolis in 1957. Since that time, the cities of Minneapolis and St. Paul and surrounding communities have seen tremendous growth in managed care. More than 67% of insured

metropolitan residents are part of a managed care network, and statewide more than 68% belong to some sort of managed care plan.³

Changes in health care have also occurred as a result of the formation of large purchasing groups. In 1985, the Minnesota Employees Health Benefit Program started operations, and now obtains health care coverage for more than 144,000 enrollees. In 1991, a group of 14 large employers banded together and formed the Business Health Care Action Group. This purchasing organization buys health care for approximately 85,000 members. These groups have changed the way health care is provided in the state today. In response to these purchasing groups, physician and hospital groups came together with HMOs to bid for the contracts which would provide services to the groups. These groups of providers have been referred to as Integrated Service Networks (ISNs), though these groups are not licensed as such. Health services researchers believe there are 18 ISNs that currently exist or are in the formation process.⁴ Similar to the ISN but smaller rural versions, Community Integrated Service Networks (CISNs) have also been formed, and are already licensed and operating in the state. There are currently four CISNs in operation.

In 1992, the HealthRight Act (now known as MinnesotaCare) was introduced to the State as a means of reforming the current health care system and of improving access to health care for many state residents. MinnesotaCare was particularly designed to offer out-patient care for the substantial number of uninsured Minnesotans needing health care coverage. The program is funded through the premiums and co-payments paid by members and a state tax on health care services.

Long-Term Care

Historically, Minnesota has had a high proportion of nursing home beds per elderly population relative to other states. In 1992, it still ranked highest of all states in terms of nursing home supply for the population aged 65 and over, despite a moratorium on all nursing home construction in effect since 1985, and despite the fact that Minnesota ranked second only to Colorado in its ability to reduce its growth of nursing home beds over the 10-year period between 1980-81 and 1990-91 (a 13% reduction). The nursing home industry in Minnesota, which is about 45% nonprofit, enjoys an excellent reputation for quality. Minnesota is one of only two states with an "equalization" statute for nursing home reimbursement. This holds that any nursing home participating in the Medicaid program (which is all but a very few of Minnesota's 442 nursing homes) cannot charge a private-pay resident any more than the state would pay for a

³The AMCRA Foundation, 1994, *Managed Health Care Database*.

⁴Kralewski, J.E., de Vries, A., Dowd, B., & Potthoff, S., "The development of integrated service networks in Minnesota," *Health Care Management Review*, 20(4), 1995.

Medicaid resident. The state's philosophy here was that, given that it intends to pay sufficiently for delivery of care, its policies should prohibit facilities from hastening spend-down to state Medicaid eligibility by even higher rates in the private-pay market. In 1985 Minnesota instituted a nursing home case mix reimbursement scheme that entailed establishing 11 facility-specific rates for each nursing home's reimbursement under Medicaid (and, by dint of equalization, its private pay charges) depending on each resident's functional status, behavior problems, and use of special nursing services.

Home and community-based LTC services are provided in Minnesota through a Medicaid 1915C elderly services waiver, known as the Elderly Waiver (EW). Those who qualify by income and assets for Medicaid are eligible for the EW program. In addition, the state funds a program called the Alternative Care Grant (ACG), which got its start in 1983, when Minnesota also instituted a nursing home preadmission screening program (PAS). Clients include these older adults whose financial situation affords no more than 180 days before they would spend down to Medicaid if they lived in a nursing home, who are functionally eligible for nursing homes, but who prefer to remain at home are eligible for ACG. The PAS, the EW, and the ACG are administered in each of the state's 87 counties. Lead agencies are either the community health department or social service department. Teams of nurses and social workers are responsible for initial assessments and the ongoing case management. A uniform assessment tool is used.

In 1990, a new program arose from the work of INTERCOM, the Interagency Long-Term Care Planning Committee comprised of 11 state government managers all working with older people served in the state LTC-related systems. The new program is called Seniors' Agenda for Independent Living (SAIL). SAIL is a project designed to achieve the following four policy improvements:

- Simplifying access to home care services;
- Encouraging further development of alternatives to institutionalization;
- Ensuring appropriate protections and service quality; and
- Providing policy directions for future long-range spending decisions.

The program has been piloted at 6 sites in the state, covering 35 counties, and is now coordinated through the Minnesota Board on Aging. While SAIL has a 20 year long-term perspective regarding the changes it hopes to institute, SAIL has already increased the recruitment efforts for expanding the number of adult foster care homes in its service area, and has also increased the number of agencies offering chore services to older people while providing those agencies with specific training in working with older adults.

Aging network involvement in community-based LTC is primarily limited to Older Americans Act (OAA) funded programs. There are 14 AAAs in Minnesota, covering 87 counties and 1 tribe. AAAs typically contract with counties and other nonprofit organizations for the provision of Title III services. AAAs are not part of the ACG or EW programs. However, in July, 1995, the state Department of Human Services held a conference which included HMOs and Medicaid officials to discuss the way integrated acute care and LTC might take shape. AAAs and county agencies operating EW/ACG programs were very much a part of this conference.

THE PREPAID MEDICAL ASSISTANCE PROGRAM (PMAP)

The popularity and success of managed care has not been lost on state government in Minnesota. Increasing difficulty in getting access to services for its MA recipients led Minnesota to identify ways to open the doors to health care services for this population. Beginning in 1985 and operating with a newly obtained §1115(a)(1) waiver, the Prepaid Medical Assistance Program (PMAP) started operations in three Minnesota counties, one urban, one suburban, and one rural. Over the past 11 years, PMAP has obtained waivers supporting it into 1997 and has added 13 more counties to the three already served by the program.

Eligibility

PMAP is a prepaid capitated program for Medicaid, and covers MA recipients in Aid to Families with Dependent Children (AFDC), the aged, and other adults enrolled through the state's General Assistance Medical Care (GAMC). Enrollment is mandatory, though there are several exclusions for the program, including:

- Recipients who have private health care coverage through a certified HMO. A person excluded under this category may enroll on an elective basis if the private health insurance health plan is the same as the individual will select under PMAP.
- Community-based medically needy individuals who are Medicaid eligible on a spend-down basis;
- Recipients of the Refugee Assistance Program;
- Blind and disabled recipients under 65 years of age;
- Recipients residing in state institutions;
- A group of recipients in Itasca County who live near the county border and who use providers in a neighboring county;

- Children in designated out-of-home placements (they may choose to enroll on an elective basis); and
- Children eligible for Medicaid through subsidized adoptions (MN DHS, 1995).

The first exclusion means that older people already in TEFRA HMOs prior to qualifying for Medicaid were not required to change providers if their HMO did not happen to be a PMAP provider. Furthermore, elderly PMAP clients may convert to a TEFRA HMO at any time, and revert to fee-for-service Medicaid. This exemption was stipulated in part to avoid the problems other states have had in enrolling Medicaid recipients in Medicaid managed care plans when the enrollee is already enrolled in another plan for their Medicare services. Arizona, Oregon and California have had to work out the issues differing managed care plans have posed. Minnesota chose to avoid the problem completely by excluding those people who choose Medicare HMOs for their Medicare services. Rather than introducing a new managed care plan to the puzzle, the state provides the Medicaid portion of co-payments and other costs on a fee-for-service basis to those beneficiaries. Medicare HMO enrollees who are dually eligible may, however, elect to enroll in a PMAP plan offered by the managed care organization currently covering their Medicare services. Dually eligible persons in PMAP may also decide to enroll in a Medicare HMO (including EverCare,³ if they are in a nursing home) and become dis-enrolled from PMAP, reverting to fee-for-service Medicaid. It is not known how many people have made such decisions.

Enrollment

PMAP enrollees have the option of choosing among several participating plans. These plans provide members with all MA-covered services, except for most long-term care services, including nursing facility and waived services. Enrollment in each plan lasts for one year, with a 30 day open enrollment period offered annually. The State provides each plan with a monthly capitation payment for every person enrolled in the plan. By September of 1995, there were 13,910 older Medicaid recipients enrolled in PMAP throughout the eight counties. This figure includes over 26% of the total older Medicaid population in the state of approximately 53,000. Residents of nursing facilities are also required to enroll in PMAP, though only a portion of the services received in the nursing home are covered by PMAP (e.g., drugs, oxygen, physician co-payments).

³EverCare is a Medicare Risk Contract that is available only for nursing home residents.

Benefit Package

PMAP health plans are required to provide the basic services covered by Medicaid in Minnesota, including:

- Primary care services;
- Acute care services;
- Pharmacy services.
- Mental health services;
- Substance abuse services; and
- Some LTC (includes home health services, therapies, medical supplies and equipment, transportation for medical appointments, personal care).

PMAP has been working closely with plan providers to educate them on the process of referral to county Alternative Care Grant programs for assessments when LTC services are needed. This process connects enrollees with waived services to provide for their community-based LTC needs. PMAP staff indicate that the referral process seems to be working well in most counties.

Rate Setting and Capitation

Rate setting in PMAP has gradually evolved through its years of operation. The capitation rate remains based on a rate cell determination involving the following factors: age; sex; Medicare, institutional, and eligibility status; and geographic area. Rates are based on historical utilization and cost. For calendar year 1996, a new methodology was formulated with the assistance of the actuarial firm of Deloitte and Touche. Rates are based on fee-for-service costs and utilization over a three-year period, with several adjustments made to the rates to determine PMAP rates. See Table 1 for actual 1996 monthly capitation rates.

PMAP enrollees receive their Medicare services from PMAP providers, who have, as part of the program, agreed to waive deductibles and co-insurance for those whom PMAP covers. However, the plans ordinarily bill Medicare on a fee-for-service basis for reimbursement of Medicare-covered services.

Quality Improvement

Health plans operating under PMAP are required to have both an internal and an external review process in place. The internal quality improvement (QI) system is set forth in the contract each plan makes with DHS, and is comparable to the system required for state HMO licensure. Quality improvement reviews are completed annually by the state Department of Health HMO licensure staff. Licensure reviews include clinical site reviews and a medical records audit. DHS contracts with the Ohio PRO to provide external QI reviews for ambulatory care services provided through PMAP plans.

In addition to the ongoing quality improvement efforts standard to PMAP, Minnesota became one of three sites selected to participate in a demonstration project funded by the Henry J. Kaiser Foundation, administered by the National Academy for State Health Policy, and known as the Quality Assurance Reform Initiative (QARI). QARI was part of the development of the Health Care Quality Improvement System (HCQIS) designed for Medicaid managed care programs. QARI development was completed in April 1995, and provided PMAP and the State DHS with valuable information on childhood immunizations, prenatal care, asthma, and diabetes.

Grievance Process

Each PMAP health plan has its own procedures for addressing problems members have in using the health plan. The informal process consists of:

- The member calling the health plan's member services department and filing a concern about the service received or about administrative issues.
- The health plan tries to address the complaint without going through the formal process of a written grievance.

PMAP also has its own ombudsman program, which has been able to resolve most issues before they get to the formal phase. If unsuccessful, however, the formal procedure is:

- The enrollee submits a written complaint to the health plan.
- The plan has 30 days in which to provide a hearing on the complaint and to resolve the grievance in writing.

The enrollee also has the right to go through the state appeals process at any time, offering enrollees the option of skipping the plan appeals process if they choose. The state appeals process is open to all state Medicaid recipients, and resolves issues regarding services, eligibility and administration. This written notice, referred to as a denial, termination or reduction (DTR) notice, must be provided 10 days prior to the proposed health plan action.

Table 1 1996 PMAP Rate Schedule

Age	Sex	Metro 96 Rate	Regional 96 Rate
AFDC/AFDC Related			
sz-1	F	\$292.25	\$252.74
2-15	F	\$55.22	\$47.54
16-49	F	\$172.83	\$149.12
50 +	F	\$255.42	\$220.60
0-1	M	\$331.33	\$286.57
2-15	M	\$63.71	\$54.89
16-49	M	\$95.43	\$83.00
50 +	M	\$204.49	\$176.52
Needy Children/ Newborn (automatically enrolled)			
0-1	F	\$453.00	\$391.88
2-15	F	\$203.95	\$176.27
16 +	F	\$307.94	\$266.06
0-1	M	\$535.77	\$463.51
2-15	M	\$220.40	\$190.51
16 +	M	\$187.42	\$161.75
Pregnant Women			
All Ages	F	\$469.58	\$405.96
Aged Institutionalized			
65-74	F	\$459.99	\$397.63
75-84	F	\$351.03	\$303.32
85 +	F	\$278.63	\$240.66
All Ages-Non MC	F	\$752.75	\$551.02
65-74	M	\$447.49	\$386.81
75-84	M	\$341.32	\$294.92
85 +	M	\$296.35	\$256.00
All Ages - Non MC	M	\$947.73	\$819.78
Aged Non-Institutionalized			
65-74	F	\$308.11	\$266.18
75 +	F	\$359.61	\$310.75
All Ages Non MC	F	\$441.71	\$381.81
65-74	M	\$379.01	\$327.55
75 +	M	\$358.86	\$310.10
All Ages-Non MC	M	\$498.62	\$431.06

Source: MN Department of Human Services, 1996.

Another consumer safeguard was added to PMAP contracts in 1989, which stated:

In all cases when services are denied, reduced, or terminated, the health plan must notify the enrollee of: the denial or the action by the health plan; the reasons for the action taken; the specific federal or state regulations or health plan policies which require the action; an explanation of grievance rights (both health plan and state); and the circumstances under which services must be continued.

Evaluation

PMAP has been evaluated on a number of fronts. The Health Care Financing Administration (HCFA) contracted with the Research Triangle Institute (RTI) to study the demonstration. Their areas of focus included:

- Cost containment effects;
- Utilization of services;
- Quality of care;
- Access to care;
- Client satisfaction; and
- Physician and institutional participation.

RTI reviewed encounter and client survey data, medical records and case studies, and found unanticipated start-up difficulties throughout the project, problems with enrollment and eligibility data, scattered problems assuring access, and reimbursement levels providers found unattractive.

A number of other studies were completed, including individual county studies, health plan studies, and those done by the Minnesota DHS. These studies examined a number of different aspects of PMAP, including PMAP mental health agencies, crisis intervention, the impact of capitation on the chronically mentally ill, client satisfaction in general, grievance panels, inpatient utilization reporting, and public health nursing.

PMAP staff report seeing improvements in the way plans serve institutionally-based PMAP enrollees. Plans have become better informed about the nursing facilities in their service areas, have improved communications with the facilities, and now make decisions about care provision based on where their enrollees already go for care. Another reported improvement has

come in the way the state PMAP staff coordinate with counties and with plans to ensure that plans refer enrollees for preadmission screening assessments when needed.

The areas of the program that PMAP staff want to improve in the future are the hospice benefit and the newly added personal care attendant benefit. In the past, most MA recipients who were receiving ongoing in-home care through a personal care attendant (PCA) were excluded from PMAP. Beginning in January, 1996, however, this group has been added to the group of MA recipients required to receive MA benefits through PMAP. PCAs had been arranged through service agencies unrelated to the health care network, but now the health plan will be responsible for the cost of the service and could require changes in provider for this benefit. PMAP has had concerns regarding the availability of hospice services in the community setting and will also be working on improvements in the provision of these benefits over the coming year.

PMAP Providers

Contract negotiations between potential providers and the Minnesota DHS identify contractors for each geographic region on a regular basis. The number of providers in a given region varies. Itasca County (a rural county in northern Minnesota) has only one provider for PMAP services, while Hennepin County (home of Minneapolis) has five plans contracting to provide PMAP services. Other PMAP counties have 2-4 providers per county. Only 3 PMAP providers currently offer TEFRA risk contracts, and these do so only for the Twin Cities metropolitan area.

Examples of providers include:

- *Itasca Medical Care (IMCare)*
Itasca Medical Care has served Itasca County as a primary care provider health plan model since 1985. IMCare has a network of 34 physicians, 23 dentists, 11 pharmacists, 3 hospitals, 8 mental health providers including the Community Mental Health Center, 7 chiropractors, 6 vision, and other ancillary providers throughout Itasca County. Dental services are provided through contract with a dental network. Administrative services and medical management (quality assurance/utilization review) are provided by a Managed Care Unit within Itasca County Human Services. The computer system is a Medicaid managed care system also being used in Arizona. The computer system has been evaluated and accepted by HCFA. Benefits are coordinated with Medicare and other third party payers.

- *Medica*
Medica is an independent practice association (IPA) model HMO which serves its Medicaid and GAMC enrollees through an open access system. Medica has participated in PMAP since the beginning of the program. The Medica Choice Care product is currently available to recipients in Anoka, Dakota, Hennepin, and Scott

Countries, and may expand its services to Ramsey County as well as the Central and Northeast regions of Minnesota. Fully half of all PMAP elderly clients are enrolled in this particular plan.

Medica provides services through a network of over 5000 physicians, 1365 clinics, 21 hospitals and over 800 pharmacies. Mental health and chemical dependency services are provided through United Behavioral Services (UBS). Dental services are provided through the Medica dental network.

■ *Metropolitan Health Plan*

Metropolitan Health Plan (MHP) has contracted with the state to serve Hennepin Medicaid recipients since 1984. In 1994, MHP expanded its service area for Medicaid recipients to Anoka, Carver, and Scott Counties. The health plan also offers a commercial group plan to Hennepin County employees.

MHP is a network model HMO that utilizes 6 hospitals, 814 primary and specialty physicians, the Hennepin County Medical Center outpatient clinic, 30 other clinic sites, including community-based clinics, and federally qualified health centers.

MHP primary care clinics offer many out-patient services at one location and require a primary care physician referral to specialty services. Mental health and chemical dependency services are provided through a network of over 106 county-operated or contracted agencies/programs. Dental services are provided by designated dentists affiliated with the Delta Dental network. MHP does not have a Medicare risk contract at this time; therefore, benefits for aged enrollees are coordinated with Medicare.⁴

Special Problems of the Dually Eligible

PMAP was designed particularly for Medicaid populations who are not eligible for Medicare. The state cannot impose freedom of choice for Medicare beneficiaries, nor can it impel Medicare beneficiaries to use an MCO instead of fee-for-service. However, the state can and does make PMAP mandatory, and declines to pay co-insurance or deductibles for elderly Medicaid clients except through PMAP. This essentially locks many older Medicaid clients into using a PMAP plan for acute care. However, exceptions exist, especially for those opting for managed care under Medicare. Essentially, three patterns are possible:

- The older person is in a PMAP program for Medicaid services and receives Medicare services from the PMAP provider, which bills the Medicare intermediary on a fee-for-service basis.
- The older person receives Medicare services through a TERRA HMO, and is exempted from PMAP. The Medical Assistance program pays for this person's Medicaid services on a fee-for-service basis, or
- The older person receives Medicaid through PMAP and Medicare through a TERRA HMO, both operated by the same provider.

Minnesota's Medical Assistance program has no knowledge of how many people fit into each category. As indicated earlier, one large PMAP provider in the Metropolitan area (accounting for half the state's approximately 14,000 elderly PMAP clients) is also a TERRA risk contractor. It is unknown how many of its dually eligible clients are served under two capitations rather than fee-for-service for Medicare.

Dually eligible older people face the dilemma of having two different funders for their health care needs. Medicare funds specific services, such as hospital and physician costs, while Medicaid covers a broader array of services, and the co-payments and deductibles for physician services received through Medicare. This overlap in coverage can be confusing, complex and expensive, and older PMAP enrollees have not been immune from the effects of this quandary. In PMAP, for example, the current capitation covers only a small portion of the services senior enrollees receive, such as Medicare co-payments and deductibles, drugs, therapies, and medical transportation.

As a result, reform efforts undertaken by states to control LTC costs may be offset by increased Medicare costs. Conversely, cuts in Medicare could have an adverse effect on state Medicaid programs. This tug of war is further aggravated by the fact that states have little incentive to address the needs of the dually eligible older adult with chronic care needs because savings would fall to Medicare, the federal program, more so than it would to state Medicaid programs.

Minnesota, however, chose to build on the strong base provided by PMAP to create an integrated service system which could address the issues of fragmentation and cost shifting created by multiple funding sources for dually eligible older adults.

⁴Excerpted from *Minnesota Prepaid Medical Assistance Program Plan: Status Report*, Minnesota Department of Human Services, October, 1995.

THE LONG-TERM CARE OPTIONS PROJECT (LTCOP): INTEGRATING ACUTE AND LTC

Although PMAP was begun to improve access to services for recipients of the state Medical Assistance Program, left unaddressed were the issues of fragmentation of services for older adults served by not only PMAP but also Medicare and a separate long-term care system. Plans to merge these funding streams, creating a more seamless system of care, resulted in the development of the Long-Term Care Options Project (LTCOP).

With funding from the Robert Wood Johnson Foundation, Minnesota embarked on several years' worth of planning to develop LTCOP and, in April, 1995, Minnesota was granted Medicare waivers under 1395(b)(1) of the Social Security Act and Medicaid waivers under §1115(a)(1). These waivers enable the State to combine funds from Medicare and Medicaid into a single capitation, which will fund primary, acute, and LTC services for older adults in the seven metropolitan counties who are dually eligible for Medicare and Medicaid.

LTCOP was designed to give the state better control of its purchasing and eliminate a situation where better integration and coordination in Medicaid LTC is likely only to save federal dollars in Medicare rather than accrue savings to the state. Minnesota is the first state to obtain a federal waiver to integrate acute care and LTC. The state's earliest preference was that the state receive the capitation directly from the federal government, allowing the state to capture savings right off the top rather than simply serve largely as a pass-through to providers. DHS next wanted providers and state to share both the risks and the savings from the program, but HCFA did not approve this portion of the waiver request. Instead, HCFA will provide the Medicare capitation directly to the provider and the state will pay the Medicaid capitation to the provider. Both funds will be pooled at the provider level. Medicare and Medicaid each take their savings off the top (5% off the AAPCC) before passing the funds on to providers.

Eligibility

Because LTCOP builds on the work already completed by PMAP, eligibility is open only to those older people eligible for and enrolled in PMAP. In addition, eligibility guidelines include:

- Being 65 years of age or older;
- Eligibility for MA, including medically needy persons (i.e., persons ineligible for cash assistance but meeting MA income and asset limitations); and
- Eligibility for Medicare parts A and B.

A number of populations are excluded from participation in the LTCOP. Exclusions include:

- Recipients eligible for the Refugee Assistance Program;
- Residents of State Regional Treatment Centers, State Institutions, and Institutions for Mental Disease;
- Individuals eligible for MA who are already enrolled in a Medicare risk contract or who have health insurance coverage through a licensed HMO;
- Individuals who are Qualified Medicare Beneficiaries (QMB) and otherwise not eligible for MA;
- Individuals who are Specified Low-Income Medicare Beneficiaries (SLMB) and otherwise not eligible for MA; and
- Individuals who have Medicare coverage through United Mine Workers and Railroad Retirees.

Minnesota DHS does not know how many people are enrolled in Medicare HMOs but not in PMAP. They guess the number to be not more than 500. It is also unclear how many people are in PMAP and also enrolled in Medicare HMOs. The State does know that there are approximately 18,000 Medicaid-eligible older adults in the seven-county metropolitan area in which LTCOP will be operating. Of these, 14,000 are enrolled in PMAP, and 4,000 are not yet enrolled due to changes in PMAP eligibility as of January 1, 1996. This group includes formerly exempt persons such as those eligible on spend down, those with PCAs, and those who are in the process of signing up but are not yet enrolled. Of the 14,000 PMAP enrollees, there are 1,500 who are not eligible for LTCOP, due to ineligibility for Medicare (immigrants and others who have not qualified for Medicare, and those who qualified but never signed up for Part A). This leaves 12,500 people eligible for LTCOP.

Enrollment

Enrollment in LTCOP is expected to begin in the third quarter of 1996. LTCOP will be open to all dually eligible older adults meeting eligibility requirements and living in the seven metropolitan PMAP counties. Potential LTCOP participants will have the choice of joining the LTCOP or may choose to stay with PMAP (meaning that they would receive their Medical Assistance through PMAP and continue to receive Medicare coverage either through fee-for-service limited to their PMAP plan provider network, or through a Medicare risk plan offered through the same managed care organization as their PMAP plan (if available)). Coverage under LTCOP is open to both nursing facility and community-based elderly.

LTCOP enrollment will be managed by county human services agencies and overseen by the State DHS. Plans will be allowed to transfer enrollees in their PMAP plans to their LTCOP plans as enrollees choose to transfer.

Enrollment may be done on a monthly basis. An open enrollment period is held once a year, permitting an enrollee to switch plans, whether PMAP-only or LTCOP. If a LTCOP enrollee chooses to disenroll between open enrollment periods, they may do so only to the PMAP-only plan offered by the same HMO. Enrollees are permitted a one-time change option between plans during their first year in Medicaid managed care.

Benefit Package

The benefits provided by the LTCOP-contracting HMO include those found in standard Medicare risk contract HMOs, all Medical Assistance-covered services (with special arrangements for nursing facility services), and services available under the Elderly Waiver (§1915(c) home and community-based services waiver). Also, the HMO provides a case manager to each enrollee to assist in coordinating care for that enrollee across the continuum provided through the Project. See Table 2 which lists the benefits provided under LTCOP.

Rate Setting and Capitation

The structure for establishing rates in LTCOP incorporates several factors. The four initial segments in the structure are:

- *Medicare Adjusted Average Per Capita Costs (AAPCC)*

Capitations to health plans will usually be at a rate of 95% of the AAPCC (established by HCFA) for dually eligible Medical Assistance recipients. For those community-based recipients considered nursing home certifiable, the AAPCC will be multiplied by 2.39 to determine their rates. The higher figure for this group is based on the figures used by the Program of All-inclusive Care for the Elderly (PACE) to determine a fair rate for serving a very frail community-based population. This figure is also a good incentive for HMOs to consider covering this population.

- *PMAP rates for Medicaid acute and ancillary services*

PMAP rates are set by the State and are based on costs in the fee-for-service arena over the previous few years. The State uses this information to forecast the coming

Table 2 BENEFITS PROVIDED BY LTCOP

Medicare Part A	inpatient hospital SNF therapies drugs
Medicare Part B	physician outpatient hospital ambulatory surgical services home health services hospice laboratory radiology drugs transportation medical equipment/supplies therapies (pt, ot, st) psychology physician's assistant services
Medical Assistance Services (Medicaid)	inpatient hospital nursing facility therapies drugs physician outpatient hospital ambulatory surgical services home health services hospice laboratory radiology drugs transportation medical equipment/supplies therapies (pt, ot, st) psychology physician's assistant services dental vision care podiatry chiropractic services personal care private duty nursing
Elderly Waiver Services	adult day care adult foster care assisted living caregiver training/education case management companion services electronic home monitoring extended home health aide extended home health nursing (LPN/RN) extended personal care extended supplies and equipment home delivered meals homemaker residential care respite care

Source: MN Long-Term Care Options Project §1115 waiver request. April, 1994.

year's expected costs, and then adjust the rates according to five factors, including: 1) Age (65-74, 75-84, 85+); 2) Sex (male, female); 3) Geographic region (Hennepin, Metro, Non-Metro); 4) Institutional status (institutionalized and non-institutionalized); and 5) Medicare Parts A and B (Only those people with both Parts A and B are eligible for LTCOP or PMAP).

■ *Average monthly Elderly Waiver payments for home and community-based LTC services*

This component is determined by the average monthly Elderly Waiver payments, adjusted for age, sex, and geographic region using the same definitions as those used in PMAP.

■ *180-day Medicaid nursing facility add-on*

LTCOP plan enrollees are eligible for up to 180 days per year of nursing facility care through the project. Payment to contractors by LTCOP will occur through a special adjustment made to the capitation rate, called the Medicaid NF (nursing facility) add-on. This rate is determined using nursing facility per diem payments paid on average by MA in one fiscal year. Contractors receive payment for Medicare skilled nursing facility days through the Medicare AAPCC which includes the amount that Medicare would expect to spend on skilled nursing facility services. The Medicare requirement of a 3-day hospitalization prior to nursing home admission has been waived for this project. If an enrollee uses the 180 day allowance and continues to need nursing facility care, the regular Medicaid program will kick in and begin covering the costs of nursing home care.

The above components together determine the rate paid by LTCOP to the participating health plans on behalf of each recipient enrolled. The proposed rate structure is included as Table 3. The table shows that a special rate is provided for those recipients who leave the nursing home and return to the community setting. They are considered "conversions" during this year-long transition, and are allowed a higher capitation rate to assist in covering the extra costs associated with the move, as well as to offer an incentive to plans to move enrollees back to the community setting.

HMOs or CISNs will be contracting with the State DHS to become providers in LTCOP. The request for proposals (RFP) is expected to be issued in February, 1996, with selection of networks occurring by May, 1996. MN DHS staff expect that three or four plans will submit proposals to become LTCOP contractors.

Table 3 Rate Structure for Long Term Care Options Project

	Column 1	Column 2	Column 3	Column 4
	Nursing Facility Recipients	NH Certificate Conversion - 1 year post-discharge	Nursing Home Certificate (NHC) (waiver eligible in the community)?	Other Community-Based Recipients
Medicare	99% of Institutional AAPCC	PACE risk adjuster ^a	PACE risk adjuster	99% of Non-institutional AAPCC
Medicaid/Adult Auxiliary Services	Institutional PMAP rate	Institutional PMAP rate	Non-institutional PMAP rate + NF Add-on	Non-institutional PMAP rate + NF Add-on
Medicaid Long Term Care Costs	Present System ^b	2 X average monthly Elderly Waiver payment	Average monthly Elderly Waiver payment	NF

1. Referred to resident in nursing facility for more than 6 months.
2. Enrollee status will change to the NHC category upon preadmission screening (PAS) using the rate PAS tool.
3. The PACE risk adjuster is 2.39 x 95% of the AAPCC.
4. LTCOP contractors will be at risk for a portion of the Medicaid nursing facility days in addition to Medicare Skilled Nursing Facility (SNF) days for those who enroll in the LTCOP from a community setting.

Source: Minnesota "Long-Term Care Options Project" Operational Protocol (1995, December 14), St. Paul, MN: Minnesota Department of Human Services.

Quality Improvement

Improving quality in LTCOP is to be accomplished using multiple strategies. Both Medicare risk plan requirements and PMAP requirements will be incorporated. The State will also require plans to meet state licensing requirements for HMOs or CISNs. Both the Minnesota Department of Health (MDH) and the Minnesota DHS will have monitoring responsibilities. Plans must also have their own quality improvement system meeting LTCOP conditions, consisting of a quality assurance (QA) "entity" who meets regularly with the governing body of the plan, qualified QA personnel, written QA plans, documentation of the annual evaluation of

quality of care; evaluation of clinical, organizational, and consumer components of the plan; and finally must make records of all of the above available to the state and federal governments for audit purposes.

Plans identify quality issues and problems using the following prescribed methods:

- Patient satisfaction survey;
- Health plan focus studies;
- Health plan utilization review;
- State review of utilization data;
- Corrective action (if needed); and
- Sanctions (if needed).

An external quality assurance review must also be conducted annually of each plan. The reviews will be conducted by the Peer Review Organization (PRO) with which the state contracts for PMAP. Minnesota's current contract is with Peer Review Systems of Ohio, and will continue through 1997, meaning it will review at least the first year of LTCOP. Reviews will consist of clinic site visits, record reviews, and clinical focused studies (e.g., adult depression).

Grievance Process

Coordinating a grievance process for LTCOP has been a complex task for planners. Medicare and Medicaid each have different requirements regarding appeals processes, making it difficult to merge this function between the two programs. HCFA and the State of Minnesota have agreed to follow the PMAP appeals process, but have added a few additional steps to the protocol. A grievance will be separated by Medicare or Medicaid status only if the appeal extends beyond the State appeals process. At that point, a determination will be made regarding whether the service in question is generally covered by Medicare or by Medicaid. Based on that decision, the appeal will either go to an Administrative Law Judge (for Medicare) or to the District Court of Appeals (for Medicaid).

All plans are required to provide every enrollee at the time of enrollment with information outlining the grievance process, including the names, addresses and phone numbers of the person(s) to contact with a complaint. Plans are also required to provide all enrollees at the point of entry into the plan with the proper forms for filing a written complaint.

A general overview of the mechanisms used to protect the rights of LTCOP enrollees incorporates:

- Health plan complaint and grievance procedures;
- The county advocate;
- The State PMAP ombudsman program;
- The State aging ombudsman program;
- Notification of Appeal Rights;
- The state appeal procedure; and
- An expedited hearing process.

Evaluation

Because LTCOP is operating via a §1115(a) waiver, an evaluation component is required. The evaluation for LTCOP will be done through contract with HCFA, but the evaluator has not yet been determined. The major questions to be answered by the evaluation are:

- Does LTCOP lead to better clinical and functional outcomes than PMAP for the same population?
- Is there evidence of under-service for LTCOP enrollees?
- Are the costs for care for LTCOP enrollees less than for those in the control group?
- How does the utilization of services differ for LTCOP enrollees compared to controls?
- What are the subgroup effects of LTCOP versus PMAP?

County Responses

Counties have responded in varying ways to the introduction of both PMAP and LTCOP. Some have been accepting, cooperative and interested, while others have been very opposed to them. The Association of Minnesota Counties (AMC) has actually come out with a position opposing the expansion of PMAP into additional counties until problems of cost shifting and

quality can be addressed. AMC is also interested in pursuing the possibility of county contracting for PMAP and LTCOP rather than using the state as the contracting agent for these programs.⁷

Hennepin County (Minneapolis) has a serious proposal submitted to the state for consideration of just this county-based contracting arrangement. This could be a complicated task in Hennepin County, however, due to the fact that Hennepin County is a provider in PMAP already, and would raise concerns of conflict of interest if it tried to contract with itself.

Provider Responses

Although early to gage, Minnesota's LTC providers are giving consideration regarding how to best position themselves to work within a new system where Medicaid LTC services would be provided or purchased by ISNs. Nursing homes and home health agencies, for example, can strive to become part of an ISN, or they can establish alliances and networks of their own that are in a better position to become subcontractors of the ISNs. Some nursing homes, for example, are in the planning stages of developing networks with the small adult foster homes in their regions, taking the view that an ISN would find contracting with a few entities better than contracting with each small provider. Moreover, the small providers would not have the ready capacity to do these negotiations on their own. In 1995, the State (partly in response to the recommendations of a Governor's Commission on LTC about encouraging innovation through modified regulations) began a demonstration that would permit some nursing homes more flexibility in the way they use and account for their Medicaid revenues. The first round of these projects will become operational in 1996, and 2 more rounds are planned. These efforts will help facilities test more flexible ways of doing business, that may, in turn, render them better able to work with and within ISNs.

AGING NETWORK INVOLVEMENT

Planning

The aging network in Minnesota consists of the SUA, called the Minnesota Board on Aging, and 14 AAAs. AAAs cover multi-county areas (except for one tribal AAA) and are usually non-profit organizations or are regional government-connected entities. The Twin Cities seven-county metro area is covered by one AAA. AAAs are not directly involved in the administration of the EW or the Alternative Care Grant (ACG), the community-based portions of the long-term care system in Minnesota. The Elderly Waiver and ACG operate through the

⁷Association of Minnesota Counties, *Recommendations of the AMC Health Policy Task Force and Legislative Steering Committee Task Force*, January, 1996.

county system, with case management provided through county employees and most services contracted out.

Initial planning for PMAP and LTCOP occurred without direct input from the aging network in Minnesota. As the plan began to take shape and hearings were held on the topic, aging network representatives testified at the hearings. As a result of this input, Network staff had further discussion with LTCOP planners. The State used data obtained from the aging network regarding older adults in the state. In addition, several aging network representatives are now sitting on the Advisory Committee for LTCOP.

Advocacy

Minnesota established an ombudsman program specifically for hospital discharge and acute care in 1988. In 1989, home care ombudsman services were added as well. The Office of the Ombudsman for Older Minnesotans is positioned to receive complaints involving managed care primarily from Medicare beneficiaries with Medicare HMOs. Most of these complaints are not from people who are also eligible for Medicaid. Since 1993, the office has intervened to assist almost 400 Medicare beneficiaries (out of a possible 614,000) with complaints about access to health care or premature discharge from a hospital. Eleven percent of these complaints were against HMOs. The types of problems addressed are reviewed below and are grouped by topic.

Enrollment/Disenrollment Issues:

- Examples include persons going from one HMO plan to another without disenrolling from the first plan and as a result, no plan pays a benefit.
- Persons going from an HMO back to a Medicare supplemental insurance without formally disenrolling from the HMO, resulting in neither plan paying.
- Persons being enrolled in a new plan and disenrolled in the first plan by HCFA without their knowledge due to the confusing sales and marketing materials.
- Persons disenrolling from the HMO to receive hospice benefits but not advised to disenroll only from Part A and are left without the Part B physician coverage.

Access to Health Care:

- Referrals to a specialist denied or delayed.
- Requests for second opinions not covered.
- Hospital care denied or delayed.

- Lack of coverage for ambulance transportation when ambulances are routed to a hospital which is out of network.

Transfers and Discharge Issues:

- Premature hospital discharge without proper discharge planning resulting in people being sent home without adequate home care services or equipment.
- Changes in level of care within the same facility i.e., acute to subacute/transitional care without informing people of the change or their Medicare rights resulting in loss of Medicare coverage for subsequent SNF care.

Network/Service Area Issues:

- HMO enrollees who are snowbirds and split their residence during the year have no coverage for providers out of network.
- Enrollees join a plan when they are healthy and are not told that their choice of nursing home or home health providers will also be restricted.
- Network providers change and consumers are not informed in a timely fashion that coverage for that provider will not be provided.
- Enrollees are not always protected against accessing services out of plan when they become confused or disoriented. Friends and family members may not be aware of the person's specific providers, of limited service areas, or of contract obligations.

Utilization Review Issues:

- Utilization review employees are not qualified in certain areas, i.e., a prior authorization request for chiropractic services was denied because the person had a history of chemical dependency. The reason for the denial was that the person "might become dependent" on the chiropractic services.
- Utilization review decisions are not timely and consumers don't receive copies of the utilization review denial, resulting in people not knowing until surgery is over whether or not the procedure will be covered.
- Lack of the consumer's right to challenge a utilization review decision and provide a second opinion when a procedure is denied as not medically necessary.

The Office of the Ombudsman for Older Minnesotans also provided some case examples specifically illustrating some of the managed care issues that have come to its attention. Once again, these are not all enrollees who are dually eligible or who are enrolled in PMAF. They include:

Case #1: A Medicare beneficiary was disenrolled from her primary HMO (HMO #1) because she had signed an application form for another HMO (HMO #2) not realizing it was a contract. She was disenrolled at the HCF A level unbeknownst to her because she can only be enrolled in one HMO at a time. HMO #2 had forwarded her application to HCF A along with other new enrollees. She received a termination letter from HMO #1 based on a notice they received from HCF A. Her contract requiring a written letter from her to terminate services did not apply under these circumstances. She was distraught at losing her primary care doctor and specialists who had been successfully treating her for a chronic health problem.

She immediately wrote a letter to HMO #2 to clear up the misunderstanding and requested to be discontinued. In the meantime she was told she could not re-enroll in HMO #1 because she has to wait 30 days for the paperwork to be processed and be disenrolled from HMO #2. She was advised to send a premium payment to HMO #2 in order to have coverage even though she had sent a premium payment to HMO #1. HMO #1 did not accept the premium payment because she was disenrolled. HMO #2 did not accept the premium payment because they had received her letter requesting termination first.

This senior citizen had paid two premiums and was not covered for health care services under an HMO for one month because she signed an application believing it was simply a request to provide more information and she would have an actual contract to sign before she "agreed" to change plans. She had asked if this paper would "get her into" HMO #2 and reports she was told "no."

The situation was successfully resolved after a number of letters were written on her behalf. The HMO followed through by providing sensitivity training for their sales representatives.

Case #2: In another case, a Medicare beneficiary moved to another county and was approached by a sales representative from a major HMO. She was quoted a premium price and given an application to sign. She, too, was shocked to find out that she has signed a binding contract and she was billed a lot more than the quoted premium price.

Summary and Recommendations: Seniors often encounter sales representatives who will call them by phone and visit them in their homes. Smaller incidents can be avoided by requiring assurances that HMO sales representatives are accurate and ethical in portraying

the products they sell, and are skilled in working with vulnerable populations. HMOs need to provide clearly labeled contracts (i.e., "This is a contract for services") and clearly labeled information (i.e., "This is not a contract"), so that people are clear about what they are signing. Note: Direct sales of this sort are not allowed by PMAP or LTCOP.

Case #3: A 71 year old Medicare beneficiary had gone to the emergency room with vice-like chest pain. Her medication was adjusted. A week later she presented in the emergency room (ER) again with severe chest pain. The ER physician told her that her symptoms were something she would have to live with. She insisted she could not function with that pain. She reported that he told her it sounded as though she wanted him to hospitalize her. Even though she believed he was unhappy with her, she said "yes" and was hospitalized. A cardiologist determined she needed quadruple bypass heart surgery as soon as possible. An HMO care coordinator visited her in the hospital two days after her surgery and told her she would have to leave the hospital because "she was ready to go home." Despite this senior's protest that she did not feel ready to go home, the care coordinator insisted that she would have to pay \$100.00 a day out of her own pocket if she stayed in the hospital any longer. This patient had not talked with her doctors regarding discharge or discharge planning or started rehabilitation at that point.

Case #4: A 76 year old Medicare beneficiary went to the clinic feeling very ill with possible ketosis. He had kidney problems and diabetes mellitus. He was sent home. Ten days later his condition had deteriorated even more and his 73 year old wife, at that time frantic, called the clinic. The doctor said he would have to come back to the clinic before he would even be considered for hospitalization. The patient was so ill he could not sit up in the car or be transported. His wife called 911 out of desperation. He was taken to the hospital and admitted for a heart attack. He is now required to have dialysis 3 times a week for the rest of his life. His wife felt that the decision to hospitalize him was a burden inappropriately put in her hands.

Case #5: An 84 year old woman was suffering from flu-like symptoms. She went to the clinic and was told she probably has the flu. She was sent home. She returned to the clinic five days later. She was told she had pneumonia, given a prescription and sent home. During the night she fell and hit her head. The next day a home health worker arrived to find her on the floor. She was taken to the hospital and diagnosed with double pneumonia. She has fluid in her lungs. She was hospitalized and told she would be discharged two days later which was Saturday. She would have had no home health services until Sunday. She stated she did not feel well enough to leave. She died while in the hospital the following week.

Case #6: An 89 year old Medicare beneficiary was hospitalized for a hip fracture. The attending physician discharged her to a nursing home after two days in the hospital. She would have

met the criteria for Medicare coverage for skilled nursing care had she the qualifying three day hospital stay. Her husband was informed by nursing home staff and her primary physician that she could have stayed in the hospital one more day because of the level of care she needed. Her nursing home stay was much longer than originally anticipated. She incurred the entire cost.

Summary and Recommendations: Medicare beneficiaries are confronted with numerous access and discharge issues as HMO enrollees. They may have more difficulty gaining access to clinics and hospitals because their vulnerability or frailty is not considered soon enough. They may have problems with transportation or timely access when their medical conditions deteriorate rapidly. At these times, the standard HMO hoops may be inappropriate and inefficient.

The three day qualifying hospital stay remains a criterion for Medicare beneficiaries to receive assistance with their nursing home costs. With more emphasis on shorter acute care stays and subacute care, earlier discharges are more common. Medicare beneficiaries do not always have the means to cover the expenses incurred with more extended subacute and nursing home stays. They are not always informed of their rights, their rights can be confusing compared to traditional Medicare rights, and discharge planning is often neglected in lieu of earlier discharge.

Medicare beneficiaries need to be guaranteed timely access to and appropriate discharge from health care facilities. This should include assessments and treatment that take into consideration geriatric medical problems and complications. Medicare beneficiaries need to have advocacy and conflict resolution available to ensure and protect their rights. This intervention may enhance timely care and help seniors to resolve numerous problems with the HMO bureaucracy.

AAA Efforts with Managed Care

Metropolitan AAA. The Metropolitan Area Agency on Aging, serving the seven-county metro area of the Twin Cities, has been speaking with a couple of large HMOs in the area regarding possible joint working arrangements in setting up a program called the "Aging Plan," a one-stop shopping network to better coordinate community-based social model services for seniors. This work was originally begun by the AAA as they planned for needed changes in service delivery for the coming decade. The HMOs have seen the value of structuring these services to be more accessible to older adults in an effort to help seniors remain healthier and more independent. Details of the arrangements between the AAA and the HMOs are not yet completed, but could include financial support for the project.

Central Minnesota Council on Aging. The Central Minnesota Council on Aging serves a four-county area in the middle of the state, including the city of St. Cloud. This AAA has a keen interest in managed care and its effects on the older people in the area being served or who will be served by it. The agency's connections with managed care have come in two forms: co-sponsoring conferences and AAA input on proposed managed care products.

Central Minnesota Council on Aging has, in the past, arranged resource fairs for seniors in the PSA. They have had co-sponsorship for this event from a managed care organization operating in the area. The AAA has limited the MCO's involvement to the organization's name being printed in the program and on signs, identifying them as co-sponsors. The AAA is no longer holding these fairs, so it no longer has the joint sponsorship arrangement with the MCO. They have, however, been approached by MCOs who have offered the agency money in exchange for the opportunity to sponsor other conferences. The AAA believed this to be a conflict of interest and declined the offers.

At various points in the past few years, this AAA has been approached by MCOs who are developing new products directed toward the mature market, and are looking for input from the AAA regarding whether the proposed product would be attractive to older adults. This has given the AAA opportunities to provide feedback which could potentially influence the quality and types of products provided to seniors.

Another issue specific to this PSA concerned a period of time about ten years ago when two substantial MCOs pulled out of the region due to much higher utilization than expected and thus loss of profit in the market. This pull-out created problems for older adults covered by these MCOs, because many were left without any health care coverage for a period of thirty days. The AAA became involved in advocacy efforts on behalf of these seniors, particularly for one woman who had no coverage for her kidney dialysis during this month.

Central Minnesota Council on Aging held a town meeting in 1995 on managed care in long-term care for older adults. The meeting resulted in a lot of interest in the topic among elders in the PSA. The AAA's Board of Directors has taken particular interest in the issue. The decision has been made that this AAA will not become a vendor for any services provided through managed care entities, because the agency would then lose its ability to advocate for older adults using that system.

Central Minnesota Council on Aging is, however, interested in pursuing funding from sources in the managed care arena in another way. All HMOs in the state are required to put funds into foundations or other such mechanisms to provide services back to the communities in which they operate. Central Minnesota Council on Aging is interested in getting some of this funding to go into serving older adults in the community by supporting social model services such as transportation, respite, and chore services. The agency has just begun to pursue this prospect.

Aging Network Concerns

Aging network representatives have expressed concern about trying to extend PMAP throughout the state, which the MDH and MN DHS would like to accomplish by 1997. Aging network staff are also concerned about the potential effects of bringing the larger managed care organizations into rural areas to provide services through LTCOP. Traditionally, MCOs have brought their own community-based services to them, setting up satellite offices for their metro-based home health agencies. Should MCOs replace the services previously provided through local, often nonprofit agencies, the concern is over what will happen to those local agencies. Could they compete? Would they be transformed in the process of competing? Questions have been raised about who is best qualified to serve the community and how socially-oriented services will be nurtured and preserved.

CONCLUSIONS

The Minnesota experience illustrates the importance (and the difficulty) of integrating acute care and LTC at the funding and operational level. From the State's perspective, this kind of consolidation would lead to better accountability as a purchaser. After more than a decade of experience with attempting to manage Medicaid acute-care expenditures for the elderly in spite of the fact that the Medicare expenditures were out of the State's control, Minnesota pursued its new waiver for the LTCOP. Initially, the State was interested in having the State itself hold the capitation rather than passing it through to ISNs. Once that proved infeasible, the current plans were developed for the State and HCFA to make separate payments. Funds will be co-mingled at the plan level, presumably leading to better care and perhaps savings. The State may recoup some of the savings on its annual readjustment of Medicaid rates, though that is by no means certain.

Rate-setting for the new product was a major issue. In establishing the rate for enrollees with nursing-home-level disabilities, the effort was to be fair to the taxpayers in the sense of estimating likely costs, and not over-paying, while fixing a generous enough rate to produce some enthusiasm among potential MCO providers. The PACE experience was used as a basis for this rate-setting. As the program becomes operational, the validity of the rate-setting can be examined. It may well be that LTCOP will not prove any less expensive (given the rates), but will prove more effective in terms of better managed care with better results.

The operational phase will be of great interest to policy watchers around the country, who are keen to observe the extent to which financial consolidation can lead to better processes and outcomes of both acute-care and LTC for the consumer. They will also be interested in describing how a medically-oriented ISN makes use of a combined capitation for acute care and LTC. What kinds of internal changes will the organizations make? What new alliances will they form? Presumably other states will attempt different models with two separate capitations, so

that the advantages of each can be examined. How eager will they be to compete for the demonstrations in the first place?

Of interest is the extent to which flexible, community-based services can be incorporated into care that is capitated to a single medically-oriented Integrated Services Network. The State is optimistic that the incentives will be in place for innovation, and that ultimately such innovations will serve the interest of the consumer. Observers will also want to see how, if at all, existing community-based, county-level case management programs will be incorporated into ISN plans for LTC. The State has been sensitive in its planning to the wide range of concerns that such agencies express, ranging from pure survival worries to fears that the neighborhood and community basis for planning services will be eroded. Details are as yet unclear as to the particular mix of case management that will characterize the LTCOP programs—e.g., the balance between case management internal to the ISNs and case management subcontracted to organizations with experience in community-based LTC case management.

Also worth watching will be the reactions of local LTC provider agencies. In anticipation of LTCOP and various other managed-care developments, nursing homes in Minnesota and elsewhere are already creating networks that include residential settings, adult foster care, and home care; these might become convenient vendors for ISNs. Some nursing homes are developing these arrangements under a State demonstration project that allows greater flexibility of payment categories to nursing homes in order to foster innovative programs. What is of greatest interest to advocates is how these changes will affect the consumers—they have potential to be helpful, but also carry risks.

From a consumer perspective, the incentives to join LTCOP are unclear. For example, LTCOP would be more likely to offer restricted choices for LTC providers, including nursing homes and other residential settings, whereas almost all of Minnesota's nursing homes accept Medicaid clients. If the plans perceive it is in their interest to enroll PMAP clients in LTCOP, they might be able to develop and emphasize packages of benefits that are more coordinated and user-friendly.

In summary, then, Minnesota's proposed programs create a laboratory for the nation to examine the effects on both costs and quality of increased integration under a model where the capitation goes to ISNs responsible for both acute care and LTC and where the State keeps channels for accountability for both cost and quality. The program should reveal a great deal about the behavior of both providers and consumers under such a system.

INFORMATION AND RESOURCES

Minnesota state agency, AAA, and county staff were very generous with their time and resources. Thank you to the following agencies for their time:

- Minnesota Department of Human Services, including:
 - Board on Aging
 - Health Care Administration - Managed Care Division
- Central Minnesota Council on Aging
- Metropolitan AAA
- Hennepin County Community-Based Long-Term Care
- Association of Minnesota Counties

The following resources were reviewed for development of this document:

- Minnesota Prepaid Medical Assistance Program Plus - Status Report - October, 1995
- Model PMAP Contract - December, 1995
- Proposal and Application for §1115(a)(1) and 1395(b)(1) Waivers to integrate Medicaid and Medicare financing and delivery systems to create the Long Term Care Options Project - April, 1994
- Minnesota "Long Term Care Options Project" Operational Protocol - December, 1995
- Updated Summary: Long Term Care Options Project - April, 1995
- Recommendations to the Minnesota State Legislature from the Association of Minnesota Counties regarding the Prepaid Medical Assistance Program - January, 1996

MANAGED CARE, MEDICAID & THE ELDERLY

THE ARIZONA EXPERIENCE

Prepared by
TRISH RILEY
ROBERT MOLLIKA

Contents

Summary	35
Overview	38
History of ALTCS	38
Relationship between ALTCS and AHCCCS	41
Eligibility	41
Outreach	43
Eligibility Determination	43
Enrollment	44
Benefit Package	45
ALTCS Program Contractors	46
Maricopa Managed Care System	47
Ventana Health Systems	48
Links between Acute and Long Term Care	50
Does ALTCS have an incentive to underserve participants?	51
Plan and Provider Recruitment	52
Rate Setting and Capitation	52
Cost Containment	54
Quality Improvement	55
Grievance process	56
Role of the Aging Network	59
ALTCS role	60

Conclusions	62
Information Sources	63

Summary

Arizona began providing acute care services to Medicaid eligible residents in 1982 through the Arizona Health Care Cost Containment System (AHCCCS), a Section 1115 Research and Demonstration Waiver demonstration program approved by the US Health Care Financing Administration (HCFA). Long term care services were covered under the Arizona Long Term Care System (ALTCS) beginning in December 1988 under an amendment to the 1115 demonstration waiver. ALTCS provides acute care, behavioral health and long term care services to the elderly, the physically disabled and people with developmental disabilities with incomes up to 300% of the federal SSI benefit standard (\$1374 in 1995). Members must also meet the nursing facility level of care criteria to participate. Enrollment in the managed care long term care system is mandatory (members cannot choose a fee for service system). While members do not have a choice of ALTCS contractors, they may select their case manager and primary care physician within the program contractor's network. They may also select nursing facilities and home and community based (HCB) services providers based on their availability. On October 1, 1995 the program served 20,919 people, and nearly 50%, or 10,325, were elderly. The program is unique in that it was among the first to contract with managed care plans on a capitated basis for both acute and long term care services and remains the only state to provide this comprehensive plan statewide. Although the majority (97%) of elderly members are dually eligible¹ and receive their Medicare services separately, ALTCS program contractors in some instances are also Medicare certified HMOs which have been selected by members as both the Medicare and ALTCS provider system. If the ALTCS contractor has not been selected, or is not a Medicare provider, the contractor coordinates care with Medicare providers.

Key Points

- The state contracts with 8 program contractors to operate ALTCS. Counties, which finance the state Medicaid match for ALTCS services, initially received preference to operate ALTCS (the two urban counties² are designated by statute to contract with the state). Private sector plans are responsible for the program in 10 rural counties. The Department of Economic Security/Division of Developmental Disabilities (DES/DDD) provides ALTCS services on a statewide basis as the program contractor to persons with developmental disabilities.

¹ Dually eligible refers to elderly persons and people with a physical disability who are eligible for both Medicaid and Medicare.

² Maricopa County, which encompasses the Phoenix area, and Pima County which includes the Tucson area.

- ALTCS serves people who have a high level of functional impairment and health conditions. The state's nursing facility level of care criteria require a combination of ADL impairments, disorientation and/or behavior problems, medical and nursing treatments and the presence of one or more health conditions.
- The high impairment levels require coordination of care between acute and long term care and case managers with health care expertise.
- ALTCS attempts to promote better linkages between case management, acute care, behavioral health and long term care services which are bundled in the ALTCS program but linkages are hindered by conflicts between the Medicaid and Medicare laws and regulations.
- Barriers posed by dual eligibility are addressed when an ALTCS contractor also has a Medicare risk contract and is selected by the member for Medicare services.
- The ALTCS program design and the stringent preadmission process were partially based on AHCCCS' desire to allay HCFA's concerns about a potentially large windfall effect.
- HCFA has capped the number of elderly and disabled members who can receive HCB services. AHCCCS has successfully negotiated to increase the cap from 5% of spending in 1988 to the current 40% statewide cap based on member months.³
- With a higher cap, new members have higher acuity levels and many new members have transferred from nursing homes to community settings upon enrollment. To provide more choice to members and to accommodate the housing needs of ALTCS members, particularly people with higher acuity levels, AHCCCS has received legislative authorization to expand options available through two pilot programs: Supported Residential Living Centers in Maricopa County and Adult Care Homes.
- ALTCS enrollment has increased 8-10% a year.
- Capitation is based on actuarial estimates of the cost of nursing facility services, HCB services, case management, behavioral health services, acute

³ Member months means the number of members enrolled in a month times the number of months of enrollment during the fiscal year.

care costs and administrative and risk insurance costs. Administrative costs are capped at 6% in Maricopa and Pima counties and 8% in rural counties. The capitation assumes that 35% of the members will receive HCB services.

- The capitation payment creates incentives to use HCB services (within caps set by HCFA) and the flexibility to shift funds from nursing facilities to other settings.
- During interviews, staff described close working relationships between ALTCS case managers and the program contractor's primary care physicians.
- On September 1, 1995, an ALTCS transitional program was implemented to serve people who improve after entering the program and no longer meet the nursing facility level of care criteria. This program provides HCB services that are authorized by the case manager.
- The Aging and Adult Administration,⁴ the State Unit on Aging, within DES was involved in the development of the program and participates in regular meetings to review emerging issues with the transitional program. The statutes creating the AHCCCS and ALTCS programs require that AHCCCS and DES fund services for different populations⁵ in order to eliminate overlapping services. As a result, DES/AAA does not become involved in the administration and operation of ALTCS.
- Area Agencies on Aging meet regularly with AHCCCS administrators and have been successful in identifying problem areas and issues.
- In some counties, contracting policies have created a broad single entry system by channeling all long term care services funded through ALTCS and the SUA (state revenues, OAA, SSBG) and acute care services through the same agency. The single entry agency develops a care plan based on the available sources of funding.
- The HCB services component of ALTCS has some similarities to systems in other states. The methodologies for paying contractors for HCB services are

⁴ Throughout the report, the Aging and Adult Administration, within the Department of Economic Security, is referred to as the State Unit on Aging.

⁵ ALTCS serves nursing facility eligible Medicaid recipients while the State Unit on Aging serves elders and people with disabilities who are not eligible for nursing facility placement.

similar. Other states set fixed budgets for HCB services or cap care plans at a percentage of the cost of nursing facility care. AHCCCS sets a per member per month payment. In addition, AHCCCS and other states use a standard assessment tool, care planning protocol and comprehensive case management function. Unlike other state systems, the ALTCS capitation rate includes institutional costs, HCBS costs, acute care, case management, administration, and reinsurance and ALTCS contractors are responsible for Medicaid acute care services.

Overview

Unique among the states, Arizona entered the Medicaid program in 1982 after receiving approval from HCFA for an 1115 Research and Demonstration Waiver. The waiver allowed the state to launch Medicaid as a statewide managed care program. The Arizona Health Care Cost Containment System (AHCCCS) provides a range of acute and primary care Medicaid services for all members including elderly persons. Long term care services were fully added in 1989, when the Arizona Long Term Care System (ALTCS) was implemented, combining acute care and long term care, including HCB services for the elderly, physically disabled, and developmentally disabled persons. Behavioral health services were phased in over time. In 1990 behavioral health was offered to children up to 18 and expanded to those through age 20 in 1991. In 1993, behavioral health services were expanded to persons 65 and over who were enrolled in ALTCS and on October 1, 1995, to members between 21 and 64 years. With the addition of these services, all AHCCCS members were covered for behavioral health services.

History of ALTCS

Before the creation of ALTCS in 1988, long term care was provided primarily through county governments. There was no major provider base, and no Medicaid financing for long term care. Arizona's counties provided nursing facility services to elderly or physically disabled persons to variable degrees and in a few counties, services were quite extensive for that time period. The Department of Economic Security (DES) provided institutional and HCB services for the developmentally disabled through state funds and DES/AAA provided limited HCB services for the elderly or physically disabled through the Older Americans Act and the Social Services Block Grant. The Indian Health Services, Bureau of Indian Affairs and Tribes provided referrals off reservation to nursing facilities and two reservations had nursing facilities on reservation.

The ALTCS program was implemented on December 19, 1988 for the developmentally disabled population and administered through the DES/DDD. The program for the elderly and physically disabled population was implemented January

1, 1989. Prior to ALTCS, Area Agencies on Aging provided case management and home care services through the Older Americans Act, state general revenues and the Social Services Block Grant. Counties funded some nursing home care for low income residents. The ALTCS model uses county funds as the state's federal Medicaid match (35%) for services. AHCCCS covers the state match for administrative costs. The state contracts with program contractors to coordinate, manage and provide all ALTCS services to enrolled members through a competitive bid process. Only one program contractor operates in each county and members must enroll with the contractor in their county of fiscal responsibility⁶ to receive service. Once enrolled the member has a choice of available primary care physicians who coordinate care and act as a gatekeeper for acute care services. Arizona law mandates that the two largest counties, Maricopa and Pima, must participate in ALTCS as the program contractor in their respective counties. Until 1995, the remaining thirteen counties had the right of first refusal to participate as program contractors. The county preference reflects the financing role played by counties. If a county chose not to participate, AHCCCS sought competitive bids from private entities to provide the services within that county. Recent legislation eliminated the right of first refusal for counties that have not been participating as program contractors, although counties are still expected to provide matching funds.

The managed care system in Arizona serves four types of elderly persons.

- Group 1. Participants who are not eligible for Medicare and who meet the nursing facility level of care criteria. These members receive all their acute care, behavioral health and long term care services through the ALTCS system.
- Group 2. Participants who are not eligible for Medicare and who do not meet the nursing facility level of care criteria. These members may be served through AHCCCS, if financially eligible, until such time as they become eligible for ALTCS.
- Group 3. Participants who are Medicare beneficiaries (dually eligible) and who meet the nursing facility level of care criteria. These members receive their long term care services through ALTCS and acute care through the Medicare system, either the fee for service system or TEFRA contractors. These members may sometimes elect to use ALTCS program contractors for Medicare services.
- Group 4. Participants who are eligible for Medicare and do not meet the

⁶ Generally the county of residence except when a person must enter a nursing facility in another county and the former county of residence retains financial responsibility.

nursing facility level of care criteria. These members are enrolled in AHCCCS for acute care, if eligible, but receive most of their acute care from Medicare. When members choose to receive health care through AHCCCS and Medicare (either fee for service or a TEFRA risk contractor), coordination of care becomes problematic. See table.

The resulting combinations make coordination of care between payers (Medicare and Medicaid), and between acute and long term care providers quite complex. Medicare covered services for dually eligible members must be billed to Medicare. In some instances, members who have joined TEFRA HMOs sometimes go outside the HMO network and receive acute care services from AHCCCS providers who are not aware of their Medicare HMO membership. Neither Medicare nor the TEFRA plan has any responsibility for paying for out of network care.

Member Patterns			
Group	Eligibility	Medicare	Medicaid
1	NF eligible	Not eligible	ALTCS
2	Non-NF eligible	Not eligible	AHCCCS
3	NF eligible	FFS or TEFRA	ALTCS
4	Non-NF eligible	FFS or TEFRA	AHCCCS

As of October 1, 1995, ALTCS enrolled 20,919 members across the state. 10,325 were elderly; 3,225 were persons with physical disabilities or chronic illness; and, 7,369 were developmentally disabled. Today ALTCS includes five county-based program contractors and two program contractors which are private plans - Ventana Health Systems and Arizona Physicians IPA. Ventana serves as the program contractor in eight of Arizona's fifteen counties and has enrolled 1,051 ALTCS members. Maricopa Managed Care Systems (MMCS), a county-based contractor, covers 7,785 ALTCS members, and Pima Health Systems is responsible for 2,150 members. Six Arizona American Indian Tribes contract to provide case management for ALTCS members and procure long term care, acute care, and behavioral health services. Unlike the other ALTCS county-based contractors, tribes provide these services on a fee-for-service basis. They provide some case management and participate in ALTCS without any risk-based arrangements.

Providing long term care services throughout Arizona is a challenge because of its size and rurality. Over 75% of Arizona's 4 million people live in the Phoenix and Tucson metropolitan areas. Less than 1/5 of the land area is privately owned with the

remainder comprised of federal, state, or Indian reservations. Six of Arizona's counties have population densities of less than 7 people per square mile.

Further complicating the work of ALTCS in providing care for the elderly or physically disabled is the federally imposed cap on HCB services. Initially, because of HCFA's concerns about increased demand or the woodwork effect, only 5% of Medicaid funds for the ALTCS program could be spent on HCB services. Subsequently, the cap was modified from a dollar amount to member months or the number of members times the months of enrollment. HCFA has allowed ALTCS to increase the HCB services cap by 5% a year. Presently 40% of the member months may be placed in HCB settings. The program contractors report no waiting list for HCB care.

As the HCBS cap increased, members were able to transfer from nursing facilities to HCB settings. The program has experienced an 8-10% growth rate.

Relationship between ALTCS and AHCCCS

The AHCCCS program is a managed care system which provides acute care, behavioral health and limited long term care services for AFDC, SSI and Medically Needy members who do not meet the nursing facility level of care criteria. The acute care program provides all Medicaid services and a maximum of 90 days of nursing facility care or home health care in lieu of hospitalization. ALTCS provides the full range of services needed by long term care members: acute care, institutional services, HCB services and behavioral health. AHCCCS requires that an individual enrolled in the AHCCCS acute care program transfer from AHCCCS to ALTCS when they meet the nursing facility level of care criteria. Since some primary care providers participate in both ALTCS and AHCCCS, some members can retain their primary care providers after enrollment in ALTCS. In other instances, ALTCS members are required to choose a new physician through the ALTCS program contractor.

Eligibility

Individuals eligible for ALTCS must be residents of Arizona, United States citizens, or documented persons. Although AHCCCS provides acute care to state-funded medically needy members, ALTCS is not available to this population. ALTCS serves people with income up to 300% of the federal SSI benefit. About 67% of ALTCS participants are eligible under the 300% rule and 33% are SSI recipients. In 1995, the income maximum was \$1,374 per month. Liquid resource limits are \$2,000 for SSI related beneficiaries (aged, blind and disabled) and \$1,500 for children who meet AFDC criteria.

Arizona AHCCCS and ALTCS Enrollment by County				
County	AHCCCS		ALTCS ⁽¹⁾	
	# Plans	Enrollment AFDC, SSI, MN	Elderly, Physically Disabled	Develop- mentally Disabled
Apache	2	18,626	38	171
Cochise	2	13,587	411	184
Cocconino	2	13,510	94	210
Gila	2	6,882	218	78
Graham	2	4,535	103	59
Greenlee	2	725	18	7
Maricopa	9	211,626	7,785	4,104
Mohave	2	13,431	397	177
Navajo	2	18,628	137	178
LaPaz	2	2,026	35	50
Pima	6	71,291	2,150	1,314
Pinal	2	17,522	482	400
Santa Cruz	2	5,622	105	68
Yavapai	2	9,628	536	253
Yuma	2	19,392	323	146
Total		427,035	13,550	7,369

1. There is one program contractor per county.

Financial eligibility is reassessed annually, however, medical eligibility is assessed either annually or every two years. For some participants, functional conditions improved as a result of participation in ALTCS and they could no longer meet the nursing facility eligibility criteria upon reassessment. Through advocacy efforts, in part from the Area Agencies on Aging, the state implemented the ALTCS transitional program on September 1, 1995. This program allows individuals who are ALTCS members (both those in nursing facilities, ICF-MR, and those receiving HCB services) to remain in the ALTCS program even though they have improved either medically, functionally, or both and are deemed no longer "at risk of institutionalization" but continue to need HCB services. ALTCS members who fail the

preadmission assessment at reassessment but who still need covered services that are medically necessary, may qualify for all HCB services. Because the program is transitional, it is not available to applicants. An enrollee living in an institutional setting who qualifies for the transitional program has 90 days to transfer to another HCB setting. Members are eligible for the transitional program if they need assistance with 3 out of 5 ADLs, or have a diagnosis of Alzheimers' Disease or a related disorder that affects ADLs and meet specific scores on items in the emotional and cognitive functioning category. Financial eligibility remains the same as for the regular ALTCS program.

Individuals residing in supervisory care homes (board and care) are not eligible for ALTCS since by definition they would not meet the nursing facility level of care criteria and the homes are not eligible HCB settings.

Outreach

Outreach is conducted directly by the AHCCCS staff. AHCCCS has a public information office which conducts presentations and provides brochures about ALTCS. There are two outreach workers - one with a minority focus and one who handles both acute and long term care. Additionally, outreach meetings are conducted and informational materials distributed by staff in the 15 ALTCS field offices. Most outreach focuses on organizations such as home health agencies, hospitals, nursing facilities and attorneys. Less outreach appears to be done with older people although the state regularly makes presentations to organizations representing or serving the elderly, like the Alzheimer's Association, and bi-monthly meetings are held with the Area Agencies on Aging.

AHCCCS has identified a significant problem with inappropriate referrals to the ALTCS program. The aging network, in particular, tends to refer older people who do not meet the ALTCS standards which increases the denial rate. AHCCCS has designed an extensive outreach effort to improve referrals and is working directly with the aging network to improve referral patterns. ALTCS has a member advocate housed in the director's office. Each program contractor has its own handouts describing the program. Because program contractors are responsible for case management, they are also responsible for member education. Contractors develop their own handbooks for members which are prior approved by the state.

Eligibility Determination

The Department of Economic Security (DES) determines eligibility for and operates a state funded program for developmentally disabled persons who are not eligible for AHCCCS. AHCCCS determines eligibility for all Medicaid eligible persons. If AHCCCS determines a person to be developmentally disabled and ALTCS eligible,

he/she is enrolled with DES, which is the ALTCS program contractor for this population. Financial, medical and functional eligibility for ALTCS applicants is determined by state ALTCS workers located in 15 regional offices across the state. Initially, eligibility determination was conducted by a team including a social worker and a register nurse. Currently, the program uses either an RN or social worker but has had difficulty in recruiting registered nurses to the position.

There are currently 126 eligibility workers and 62 preadmission screeners. To become eligible for ALTCS, a potential enrollee or family member must apply and the enrollee must meet both the financial and functional eligibility standards. When determined eligible, applicants are enrolled with the program contractor in their county. Enrollees do not have a choice of program contractor though they do have a choice of primary care provider and case manager. Fee-for-service is only available to Native Americans.

Eligibility workers complete a lengthy assessment form which is 16 pages for elderly and disabled applicants and 16-19 pages for developmentally disabled applicants, depending upon their age. The forms have been refined to limit "gaming" and no longer provide a provision for the screener to make an overall assessment of an individual's need. The preadmission screening (PAS) tool is viewed as rigorous and the state conducts ongoing quality control and chart reviews to verify consistent application of the tool. Quarterly meetings are held with physician consultants to ensure consistency among screenings. Once a screen is completed, it is scored by computer. It is possible for the physician consultants to review a screening and override the score to allow a person to become eligible. After an applicant is determined eligible and enrolled with the program contractor, the contractor must notify the member within five days and complete an assessment within ten days. Services must be initiated within thirty days but most service plans start immediately. Case managers review the member handbook with new members which addresses the right and responsibilities of members.

Enrollment

During the first 9 months of 1995, 8,402 assessments were completed, 6,302 were approved and 2,100 were denied. The number of reassessments completed was 9,756 of which all but 380 were approved. Physicians were asked to review 23% of the initial assessments and 17% of the reassessments.

Each month, between 2-3% of the elderly ALTCS members leave the program. The majority of case closings, 70% of elderly members, are due to death; 4% no

longer meet the nursing facility level of care criteria⁷ and 5% move out of state. About 9% voluntarily leave the program. ALTCS staff try to call each member who voluntarily withdraws from the program to learn the cause of disenrollment, but reliable data is difficult to collect. According to case managers, the reasons given by members are sometimes misstated to protect their privacy. Additionally, a systematic method for recording and analyzing the reasons for leaving has not been developed. However, staff reported no instances of members with major care needs being discouraged by contractors from participating in ALTCS.

Contractors reported that they are not allowed to disenroll members without approval, unless a member becomes ineligible for care or their HCB care exceeds the cost effectiveness threshold. While members sign an agreement that they can receive HCB service only as long as they are cost effective, in a few cases, members have refused to enter a nursing home. Contractors have been concerned about providing a level of care within the cap and risking liability for providing less care than is needed even though the member agreed to a maximum level of care. On the other hand, if contractors increase the care plan, eg., to 120% of the cap, they will lose money. Disenrollment of a member, whether for medical or financial reasons, is performed by AHCCCS staff. Members are notified by mail of the pending disenrollment and provided the opportunity to request a hearing. The member remains enrolled until a final determination is made through the appeals process, if the member requests a hearing in a timely manner.

If the contractor believes a client is at risk or providers are at risk because the level of care needed is not safe regardless of the cost effectiveness test, the client may be asked to sign a form making clear that he or she is aware of the risk identified by the agency. The contractor is expected to continue to provide care.

Benefit Package

ALTCS services include case management, institutional care including nursing facilities and ICF-MR, HCB services, hospice, acute medical care services, and behavioral health services. The HCB package includes adult day health care, home health agency services, personal care, attendant care, homemaker services, home delivered meals, hospice, individual habilitation type services, respite care (short term or intermittent) and transportation. Environmental modifications are also covered when they are determined to be cost effective. In addition to these services, developmentally disabled members receive habilitation, day care and life line alert.

The program provides a range of residential options and is actively engaged in

⁷ This percentage will decrease as a consequence of the transitional program.

demonstrations of new housing options. Members may be served in their own home, in residential care including certified adult foster care homes, developmental disabilities group homes, child development foster homes, and adult development homes (DD only), and group homes for the traumatic brain injured. Supervisory care (board and care) is not a setting eligible for ALTCS.

In addition, ALTCS has launched two demonstrations of alternative residential living. The supported residential living center program is an assisted living demonstration for the elderly and physically disabled members in Maricopa County. Certified by the Department of Human Services, the program provides private, key controlled apartments, group dining, housekeeping, personal care and nursing services as needed.

The state is also piloting an adult care homes program, licensed by the Department of Human Services. These facilities must have ten or fewer beds and are likely to share rooms. Skilled care can be provided in the home if performed by licensed health care professionals.

HCBS services provided by spouses or parents for those under 21 are not reimbursed, but adult children providing HCBS care for their parents are reimbursable under attendant care. Home health care must be provided by certified home health agencies. If none are available, independent nurses may be used. Up to 720 hours of respite care is available and all services must meet the test of "medical necessity."

Currently, contractors are required to maintain a case management caseload of 1 case manager to 55 members in home based services and 1 case manager to 120 members in institutional settings. The state and contractors agree that this ratio needs to be reviewed as it may be too high. Case managers must be R.N.s or social workers or have two years experience in case management. The case manager is responsible for developing a plan of care in coordination with the primary care provider and the member and/or member's family. The primary care provider of the program contractor is responsible for all acute care of ALTCS members, while the case manager coordinates that care with the service plan for which he or she is responsible. Care plans are computerized on a member assessment tracking system which contractors are required to use. The care plan includes placement history of the member, cost effectiveness calculation and the service plan. The case manager must visit the member on site, every 90 days when he/she is in an HCB setting, every 180 days when the member is in an institutional setting and every month for ventilator dependent members.

ALTCS Program Contractors

Interviews were conducted with two ALTCS program contractors: the county

based Maricopa County Managed Care System (MMCS) and a private plan, Ventana Health Systems, which serves 8 rural counties.

Maricopa Managed Care System

MMCS includes four separate health plans:

- The "Maricopa County Health Plan" serves AHCCCS members;
- MMCS serves as an ALTCS contractor;
- MMCS offers the "Senior Select Plan" as a TEFRA contractor for Medicare beneficiaries; and
- MMCS offers "Health Select" to county employees and small employers.

The MMCS health network is comprised of 14 primary care centers and 3 hospitals. When a person enrolls in the Maricopa County Health plan, the AHCCCS plan, the case manager arranges assignment of a primary care physician, and requests the medical records from the previous physician. They also schedule the first primary care appointment with one of the county primary care centers. Many ALTCS members were originally in AHCCCS and, if dually eligible, received all acute care services through MMCS. When these members transfer to ALTCS, they maintain their same primary care physician and network.

Most ALTCS members are dually eligible. MMCS can serve dually eligible members through "Senior Select" if members select it for their Medicare services. About 20% of MMCS's ALTCS members are enrolled in a TEFRA HMO with 8-10%, or half the TEFRA enrollees, selecting MMCS as the TEFRA plan. Those belonging to a TEFRA HMO, other than MMCS, retain their previous acute care providers. ALTCS covers long term care services and coordinates with the other TEFRA HMO. Members participating in other HMO plans pose many challenges to coordinating care because of the two primary care providers trying to manage the member's health care needs.

ALTCS has utilization management staff perform concurrent reviews in each of the hospitals outside the county network. The ALTCS utilization manager also tracks the member to plan the discharge. There is no overlap in acute care benefits between ALTCS and Medicare since the HMO covers deductibles, prescription drugs, durable medical equipment and other services that are generally not covered in the Medicare fee for service system. ALTCS continues to cover the long term care benefits. However, there is often a problem in determining which plan should pay for the service. For example, ALTCS members who join FHP, a competing TEFRA plan, have a limit on prescription drug benefits. When the member reaches the cap, ALTCS staff

are faced with covering the drug costs or risking adverse health consequences. MMCS usually covers the costs but the member has to see a plan physician to review the conditions and treatment plan. Continuity of care is compromised when the member's prescription drug coverage is restored through FHP at the beginning of the next contract year.

TEFRA plans also experience problems coordinating care between each other. For example, one TEFRA plan may not have a nursing facility with the capacity to serve a resident with special needs yet the Maricopa providers can meet the needs. Disagreements among plans about whether a particular service is a covered Medicare benefit or an ALTCS benefit arise frequently. Since ALTCS is the payer of last resort, problems arise concerning responsibility for payment of services covered by both Medicare and ALTCS.

When a person enrolls in ALTCS from the Medicare fee for service system, an ALTCS physician must be selected if the member decides not to retain their existing physician. Some difficulties in making the transition were reported in the early months of the program. For example, if the member's previous physician had just written a prescription, ALTCS may not have filled it pending formal enrollment or if the first appointment with the new primary care physician had not been completed. Over time, these transition problems have been resolved. Better coordination has minimized disruptions. Arrangements have been made for primary care physicians to review and approve a prescription prior to the first appointment when necessary. Since members are generally referred by the previous plan to ALTCS, the former plan staff now call the AHCCCS staff to initiate a PAS assessment. Once determined eligible and assigned to an ALTCS case manager, both the plan and the contractor work to facilitate the transition. For enrollees in an HCBS setting who receive both acute and long term care services from Maricopa Managed Care System, case managers and primary care physicians work together to plan and monitor care. After initial clinic visits, the primary care physician and case manager will discuss the service plan. Case managers will notify the physician when the member's condition changes and when questions arise about medications. Formal care planning meetings are not held and most of the communication between primary care physicians and case managers occurs by phone or fax. Copies of all service plans are sent to the clinic and are available to the physician.

Ventana Health Systems

Unlike MMCS, which is a county based contractor, Ventana Health Systems is a private health care organization that serves as the ALTCS contractor in 8 rural counties. Between 80-85% of the primary care physicians and all but a few hospitals in the 8 counties are part of the Ventana network. Ventana has negotiated fee for service contracts with non-network hospitals. A total of 14 case managers serve

ALTCS members. Ventana serves approximately 1,058 ALTCS members in its 8 county area and an application to receive a Medicare risk contract with HCFA is pending. Currently, an HMO in Las Vegas operates as a TEFRA plan and recruits members in the northwestern section of Arizona. Since ALTCS cannot restrict a member's choice of Medicare providers, members who join must travel 3 hours (one way) to see network providers in Las Vegas, Nevada. The local hospital, which contracts with Ventana, is not a member of the Las Vegas HMO network so TEFRA HMO members cannot be served there.

To respond to the problem of dual eligibility, ALTCS enrollees are asked, but are not required, to select a Ventana physician as their primary care physician. Network physicians receive \$20 - \$30 per member per month for primary care services for members who receive all acute and long term care services through ALTCS and for dually eligible members. Plan representatives reported that only a very small percentage of members continue to see a primary care physician who is not part of their network. Most either change physicians or most often already see a physician who is part of the network. Representatives reported no repercussions from this policy and indicated that while most physicians belong, those who do not continue to work closely with case managers on individual cases.

The capitation payment for primary care physicians is paid for dually eligible members to ensure that primary care services, some of which may not be billable to Medicare, are provided to avoid emergency room visits and hospitalizations. Officials indicated that many members contact or visit their primary care physician frequently for reasons that may not be reimbursed by Medicare. If the physicians do not see the person, the member may instead visit the emergency room. The capitation payment allows physicians to be compensated for seeing people in their offices. In rural areas, each physician has a very limited number of ALTCS members and the total amount of compensation is not large. The ALTCS contractor's total capitation rate assumes a rate of Medicare billing for reimbursable services based on actuarial analysis. Ventana Health Systems' social workers, nurses and case managers maintain contact with physician offices as appropriate. Coordination of care when ALTCS members maintain their non-Ventana primary care physician is more difficult.

Ventana primary care physicians and hospitals receive a monthly list of ALTCS members. The hospital social workers check to see if new admissions are ALTCS members in order to coordinate service planning. As in Maricopa County, the Ventana utilization manager works with the hospital staff. ALTCS members are encouraged to contact their case manager as health needs arise. While many members contact their physicians directly, some physician contact is initiated through the case manager. Representatives reported that case managers and physicians are in frequent contact concerning members. Because of the distances involved, most of the communication is by phone. Discussions focus on pre and post hospital service plans and changes

made by either the case manager or physician that require evaluation or adjustments in the service plan.

Links between Acute and Long Term Care

Of the elderly ALTCS members, 97.1% are dually eligible and among all disabled members, only 38.3% are dually eligible. Dual eligibility in Medicaid managed care systems creates two problems: coordinating acute care services between two systems and coordinating acute and long term care services.

Acute care. Both health plans we interviewed reported that some members receive both their acute care services under Medicare and ALTCS long term care services from the same health plan providers. This situation facilitates integration of the delivery system while the financing streams remain separate. The ALTCS program promotes better coordination and linkages among the acute care providers and between the acute and long term care systems but, as in other states, the lack of integration with the Medicare system creates challenges. Coordination between acute and long term care services varies, due primarily to the barriers posed by Medicare for dually eligible members.

Acute and long term care. The role of the case manager is essential in coordinating delivery of the acute and long term care services and adjusting services based on health and functional changes. The ALTCS case management procedures manual describes that the case manager is responsible for coordinating services with the primary care physician. The services which case managers must record in the service plan include institutional services, HCB services, behavioral health, durable medical equipment, medically necessary transportation, therapies, individual/group and/or family therapies. The manual requires that case managers contact the primary care physician to discuss changes in the client's condition and to determine whether any changes are needed in the physician's order concerning the level of care, care plan, medical services, behavioral health services, prescription drugs or medical equipment. Case managers use the PAS instrument as a guide in determining when to contact the physician. Disagreements between the case manager and the physician are referred to the contractor's medical director. Physicians are involved in decisions or recommendations to transfer or terminate a member.

The process for developing and coordinating plans of care for individuals who are dually eligible for Medicare and Medicaid varies depending upon the member's choice of Medicare providers. While ALTCS is responsible for acute care for its members, most elderly members are also eligible for Medicare and may receive care paid by Medicare outside the approved ALTCS plan of care. The ALTCS capitation rate assumes some care will be billed to Medicare.

Program contractors require providers to be liable for Medicare payments. An HCBS or nursing facility provider must bill Medicare before billing ALTCS. The member assessment tracking system shows Medicare liability. In addition to dually eligible members being able to select fee-for-service Medicare outside the approved ALTCS plan of care, a problem exists particularly for members who may be enrolled in two HMOs, one for Medicare and another for ALTCS services. However, current Medicare law requires that Medicare recipients be given a choice and states have little authority to limit selection to one plan for services provided through both systems. AHCCCS has submitted a waiver proposal to HCFA that will combine ALTCS and Medicare financing through a single contractor, however, beneficiaries are still likely to retain freedom of choice in selecting a Medicare plan.

Does ALTCS have an incentive to underserve participants?

Critics of managed care systems serving elders believe they have financial incentives to deny access to care because they are paid a flat per capita payment each month, regardless of the services delivered. It is interesting to note that critics of the current fee for service system complain that incentives reward providers for delivering more services than people need. However, in a risk based capitated system, the opposite incentive is created. Case managers work directly for the risk bearing program contractor. While it could be expected that case managers would be exceedingly budget conscious and potentially inclined to underserve clients, there was a consistent view expressed by the state officials, contractors, aging agencies and providers that case managers are member advocates. The state's case management procedures manual stresses that "the purpose of case management is to ensure that ALTCS members obtain necessary services in a cost effective manner. Case management serves as the framework for effective service utilization and quality of care review." The manual describes four roles of the case manager: 1) gatekeeper, 2) broker, 3) service planner and 4) coordinator and facilitator.

During our interviews, we identified several factors that protect members from incentives to offer fewer services than people need, as well as monitoring/oversight activities that are designed to detect barriers to obtaining appropriate services.

First, the capitation payment, described later in this report, assumes a mix of institutional and HCBS participants. ALTCS contractors are at risk for costs which exceed their capitation payments. If contractors do not provide members an adequate level of services, the risk of admission to a nursing facility or a hospital increases. Denial of care can lead to increased institutional expenses.

Second, case managers follow a cost effectiveness formula in developing HCBS services. Service authorizations are limited to 80% of the cost of care in a nursing facility. However, exceptions can be made to exceed the 80% cap. The

provisions set guidelines against which spending patterns can be compared.

Third, functional assessments and level of care determinations are made by AHCCCS staff not by the ALTCS contractor. Based on the assessment data and reports filed by ALTCS contractors, AHCCCS staff can identify under and over spending. Field staff are deployed to review case records and service plans to determine whether the plan and service costs are warranted based on the member's assessment.

Plan and Provider Recruitment

By law, Maricopa and Pima Counties, which account for 74% of ALTCS elderly and disabled members, must be the program contractors. For the remaining 13 counties, the state develops a competitive bid. Counties that were previously serving as program contractors retain the right of first refusal. Other counties which were not previously ALTCS providers do not enjoy that protection. All counties provide the 35% state match for the ALTCS program whether or not they are program contractors. Maricopa and Pima must also complete a proposal pursuant to the state's bidding process.

The first ALTCS contracts were effective January 1, 1989. The state developed scoring guidelines to evaluate bids. This review was done by AHCCCS/ALTCS staff. The RFP spells out standards of case management and expectations for services. The state notes that the RFP itself is the contract; there is no separate contract between the state and program contractors. Contractors must demonstrate network adequacy by submitting letters of intent from service providers. Some question whether the letter of intent is sufficient proof of access, but measuring access to service providers is difficult, particularly in rural areas. ALTCS allows plans to contract with individual providers. The state is currently testing software which would provide additional detail about the extent and accessibility of the provider network. For primary care in the AHCCCS program, the state has developed standards for access to care. Similar standards do not yet exist for home based care, but they are being considered.

Rate Setting and Capitation

In addition to the federal cap of 40% of member months for HCBS provided to elderly and disabled members, the state also applies a cost effectiveness test. HCBS care plans are limited to 80% of institutional costs. However, plans may exceed the cap and reach 100% of the institutional cost on a per-case basis for up to six months with prior state approval. There is no HCBS cap for developmentally disabled members. Capitation rates include, but are not limited to, case management, administration, acute care, behavioral health services, nursing facility care and HCB services. AHCCCS stresses the importance of having experienced financial staff

working for the state and notes that relying on consultants alone does not provide appropriate oversight. However, consultants are important and AHCCCS stressed the role of independent actuaries who establish an actuarial sound rate each bid year.

Rate development includes recent encounter data, financial reports from program contractors, private sector data sources and an inflation factor established by the Data Resource Institute. Rates have the following components:

- an institutional per diem, less anticipated revenue from Medicare and other third party liabilities and individual cost-sharing responsibilities;
- an HCBS component whose costs are determined by encounter data and a fee-for-service survey of HCBS;
- an administrative component which is set at 6% of costs in Maricopa and Pima Counties and 8% in rural counties;
- a component for behavioral health; and,
- an acute care component.

The state has developed a shared savings program through which plans are allowed to keep some funds which accrue when they maximize placement of home care clients. In order to avoid windfalls and assure that incentives do not exist for inappropriate home care placement or underservice, the state shares the savings with plans. Contractors retain 20% of the savings and the state retains 80%. That is, plans must return part of the savings to the state.

The program limits risk in acute care through the establishment of state funded reinsurance. Reinsurance is a stop loss program provided by the state to program contractors for the partial reimbursement of covered in-patient facility medical services incurred for a member beyond an annual deductible. Regular reinsurance covers only acute in-patient hospitalizations and is, therefore, not often used for elderly enrollees, since Medicare usually pays these costs. The program also includes catastrophic reinsurance coverage for transplants. All TCS enrollees who are ventilator dependent have a rate uniquely established for their services. Contractors with fewer than 500 enrolled members are paid a monthly amount for case management costs for ventilator dependent members plus fee-for-service reimbursement for all other medically necessary services.

Example of Capitation Calculation, 1995-1996	
1a. Institutional per diem	\$ 88.17
b. Medicare/TPL	- 1.65
c. Institutional per diem (a-b)	\$ 86.53
d. Institutional/month (c x 365/12)	\$2631.82
e. Member's share of cost/month	\$ 485.27
f. Capitation lag/month	\$ 8.16
g. Institutional/month (g-e-f)	\$2138.39
h. Institutional mix	65.1%
i Net institutional (g x h)	\$1392.09
2a HCBS/month	\$ 791.84
b. HCBS mix	34.9%
c. Net HCBS (a x b)	\$ 276.35
3. Case management	\$ 48.61
4. LTC subtotal (1+ 2 + 3)	\$1717.06
5. Administration/risk	\$ 104.50
6. Behavioral health	\$ 13.34
7. Acute care	\$ 307.06
8. Net capitation	\$2141.96

Cost Containment

Some cost containment is built into the program design since 1115 waivers must meet a budget neutrality test. That is, the program cannot spend more than would have been spent in a fee-for-service Medicaid program. In addition, HCB services costs are capped at 80% of the nursing facility rate, however, the capitation methodology assumes a mix of institutional and HCB members which assumes a

lower average cost per HCB members. Although HCFA limits the use of home care services to 40% of member months, the state reports no waiting list for home care and does not perceive the limit on home care use as a significant problem.

Program contractors must report, in considerable detail, about both finances and service use. Encounter data and individual units of service must be reported. Unlike many employer managed care plans which hold plans accountable for expenditures and outcomes, HCFA waivers require considerable encounter data which is reported by ALTCS program contractors. In addition, the state requires annual CPA audits as well as annual reviews of program contractors by ALTCS staff. The state has developed an audit guide for contractors to assist in their mandated annual CPA audit. Currently the ALTCS capitation rates for fiscal year '95-'96 range from a low of \$1,926.68 in the eight counties administered by Ventana Health Systems to a high of \$2,384.00 for the Department of Economic Securities' Developmentally Disabled Program.

Quality Improvement

AHCCCS has a well developed set of quality and utilization management requirements that program contractors must meet. Program contractors must meet quality assurance indicators in four areas: quality, financial, member satisfaction and provider satisfaction. The following eleven standards are spelled out in detail in state regulations:

1. General criteria for written quality management/utilization management (QM/UM Plan).
2. QM/UM monitoring evaluation and improvement requirements.
3. Accountability and participation of ALTCS program contract executive management.
4. ALTCS program contractor quality assessment and improvement committee.
5. Delegation of responsibility for QM/UM plan implementation.
6. Required resources and staffing for QM/UM functions.
7. Informed physicians and providers.
8. Accountability for QM/UM plan functions.
9. Credentialing and recredentialing of contracted professional practitioners.

10. ALTCS member rights and responsibilities.

11. Medical record standards.

Program contractors are required to have an indicator related to case management as well. Unlike traditional managed care, ALTCS providers do not need to provide for an independent external review. However, the state conducts annual reviews and makes their findings public. AHCCCS staff review a random sample of up to 1000 member records to determine compliance with ALTCS policies (e.g., case management requirements, appropriateness of services, were the services delivered). In addition, 30% of the ALTCS members are contacted on a random basis to determine whether they are aware of what services they are supposed to be receiving, whether they are receiving the services, and whether they are satisfied with the services, including case management.

Program contractors are responsible for providing the state with encounter data. However, encounter data does not fully capture long term care services and does not include Medicare reimbursed services, which continues to complicate quality assurance for the ALTCS program. Program contractors report utilization data monthly and the state keeps an up-to-date report of service use and level of care. As mentioned earlier, AHCCCS staff review and compare level of care and service utilization data to identify inconsistencies.

Grievance process

Members first submit complaints to providers, and if not satisfied by the provider's response, complaints are submitted to the program contractor. The state remains the final arbiter for unresolved grievances. A member advocate is housed within the AHCCCS director's office. The ombudsman program, administered through the State Unit on Aging, is active in resolving nursing facility complaints, but is not responsible for complaints concerning alternative housing and HCB services.

Program contractors are required to conduct consumer satisfaction surveys. AHCCCS is currently conducting a consumer satisfaction survey of AHCCCS acute care members. Once completed, the survey tool will be revised to conduct an ALTCS consumer satisfaction survey. Additionally, a short survey for ALTCS members is being developed which addresses the eligibility screening process.

Since 1989, the state, with the program contractors, has conducted annual long term care studies. Some studies have been specific to sub-populations in ALTCS, such as developmentally disabled and ventilator dependent members. Others have been focused specifically on a study of fall rates, risk factors and other adverse outcomes in skilled nursing facilities. One study analyzed communication and

documentation of follow-up services between specialists and primary care providers. Twenty-five percent of referrals made between October 1, 1988 and September 30, 1989 for the long term care population were reviewed. The study concluded that primary care providers received information from specialists 62% of the time and that the greatest gaps in reporting were in neurology. Most of the studies have been specific to long term care facilities.

In cooperation with HCFA, AHCCCS will use encounter data to assess quality and to increase its quality improvement activities. The state is launching a long term care clinical indicators project for ALTCS elderly and disabled members. A separate indicator project will be implemented for developmentally disabled members. The planning for the indicator project has begun. The state is setting baseline measures for five indicators and one measure of ALTCS member utilization which weight quality within ALTCS through medical record review and the encounter data process. Data will be collected and tested during 1995. Additionally, the state is planning a medical audit of mortality rates for the HCB population to be trended over four fiscal years. The data will be analyzed to determine the trend in mortality rates and to measure the effect of member demographic variables, member diagnosis, PAS scores, service utilization and adverse events within the 30 days prior to death.

Maricopa County completed an ALTCS member satisfaction survey in September, 1995. Results of the survey are reported by service category - attendant care, foster care, HCB services, nursing facilities and total overall. The report shows an overwhelming level of overall satisfaction with ALTCS, with 95% of respondents expressing satisfaction. However, the survey shows that only 42% of members know how to register a complaint. Of those who initiated a complaint, 81% expressed satisfaction with how it was handled. Only about 40% of enrollees could identify their case manager. Thirty one percent reported that they did not know how to contact their case manager and of those who knew their case manager, 88% expressed satisfaction with case management services.

Ninety four percent of respondents expressed satisfaction with the medical care they had received at their primary care clinic in essentially the last six months. Few members could identify their primary care physician. The survey also asks for satisfaction with various providers, such as the Maricopa Medical Center. Only 9% of members reported using behavioral health services during the year. The majority of behavioral health services were provided in adult foster care (15%) and 66% say they are satisfied with that service. Twenty percent received home delivered meals and 97% indicated satisfaction with the meals. Twenty three percent were receiving home health aide services and 91% expressed satisfaction. Twenty six percent reported receiving home health nursing, with a 95% satisfaction rate. Thirty percent received personal care or housekeeping, with a 90% satisfaction rate.

Finally, the ALTCS program has been extensively studied, primarily by Laguna Research Associates. In 1992 HCFA contracted with Laguna Associates to evaluate the ALTCS program. Laguna's preliminary findings⁸ were based on the program's first two years of operation. The study found: (1) ALTCS costs of providing services to elderly and physically disabled members was \$2.7 million, or 3%, less than a traditional program in FY 1989; and (2) ALTCS cost for providing services to developmentally disabled members was \$6.2 million, or 14%, less than the estimated cost of a traditional program in Arizona in FY 1989. Because all elderly and physically disabled individuals eligible for Medicaid in Arizona are enrolled in the ALTCS program, there is no fee-for-service comparison within the state.

The Laguna study compared outcomes for nursing facility residents in ALTCS and the New Mexico Medicaid program. The preadmission screening assessment tool is more detailed than the tool used in New Mexico. The tool is scored in Arizona to determine risk while the New Mexico tool is not. The results found that nursing facility residents in Arizona had higher rates of wheelchair use, bladder incontinence and ADL impairments than in New Mexico. The study also found that Arizona nursing facility residents were more likely to have decubitus ulcers and fevers. There were no differences in the frequency of falls and fractures. New Mexico residents are more likely to have catheters. More residents had received flu shots in Arizona than in New Mexico.

The study did not attribute any differences in the quality of care to capitation. The study also did not examine quality of care in the HCBS program. In addition, the authors noted that it was not possible to determine whether quality indicators had risen or fallen since ALTCS was implemented, since no data was available prior to ALTCS. Further, the study was conducted during the initial start up of the program and could not measure changes implemented as ALTCS program contractors and AHCCCS staff perfected quality of care monitoring activities.

The Laguna study was conducted in the first two years of the program before many start up problems were identified and resolved. The delivery of services also varied across the state based on historical county patterns and the available supply and mix of services. Since the initial study, greater uniformity has been implemented. AHCCCS officials also note that the New Mexico program may not be appropriately comparable to Arizona. Though both use preadmission screening tools, it is not clear that Arizona and New Mexico's members are comparable. Inclusion of hospice patients in the Arizona sample may have biased the sample if they were not included in the New Mexico sample.

⁸ "Evaluation of Arizona's Health Care Cost Containment System Demonstration: Second Outcome Report." Laguna Research Associates. April, 1993.

A new study is currently being developed by Laguna. Preliminary data from the Laguna Research Associates draft Fourth Outcome Report shows substantial savings for the ALTCS program. Total cost savings, including program and administrative expenses, averaged 17% per year over the four-year study. (FY 1990-1993.)

Role of the Aging Network

The state unit on aging in Arizona is located in the Department of Economic Security. The aging director reports to the Division of Aging and Community Services within DES. ALTCS, on the other hand, is administered through AHCCCS program which reports directly to the governor. ALTCS is not a separate organizational unit within AHCCCS and the ALTCS functions and staff are included within the various AHCCCS divisions. The AHCCCS director, Mabel Chen, is responsible for both AHCCCS and ALTCS.

There are eight Area Agencies on Aging; three are located in Councils of Government, one on the Navajo reservation, one at the Inter Tribal Council Office and three are stand-alone, non-profits. The aging network has a number of responsibilities for long term care services. First, the state unit on aging administers a state funded, non-medical home care program through the Area Agencies on Aging. The program includes case management and pays for a range of non-medical services from a variety of formal and informal providers. The program began in 1981 prior to the ALTCS program. When ALTCS was initiated, there was an early effort to use the HCB non-medical program as a match for Medicaid ALTCS services. The non-medical home care funding was retained and the programs remained separate and discrete, with the non-medical program aimed at members who have more preventive needs and who are less at risk for institutionalization than those eligible for ALTCS.

By state law, once a member is eligible for ALTCS, that member is no longer eligible for the state non-medical home care program. The state home care program is administered through Area Agencies on Aging which subcontract for case management. In Maricopa County, the case management system is separate and discrete from the ALTCS program contract case managers. A separate assessment tool is used for the state non-medical home care program, but that tool was designed cooperatively with ALTCS and includes the same definitions of ADL and IADL impairments. The state non-medical home care program spent \$12.3 million on non-medical home care services from all sources including \$7.4 million in state general revenues and \$4.9 million in OAA and SSBG funds.

ALTCS spent a total of \$128.6 million in FY 95 on acute care, behavioral health, nursing facility and HCB services for elderly and physically disabled ALTCS members. When the costs of the developmentally disabled are added, total spending for all ALTCS members was \$513 million.

Currently there are 13,000 people being served in State Unit on Aging's non-medical home care programs. ALTCS serves 20,919 members, of which 10,325 are elderly, 3,225 are physically disabled and 7,369 are developmentally disabled. Of the elderly and physically disabled members, about 33% are in HCB settings. The State Unit on Aging programs serve more people in community settings but, by statute, they are less frail than ALTCS members. There is a waiting list of 1,200 to 1,500 people for non-medical home care services.

Since the 1970's, the state has funded State Supplement Program (SPP) for SSI clients. Initially the program paid \$70 a month in cash or paid for services directly. Two years ago the legislature closed enrollment for new eligibles to receive cash payments and now reimburses service providers only. The program will pay up to \$160 a month for services to people 65 and older and adults with physical disabilities who receive home health or visiting nurse services. Payment is made directly to the agency. There is an additional institutional payment paid through Family Assistant Services. There are no waiting lists for ALTCS HCB services.

The State Unit on Aging also administers the adult protective services program which provides services to ALTCS members. The State Unit reports that ALTCS is responsive to APS referrals and provides timely care for members at risk. A Medigap information and referral counselors program is also administered by the State Unit on Aging which receives referrals from ALTCS of individuals who are not eligible for the ALTCS program. The state has a legal services program which would conduct administrative hearings for members. The State Unit on Aging reports that they have very few complaints from ALTCS members.

The State Unit on Aging runs the ombudsman program through the Area Agencies on Aging and has an ombudsman director on the state staff. Ombudsmen have responsibility for nursing facility complaints only and provide additional quality oversight for ALTCS members residing in nursing facilities.

The SPP, non-medical home care programs and ALTCS do not pay consistent rates to providers. Aging services pays more for services such as home delivered meals and transportation than ALTCS and believes they are subsidizing ALTCS costs. At the local level, information about reimbursement rates in both programs are shared to minimize inconsistencies among programs.

ALTCS role

Although the State Unit on Aging has no formal role in ALTCS, it was active on the planning committee which developed the program and still meets monthly with ALTCS staff. The State Unit on Aging is also represented on an ALTCS committee which has oversight over the supported residential living demonstration. The two agencies

cooperated in the development of the separate assessment tools to assure the two programs were coordinated and they are now discussing possible joint training for non-medical home care and ALTCS case managers.

ALTCS has identified a problem with inappropriate referrals of people to the ALTCS program. The aging network, on the other hand, believes that ALTCS regulations change too frequently, making it hard to know who is eligible. The State Unit on Aging praised the ALTCS program as responsive to problems identified by the network. Notably, member disenrollment was identified as a serious problem, creating a roller coaster for members who alternated between eligibility for ALTCS and non-medical home care, depending on their functional assessment. As a result, ALTCS has created the transitional program discussed earlier.

Each of the eight Area Agencies on Aging administer long term care services differently. The site visit included a visit to Maricopa Managed Care System and Area Agency on Aging Region One. Maricopa County serves the largest number of ALTCS members. In Maricopa County, the Area Agency on Aging Region One is a private, non-profit agency which contracts with the county-based Maricopa Managed Care Systems. Maricopa Managed Care System provides case management services directly to ALTCS members and is a sub-contractor of the Area Agency on Aging to provide case management for the non-medical home care program, known as SAIL. In turn, the Maricopa Managed Care System contracts with the Area Agency on Aging for adult day health care and home delivered meals for ALTCS members. The Area Agency on Aging directly delivers case management services for HIV clients. Both systems use some of the same home care sub-contractors. Because the state requires home care contractors to be licensed home health agencies, it is unlikely the Area Agency on Aging would become a home care provider. In Maricopa County, the ombudsman is sub-contracted to Catholic Social Services. All other Area Agencies on Aging conduct ombudsman services directly.

The structure of the county service system is historically based and reflects the fact that the non-medical home care program predated ALTCS. In Maricopa County, efforts are underway to maximize integration of the two programs. Currently separate county case managers are responsible for the ALTCS and SAIL programs. Two case managers have mixed caseloads and serve both ALTCS and SAIL recipients, but the county is developing a team approach to facilitate the transition between the programs. It was noted that when a member transitions from the SAIL program (eg., state non-medical home care), they may need to change their primary care provider and possibly the case manager. It was noted that the two programs are different and serve different member groups and use different home care providers. SAIL is more flexible regarding eligible providers and provides more social service than medical care to a less frail population. The Area Agency on Aging is active in outreach, particularly to the Hispanic community, and assists in educating members about

ALTCS. It was noted that ALTCS has an estate recovery provision that the Hispanic community resisted in part because home ownership is often a responsibility of an entire family. The Area Agency on Aging Region One worked closely with the Hispanic community to allay fears and help people sign up for ALTCS. The Area Agency on Aging Region One has also been active in working with the county case managers to develop service providers in rural areas. It was noted that even with ALTCS rural individuals have problems finding physicians and other providers. There have also been reported problems with TEFRA HMO's (Medicare) recruiting elderly members without explaining that the HMO's physician is located in Phoenix, miles away from the client. The Area Agency on Aging Region One also conducts an information and referral service and makes regular referrals to ALTCS.

The situation differs in the 8 counties served by Ventana Health Systems. Ventana Health Systems is a subsidiary of Managed Care Solutions, a for-profit entity owned by physicians and designed specifically for the ALTCS program. Ventana Health Systems has fourteen case managers in eight offices and provides much of the care in rural areas of the state. Ventana Health Systems requires members transitioning from AHCCCS to ALTCS to change doctors and receive their primary care from a Ventana Health Systems participating physician. Ventana Health Systems reports limited engagement with the Area Agencies on Aging.

Conclusions

AHCCCS and ALTCS provide a comprehensive range of services to elderly, physically disabled and developmentally disabled Medicaid members in managed care settings. Based on our interviews, we determined that the programs operate effectively and create incentives for the use of the most cost effective and appropriate type and level of care. The state has set a high standard of impairment for admission to a nursing facility and, therefore, eligibility for ALTCS. Because of conflicts between Medicaid and Medicare, coordination of care and financial responsibility for services hinders program contractors and health care providers serving dually eligible members. AHCCCS has submitted an amendment to their 1115 waiver to address these problems. After six years of operation, ALTCS has built a solid base for the next step - integration of Medicaid and Medicare and full integration of acute, behavioral health and long term care.

Because of its traditional role, the aging network has not been an active participant in the case management component of ALTCS. However, the Area Agency on Aging in at least one county has helped to enhance integration by contracting with the ALTCS program contractor for case management and non-medical home care services funded through state revenues, the Older Americans Act and the Social Services Block Grant. The State Unit on Aging and the aging network played an important role during the initial planning, identifying gaps which supported creation of

a transitional program for people who improve and no longer meet the eligibility criteria but continue to require HCB services, and assisting with marketing and outreach. Monthly meetings have been helpful to raise and address problems, including the need for further training of aging network staff as guidelines and requirements for ALTCS change.

Information Sources

AHCCCS/ALTCS provided extensive documentation during the site visit. Documents reviewed include the following:

- Overview of the Arizona Health Care Cost Containment System - January, 1995
- ALTCS Overview - September, 1995
- A Summary of Supported Residential Living
- A Summary of Adult Care Home Pilot Project
- Long Term Care Plan - Member Satisfaction Maricopa County, September, 1995
- ALTCS Program Contractors Case Management Procedure Manual, July, 1993
- Summary ALTCS Transitional Program
- Summary of Long Term Care HCB Services Utilization
- AHCCCS/ALTCS Clinical Quality Management Indicator Project - Long Term Care
- Draft - AHCCCS Acute Clinical Quality Management Indicator Project
- Draft - Indicator Descriptions, April, 1995
- Chapter 1000 Program Contractor Quality and Utilization Management
- Summary Annual Long Term Care Studies
- Draft - Long Term Care Program Member Handbook - PIMA Health System
- ALTCS Member Handbook - Arizona Physicians IPA

MANAGED CARE, MEDICAID & THE ELDERLY
THE OREGON EXPERIENCE

Prepared by
TRISH RILEY
ROBERT MOLLIKA

64

Contents

Summary	67
Overview	69
History of Oregon Health Plan	70
Medicaid: The Oregon Health Plan	72
Eligibility	73
Outreach, Eligibility Determination and Enrollment	73
Benefit Package	76
OMAP Program contractors	79
HMO Oregon (Blue Cross/Blue Shield)	80
Linkages between acute and long term care	82
Plan and Provider Recruitment	84
Rate Setting and Capitation	84
Quality Improvement	86
Role of the Aging Network	88
Conclusions	92

Summary

The Oregon Health Plan is a multi-faceted health reform that originally involved an employer mandate to achieve universal health care coverage, an innovative restructuring of the Medicaid program, private health insurance market reforms, a high risk pool for individuals who could not be covered under private insurance, tax incentives for employers to offer insurance and a pooled purchasing program for small employers. The plan was contained in a series of bills that were signed into law in 1989 and 1991.

Phase I of the Medicaid component of the Oregon Health Plan was implemented in February 1994 after several years of legislative consideration, an extensive public process to determine what benefits would be offered, and a protracted review of the Section 1115 waiver proposal by HCFA which was finally approved in March 1993. During phase I, children and families who were categorically eligible for Medicaid and newly eligible uninsured residents with incomes up to 100% of the federal poverty level were enrolled in managed care plans. Over 300,000 people were enrolled during the first year including 120,000 newly eligible, previously uninsured adults and children and 200,000 traditional Medicaid recipients. Prior to OHP, Medicaid served children and families with incomes below 65% of the poverty level.

Enrollment in managed care began for Phase II eligibles in February 1995. Aged and disabled Medicaid recipients, SSI and categorically eligible recipients (300%), clients receiving long term care and children in foster care were enrolled. The benefit package covers acute and ancillary care services and does not include long term care in nursing facilities, institutional services provided in state hospitals and home and community based services. As of December, 1995, 50,000 Phase II clients, or 77% of the 65,000 eligible because of age or disability, were enrolled in managed care. Sixty nine percent, or 44,700, had selected prepaid health plans and 3,200 were enrolled in primary care case management programs. SDSA is working with OMAP to develop strategies to enroll the remaining clients who are eligible for managed care on a county-by-county basis. Some recipients, primarily people with disabilities, have been exempted if the member has complex medical needs and uses a specialist who is not part of an MCO or their specialist is outside the service area of existing MCOs.

Based on one year of implementation, the following findings represent the early experience:

1. The Office of Medical Assistance Programs (OMAP) has contracted with the aging network, Area Agencies on Aging (AAAs) and has worked through state SDSA field offices, to conduct counseling and enrollment for aged and disabled Medicaid recipients.

2. Managed care plans have been required by state law to create Exceptional Needs Care Coordination (ENCC) functions for certain elderly and disabled members to coordinate services among providers within HMO networks and to coordinate acute and long term care services with aging and disabled service network agencies. The creation of these functions has worked very well and provides a focus to create linkages between the two systems.

3. During the managed care enrollment process, aging network case managers and workers serving blind and disabled clients complete a Continuity of Care Referral form when members have special needs in the fee for service acute care system or the long term care system or are living in non-standard living situations. The CCR is sent to the Managed Care Organization (MCO) and alerts ENCCs to the services being received by members to promote continuity of care during the transition to an MCO or on an ongoing basis.

4. Medicaid acute care services are based on a prioritization system which ranks conditions and treatments based on their effectiveness and appropriateness for the group served. The process to develop the prioritization list within the Oregon Health Plan was extensive and provided for public participation. Two subcommittees were formed to deal with issues related to older people and people with disabilities. As a result of their work, 5 additional lines were added that addressed functional impairments linked to a disease or diagnosis. For example, as a diagnosis, cerebral palsy fell below the line but as a result of the committees' recommendation, if a diagnosis below the coverage line created functional impairments, the covered services needed to address the impairments were covered. Ancillary services can be provided to address functional impairments.

5. A similar public and open process was used to plan the OHP. Once implemented, the process is being maintained to ensure effective communication between state agencies, plans, providers, the aging network and other interested parties.

6. All Medicare HMOs in the state contract with OHP. Dual eligibles who had already joined an HMO to receive their Medicare benefits may remain in the Medicaid fee for service system or they may enroll in the MCO's OHP plan. Most recipients choose the MCO for OHP. When recipients enroll in a OHP plan, they must select the same plan for their Medicare services. This requirement has addressed some of the coordination of care and payment problems that occur when a person belongs to one HMO for Medicare benefits and a separate managed care plan for Medicaid services. Dual eligibles may also choose a Medicaid only plan and receive Medicare benefits fee for service.

7. Aging and disabled services network agencies are now examining opportunities to collaborate with MCCs should OHP be expanded to include long term care services.

Overview

In 1992, 13.8% of Oregonians were aged 65 and over and 1.4% were over age 85, a 34.7% increase since 1983. Nearly 30% of the people 65 and older live alone.¹ Oregon has one of the most extensive home and community based service systems in the nation and is the only state that spends more on home and community based long term care services than institutional care. Expenditures per elderly person totalled \$369.49² for home and community based care and \$363.39 for nursing home care. The state has a relatively low percentage of people 65 and over with incomes below the poverty level, 10.1%. The supply of nursing home beds is also quite low among states, 36 beds per 1000, and the occupancy rate is 86.2%, or 6.2% lower than in 1981. Ladd³ has measured demand for long term care in Oregon using the number of severely disabled residents 65 and older and 18-64 years of age, in relation to the total state population. Oregon has a rate of 63.5/1000 people 65 and older with severe disabilities, defined as impairments in 3 of 5 activities of daily living, and 5.0/1000 people with disabilities aged 18-64. The national averages are 71.4/1000 and 5.6/1000 respectively. Oregon provides long term care services to 28,754 people and serves more people in residential and community based settings, 21,274, than are served in institutions, 7,300. In addition to the state administered programs, Social HMO and PACE projects are operating in the Portland area.

The Oregon Senior and Disabled Services Division (SDSD) is responsible for managing the Older Americans Act, Medicaid long term care services, determining eligibility for food stamps, Medicaid, and SSI for all elders and people with disabilities, licensing nursing homes, assisted living residences, residential care facilities and adult foster homes, conducting elder abuse investigations and providing other protective services. Two other programs, Oregon Project Independence (OPI) and a Risk Intervention Program (RIP), are funded by state general revenues. OPI provides case management services to older adults requiring in-home services who are not eligible for Medicaid. The Risk Intervention Program provides case management services to

¹ Demographic and programmatic data taken from Richard C. Ladd, Robert L. Kane, Rosalie A. Kane, Wendy J. Nielson. "State Long Term Care Profiles Report." National LTC Mentoring Program. University of Minnesota. November 1995.

² Per all elders, not just those receiving services.

³ Ibid.

develop, coordinate and utilize family and community resources to delay or divert people who are at risk of becoming eligible for Medicaid or entering a nursing facility services within a year.

SDSD administers the program through SDSD field offices and contracts with Area Agencies on Aging (AAAs). Oregon has two types of Area Agencies on Aging. Type "A" AAAs administer the traditional Older Americans Act functions. SDSD field offices administer the Medicaid programs in counties that are served by eight Type A Area Agencies on Aging. Ten type "B" agencies contract with SDSD to administer the eligibility and assessment process and the Medicaid long term care services (institutional, residential, and home and community based waiver) as well as the Older Americans Act programs. Type B agencies are further differentiated between those that serve only elders, B-1, and AAAs that serve both elders and people with disabilities, B-2. See chart.

History of Oregon Health Plan

Oregon has implemented a comprehensive health reform plan which includes the Oregon Health Plan. The Medicaid reforms were constructed as a major component of the overall package of reforms which affected private employer health insurance, individual insurance and public programs. The reforms were intended to achieve universal coverage, contain costs, and restructure the delivery system. Health reform was enacted through a series of bills that were passed by the Legislature in 1989-1993. SB 27 (1989) developed a process for designing a basic benefit package to cover all uninsured with incomes below poverty. After lengthy negotiations, the basic benefit package and the 1115 waiver were approved by HCFA in March 1993.

SB 935 (1989) created the employer "play or pay" mandate. Employers were required to provide health insurance on their own or make payments to a pool which would be used to provide health insurance. The effective date of the "employer pay or play" mandate was delayed and because Congress has not granted an ERISA waiver, the legislature repealed the mandate during the 1995 session. The governor subsequently vetoed the repeal, however, because the ERISA waiver not obtained by the deadline, the mandate "sunset" in December 1995. SB 534 (1989) created a high risk pool. SB 1076 (1991) made reforms in the private insurance small group market. SB 1077 (1991) established a health resources commission to control excessive technology and facilities.

SDSD Delivery System ⁴				
Type A AAAs		Type B-1 AAAs		Type B-2 AAAs
AAA	SDSD Field office	AAA	SDSD DSO	AAA
Older Americans Act		Older Americans Act	Older Americans Act	Older Americans Act
Oregon Project Independence		Oregon Project Independence	Oregon Project Independence	Oregon Project Independence
	Title XIX Nursing facilities Waivered services	Title XIX Nursing facilities > 65 Waivered services > 65	Title XIX Nursing facilities < 65 Waivered services < 65	Title XIX Nursing facilities Waivered services
	Cash, Medical Assistance, Food Stamps Aid to Blind Aid to Disabled Old Age Assistance General Assistance Medical Assistance Food stamp eligibility	Cash, Medical Assistance, Food Stamps Aid to Blind > 65 Old Age Assistance > 65 Medical Assistance > 65 Food stamp eligibility > 60	Cash Medical Assistance, Food Stamps Aid to Blind < 65 Aid to Disabled < 65 General Assistance Medical Assistance < 65 Food stamp eligibility < 60	Cash, Medical Assistance, Food Stamps Aid to Blind Aid to Disabled Old Age Assistance General Assistance Medical Assistance Food stamp eligibility

⁴Elizabeth A. Kutza, Ph.D. "Long Term Care in Oregon." Institute on Aging. Portland State University. Portland, OR. Policy paper. Undated.

Medicaid: The Oregon Health Plan

SB 27 (1989) authorized the Medicaid Demonstration project and the prioritized list of services which replaced the benefit package provided to recipients through the state plan. A Section 1115 waiver was needed from the US Health Care Financing Administration (HCFA) to implement the plan. In addition to replacing the traditional package of Medicaid benefits, the waiver also replaced the complex system of categorical eligibility requirements with a streamlined standard that based eligibility on a percentage of the federal poverty level. Increased state costs have been financed by an increase in the cigarette tax and general revenues. An analysis by the Oregon Association of Hospitals and Health Systems showed that emergency room visits dropped 4.5% in the first 6 months after the Oregon Health Plan was implemented compared to the previous 6 months. Charity care dropped by 9.8% because more people were insured.

The prioritized list of covered services was developed through an extensive public process. The list addresses cost, medical efficacy and access to care. Coverage is based on condition-treatment pairs. The list was developed by the Oregon Health Services Commission, which consisted of five physicians, a public health nurse, social service worker and four health care consumers. The Commission ranked health services from most to least important based on the comparative benefit of each service for the population to be served. The conditions list was constructed using diagnostic codes and the treatment was defined by medical/surgical procedure codes. Subcommittees for mental health and substance abuse and people over 65 and people with disabilities were formed to consider the special needs of these populations.

Once established, costs are projected for covering each condition/treatment pair. Based on spending and revenue projections, the legislature determines how much funding will be approved and where the line will be drawn.

After lengthy analysis, public review and changes based on federal comments, the waiver was approved in March, 1993. Phase I was implemented February, 1994 and covered children, families and adults without children. The legislature provided funding for 606 of the 745 "lines" starting January, 1994. Phase II, which included SSI recipients and children in foster care, was implemented February, 1995. The 1995 legislature moved the "line" from 606 to 585 effective January 1, 1996. HCFA approved movement of the line in December 1995. Most services falling below the line include conditions which improve without treatment, conditions for which there is no effective treatment or conditions for which over the counter medicines are available. The diagnosis/treatment pairs affected include treatment for candida of the mouth (thrush), skin and nails, certain treatment and therapy for deformities of the upper

body, limbs and feet, medical therapy for chronic bronchitis and splints for TMJ disorders.

Eligibility

The OHP 1115 waiver set financial eligibility at 100% of the federal poverty level for new eligibles, including children, families, single adults and childless couples. In addition, OHP retains the eligibility category for elderly and disabled recipients receiving long term care services whose income is below 300% of the federal SSI payment standard. Prior to the OHP, Medicaid eligibility was approximately 75% of the poverty level for SSI recipients. Because of the waiver, OHP covers single adults and couples without children who were not eligible under categorical eligibility standards. Children under age 6 and pregnant women with income below 133% of poverty are eligible under separate categorical provisions.

Outreach, Eligibility Determination and Enrollment

The Senior and Disabled Services Division is responsible for outreach, choice counseling, enrollment and eligibility determination activities for elders and people with disabilities. These functions are performed by a combination of SDSD field offices and AAAs.

For the initial implementation, SDSD provided funds to Type B AAAs to hire temporary workers to perform counseling and enrollment functions. The workers received 1 day of formal training and materials that provided background on the program. The training curriculum was developed by OMAP and SDSD with consultation from health plans. The waiting area of the Multnomah County AAA displayed pamphlets in 17 languages that explained the OHP. Another pamphlet contained 22 pages of primary care physicians with their plan affiliations and an indication of which physicians had sign language capacity, the bus routes for access to the physician and notations indicating whether the physician was open to existing patients, accepted or limited new members, or was fully open. In Phase II individual contacts with recipients, rather than group sessions, were made to provide counseling and to enroll recipients in a plan. AAA staff often mailed materials and made follow up calls to make sure the person received the materials and to respond to any questions. Plans were not allowed to conduct their own marketing nor were they allowed to work individually with AAAs or SDSD offices. A number of states have employed independent benefit managers or organizations that have no financial interest in the enrollment process to conduct outreach, marketing and enrollment functions. State officials have been concerned about marketing abuses such as skimming when plans are allowed to perform these functions. However, plans felt counseling and enrollment staff needed more information about managed care, what services are covered and the differences among plans. Plans believe that a mechanism is needed that allows

plans and staff performing enrollment functions to work together.

OMAP and SDSA had anticipated that the counseling and enrollment process would take 1 1/2 hours per person. However, during Phase II, more in person interviews were conducted and fewer group sessions which raised the actual time to about 2 1/4 hours per member. The amount of time required varies with the number of plans available in each area.

Once the initial wave of recipients was enrolled, the counseling and enrollment functions were transferred to permanent staff. SDSA and AAAs provided training about OHP, and the counseling and enrollment process to their information and referral staff, case managers and staff involved in the intake process. SSI recipients who are not receiving Medicaid long term care services contact the AAAs, receive information and counseling about OHP and their MCO options, and complete an enrollment form. The AAA's intake process is used to perform these functions for new applicants. Existing Medicaid HCBS clients, or HCBS clients converting to Medicaid are enrolled by their case managers. Counseling and enrollment tasks have added to the workload of case managers who carry an average of 100 HCBS cases while nursing home case managers are responsible for 150 cases. However, the transfer of the authorization of ancillary services from AAAs to MCOs reduces the workload. State officials indicated that caseload standards would be reviewed in light of the changing responsibilities of case managers.

Managing the enrollment process is subject to the vagaries and business dynamics of the health system. As MCOs merge or are purchased by other plans, case managers have had to re-enroll members in a new plan. In one instance, after a small plan went out of business, case managers cooperated with OMAP to contact members and enroll them in another plan within a month. The AAA and state offices were able to contact and re-enroll members successfully, although it posed challenges managing these unanticipated tasks.

Medicaid recipients are encouraged to select a plan on their own after receiving information on the plans, being invited to attend an orientation session or receiving face to face counseling. While case managers have the authority to "auto assign," or select a plan for recipients who have not done so within the allowable time, auto assignment has been limited. OMAP distributes a list of recipients who have not selected a plan and case managers follow up by mail or a home visit to assist with selection. OMAP and SDSA may monitor the number of auto assignments to determine whether additional training or other intervention is needed. Dual eligibles can only be auto assigned for OHP since case managers cannot enroll a person in a Medicare HMO without the signature of the member or their guardian.

Our interviews suggested that both the MCOs and AAAs have gained

experience with the enrollment process and meet regularly to identify and resolve problems. Regular meetings were initiated involving AAAs and state offices, health plans, and hospital discharge planners. Plans indicated that some enrollment forms were incomplete and case managers had to be contacted to have a client sign a form or provide missing information. As a result, SDSA state field offices and AAAs have developed a quality control monitoring process to identify incomplete applications before they are submitted to the plan. AAAs noted that workers now track members through the process to make certain the enrollment is completed and problems are identified and resolved as quickly as possible. MCOs seem to look to the case manager as their agent to obtain needed information while case managers wonder if this is part of their role. AAAs suggested that the process is too manual and could be computerized.

The enrollment process for dual eligibles is complicated by the procedures and timetables followed by Medicare and Medicaid. Medicaid recipients cannot be enrolled prospectively and Medicare members cannot be enrolled retroactively. As a result, recipients who enroll in a plan for both Medicare and Medicaid are enrolled immediately for Medicaid and the plan bills Medicare fee for service until the Medicare process is completed - typically 60-90 days.

A process has been implemented for members who are receiving health or long term care services that must be continued or who will require services at the time of enrollment. The case manager completes a Continuity of Care Referral which identifies service needs prior to the client's enrollment in the health plan. The form is sent to the MCO's FNCC.

Disenrollment can be used as a measure of member satisfaction and plan performance. Critics of managed care are concerned that financial incentives to enroll healthy members (biased selection) may lead to disenrollment of members who are hard to serve and have high utilization patterns. Regulators track disenrollment rates as a quality improvement measure and to determine whether disenrollment is voluntary or whether plans may be forcing people with high utilization or complex needs out of their plan. In Oregon, OMAP must review and approve all disenrollments requested by the health plans. Thus far, most disenrollments to date have been members with substance abuse conditions who are non-compliant. Health plans send documentation to OMAP concerning what services and interventions were planned and how they were implemented. State officials may consult with the plan and recommend further interventions before disenrollment is approved. HMO Oregon staff noted that very few cases produced disagreements that could not be resolved. A number of interventions are attempted before plans request that a member be disenrolled.

During our discussions with both plans and state agency officials, we found that

the experience with disenrollments initiated by MCOs is minimal, and when it occurs, it is similar to service termination cases in the fee for service system. Members who refuse services, members who live in circumstances considered unsafe or members whose level of service need exceeds what professionals believe is safe to provide in a home setting were described. The examples were similar to those in which home health agencies or other providers withdraw from serving clients in what are considered unsafe environments. However, this medical orientation can be at odds with SDSD's philosophy which attempts to support people at home, even if they are at risk. If a AAA and the plan disagree about the safety of a client, the case may be resolved in a meeting which includes SDSD and OMAP.

Because of the complexity of dual eligibility, OMAP and SDSD have devised a Medicare Health Plan Disenrollment Form to facilitate changing of plans by dual eligibles. Case managers send the form to the HMO from which the member plans to terminate coverage prior to the end of the month in which enrollment ends. A copy is also sent to the new plan to alert them to the pending disenrollment from the other plan. Since HCFA's current system cannot process two transactions simultaneously, the first HMO submits a termination report to HCFA and the new plan holds the application and submits it to HCFA the following month. Medicaid enrollment takes effect in the subsequent month but Medicare enrollment is not effective for 60-90 days. This process has worked as long as disenrollment forms are filed. In many instances, the case manager is either not involved in the Medicare disenrollment, or fails to send the form. To simplify this cumbersome process, HCFA has temporarily approved a process which allows processing of termination of members using the OMAP monthly transmittal.

Benefit Package

The prioritized list of benefits includes six groups of services which are medically appropriate:

- Preventive services to promote health and reduce the risk of illness (immunizations, well child visits, physical exams for adults, mammograms and pap tests).
- All reasonable diagnostic services, such as lab, x-ray and EKGs.
- All physical health services, mental health services for areas of the state where the mental health demonstration is operating and outpatient chemical dependency services included through line 585.
- Comfort care or hospice treatment for terminal illness, regardless of where the conditions fall on the list.

- Ancillary services (prescription drugs, physical therapy, if medically appropriate for a covered condition/treatment pair.

The list does not cover treatment for conditions which get better on their own, treatment for which home treatment works (simple strains), treatment which is generally ineffective (eg., advanced cancer), cosmetic procedures, weight loss, smoking cessation clinics, breast reductions/enlargements, routine circumcision, and most infertility services.

Dental coverage includes exams, x-rays, cleanings, extractions, sealants for children, most root canals, full dentures (one set every five years) partial dentures, restorations (filling and crowns), bridge work (four units), orthodontia treatment for cleft palate, cleft lip, and repair and relining of complete and partial dentures.

Mental health services were added in 1995 and are being phased in by county. The phase in may be completed by July 1997. The Health Services Commission developed 50 mental health diagnoses and the legislature approved funding for 45 of the 50 lines. The benefits include treatment for schizophrenia, bipolar disorder, depression, post traumatic stress, eating disorders and attention disorders.

The OHP covers outpatient chemical dependency services. However, Plans are expected to coordinate four levels of chemical dependency services: outpatient care, intensive inpatient care, residential care and medically managed inpatient care. Residential treatment and community detoxification services are available through local mental health resources. Hospital detoxification is covered as a basic medical/surgical benefit.

A few services are provided outside the capitation rate through the fee for service system. These include non-emergency transportation, maternity case management, therapeutic abortions, targeted case management, personal care, health services provided by schools as part of an individual education plan and family planning services. Prior authorization is needed for non-emergency transportation.

Coverage for aged, blind and disabled recipients was excluded during Phase I because of concerns about the impact of the priority list. A subcommittee on coverage for aged, blind and disabled recipients was implemented that included advocates, consumers and providers with a special interest and training in these areas to review the appropriateness of the priority list for these populations. The committee held public hearings, solicited comments through a targeted telephone survey and community forums. Flyers were mailed to ABD recipients announcing the forums and inviting written statement from people who could not attend. The major issues cited were drug coverage, transportation and the cost of health care.

As a result of the committee's report, changes were made covering ancillary services, dental and transportation services. Examples of the use of assisted communication devices and case management were added to the list to explain the coverage of ancillary services. Five dysfunction lines to cover symptoms caused by chronic conditions were added:

- Symptomatic treatment of neurological dysfunction in breathing, eating, swallowing, bowel and/or bladder caused by chronic conditions (eg., g-tubes, j-tubes, respirators, tracheostomy, urological procedures);
- Symptomatic treatment of neurological dysfunction in posture and movement caused by chronic conditions (eg., durable medical equipment and orthopedic procedures);
- Symptomatic treatment of neurological dysfunction resulting in loss of ability to maximize level of independence in self-directed care caused by chronic conditions (eg., short term rehab with defined goals);
- Symptomatic treatment of neurological dysfunction resulting in communication caused by chronic conditions.
- Symptomatic treatment of neurological dysfunction in judgement and reasoning to be folded into the dementia line for behavioral intervention, medication and short term rehabilitation.

The Priority List has expanded benefits for elders and people disabilities by emphasizing preventive services and broadening coverage for adult dental care and vision care which had been reduced under the fee for service system.

Services authorized by MCOs must be "medically appropriate" which is defined as "services and medical supplies which are required for prevention, diagnosis or treatment of a health condition or injury and which are:

- (a) Consistent with the symptoms of a medical condition or treatment of a medical condition;
- (b) Appropriate with regard to standards of good medical practice and generally recognized by the medical scientific community as effective;
- (c) Not solely for the convenience of an OMAP member or a provider of the services or medical supplies; and
- (c) The most effective of the alternative levels of services or medical supplies

which can safely be provided and OMAP member in the Contractor's judgement."

OMAP operates a benefit hotline which is staffed by nurses to answer questions about the list and what is covered. Plans are responsible for providing Medicare covered services and paying deductibles and coinsurance for those services received within their provider network.

OMAP Program contractors

OMAP contracts with 20 health plans of which 6 also contract with Medicare. Sixty five percent of the enrolled aged and disabled recipients also receive their Medicare services through health plans with OMAP contracts. Other recipients who are dually eligible receive Medicare services through the fee for service system. In one area, physicians have signed contracts with an HMO to serve Medicaid recipients but no physician has signed an agreement to serve privately insured members. Rates to providers have increased under managed care compared to fee for service and providers had an incentive to form or join managed care networks.

The OHP uses four prepaid health plan models and a primary care case management (PCCM) program to deliver covered Medicaid services. The PCCM model is primarily used in eight rural counties, of the 36 counties statewide, which do not have a prepaid plan available. In other counties individuals exempted from FCHP enrollment may be enrolled with PCCMs.

- Fully Capitated Health Plans (FCHPs) provide inpatient hospital, outpatient, physician, vision care and glasses, pharmacy and many ancillary services. FCHPs may also provide dental services which can also be provided through fee for service or through a managed dental program. Approximately 280,000 members are enrolled in FCHPs.
- Physician Care Organizations (PCOs) receive a partial capitation payment for a more limited range of services than FCHPs. PCOs do not cover inpatient hospital care which is paid fee for service. Services not included in the capitation payment must be prior authorized by the PCOs primary care physician. OMAP used the PCO program as its primary managed care model for AFDC recipients prior to the Oregon Health Plan.
- Primary Care Case Managers may be physicians, nurse practitioners, naturopathic physicians, physician's assistants and clinics providing or arranging for comprehensive medical services. As of December 1994, 7000 AFDC members were enrolled with 500 PCCMs. This model serves members in areas of the state without other plans, members with major medical insurance

and members who have needs that are difficult to meet through prepaid health plans.

- Dental Care Organizations (DCOs) provide covered dental services. Members may join a DCO directly or through a FCHP that contracts with a DCO. After October 1996, FCHPs may no longer be capitated for dental. Services will be provided solely by DCOs and fee for service providers.
- Mental Health Organizations (MHOs) have formed to deliver mental health services. Some FCHPs provide mental health services. Community Mental Health Programs, either part of county government or non-profit organizations, have organized to provide services.

Plans have an ongoing responsibility to educate and inform members about the plan, health education, availability of ENCC services, and the appropriate use of emergency facilities and urgent care. The information also covers the location of offices of the primary care practitioners, phone numbers for information, choice of and use of the primary care physicians, the appointment system, the referral system, emergency services, and information on the complaint process.

HMO Oregon (Blue Cross/Blue Shield)

HMO Oregon is a Blue Cross/Blue Shield plan which contracts with OMAP as a fully capitated health plan. HMO Oregon has administered Medicare Risk and Cost contracts for 12 years, and has served 120,000 Medicaid recipients since 1986. Because of variations in the Medicare Average Adjustment Per Capita Cost (AAPCC), HMO Oregon offers a Medicare risk contract in only 4 counties. In eleven other counties with lower AAPCCs, HMO Oregon offers a Medicare cost product. The low AAPCC and the difficulty recruiting providers in rural areas has limited its Medicare products to the western portion of the state. However, 90% of the state's population live in areas of the state in which HMO Oregon has risk contracts. The plan has enrolled 45% of the total number of aged, blind and disabled recipients enrolled in managed care plans.

With both Medicare and Medicaid contracts, HMO Oregon serves dual eligibles through its networks. However, the two funding streams pose administrative challenges for the plan which pays its network providers on a fee for service basis. As a result, claims from providers have to be reviewed to determine which service was provided and how much should be charged to the Medicare capitation with the coinsurance charged to Medicaid. As a large organization, HMO Oregon has multiple provider panels with different reimbursement structures which makes tracking and "charging" claims quite complicated. A subgroup of claims staff from health plans has been formed to deal with such problems.

The system is unable to coordinate simultaneous enrollment with Medicare and Medicaid. Medicare enrollment applications can take 60-90 days before they are effective. In such cases, the plan will enroll the member for Medicaid and bill Medicare fee for service until the enrollment is completed.

HMO Oregon also contends that better coordination is needed between Medicare and Medicaid member education requirements. Medicare requires the mailing of plan benefit information materials and ID cards that are the same as commercial contracts. A separate guide and ID card is sent to OHP members for their Medicaid benefits. The Medicare material presents information about copayments and deductibles which are not allowed under the Medicaid program. Receiving two, sometimes contradictory, guides confuses dually eligible members.

HMO Oregon felt the counseling and enrollment process worked well although some bias appeared evident. For example, in one instance, all the residents of a group home selected the same plan. However, staff feel that aged, blind and disabled recipients need more education than commercial members about managed care and out of network use.

Differentiating members by eligibility status is difficult for plans. HMO Oregon representatives indicated that they cannot readily identify QMBs and SLMBs who are not covered by OHP. The plans believe they are absorbing the cost sharing requirements of these members. HMO Oregon staff also said the system needs to monitor the utilization of members who switch plans. For example, one member received a wheel chair from a plan, then disenrolled and joined a new plan. In the interim, the member sold their wheel chair and sought another chair from the new plan.

Plans commented that OMAP reporting requirements are difficult to meet. OMAP requires studies on OHP members in order to evaluate the program. However, HMO information systems collect information without regard to membership. HMO Oregon conducts studies on all members, for example, by diagnosis, and cannot separate OHP members without additional modifications to their systems. OMAP expects that such modifications will be made in order to evaluate issues that apply to publicly funded members.

Plans noted problems with the cross over between acute and long term care. Nursing facilities must submit requests for prior approval of therapies for residents. The MCO approves the treatment plan, the therapies to be provided and the number of visits. If denied, some facilities have submitted bills on form UB 92 to the Medicare fiscal intermediary and the managed care plan receives a bill for the copayment and deductible. As an approved OHP benefit, nursing homes are not allowed to balance bill for therapies.

HMO Oregon representatives said that regular meetings between the plans and case managers have helped identify and discuss problems as they arise which leads to earlier resolution and clarification. In addition to meetings with state and AAA representatives, six plans have held regular meetings to review Medicare/Medicaid issues. Representatives from the HCFA regional office and OMAP have attended these sessions.

Linkages between acute and long term care

The OHP does not include long term care, however, as described, the system uses the aging network to conduct counseling and enrollment functions. This responsibility builds a relationship between MCOs and agencies managing the state's long term care system. Creation of the ENCC role has facilitated development of the relationship which is needed to coordinate acute and long term care services.

ENCC services are designed to:

- identify members who have disabilities or complex medical needs,
- provide assistance to ensure timely access to providers and capitated services,
- coordinate services with providers to ensure consideration is given to the unique needs in treatment planning,
- assist providers with coordination and discharge planning and
- coordinate community supportive and social service systems linkages with the medical system.

ENCC services have two components: medical case management and coordination between the medical and social service systems. The medical case management component covers all services included in the capitation payment and is designed to assure that members obtain health care services necessary to maintain physical and emotional development and health. Medical case management includes a comprehensive, ongoing assessment of medical and/or dental needs plus the development and implementation of a plan to obtain needed medical or dental services that are capitated services or medical case managed services and follow-up, as appropriate, to assess the impact of care.⁵

⁵ Oregon Health Plan Administrative Rules, 410-141-000.

ENCC services in MCOs cover all capitated services and medical case managed services such as inpatient hospital care and prescription drugs. Services are available at the request of members, their representative, a physician or other medical personal, or the member's case manager. Staff providing ENCC services must have skills and training in the unique needs of aged, blind and disabled members. Requests must be responded to by the next work day following the date of the request. Medical practitioners must also be informed of the availability of ENCC services. Services are also available for members who exhibit inappropriate, disruptive or threatening behavior in a practitioner's office when they are related to the member's disability.

The plan's primary care physician (PCP) is the focal point for all services. Hospitals are required to notify HMO Oregon of all admissions and discharges on a daily basis. ENCCs receive the daily admission logs and communicate with PCPs. Upon admission, the RN reviews the reason for admission and anticipates the member's needs upon discharge. The RN would then contact the PCP, the hospital discharge planner and, if the member plans to return home, the AAA or SDSD case manager. Team conferences are held as needed to develop plans of care for members returning home. The Continuity of Care Referral informs ENCCs when a member is receiving long term care services from the aging network. When the ENCC receives the form during the enrollment process, the form is reviewed for potential medical needs and sent to the primary care physician.

HMO Oregon employs nine ENCC FTEs who have 40-60 active cases each and estimate that 20% of the members require 80% of their time. All but 2 of the ENCCs are registered nurses. ENCCs track claims and emergency room use to monitor member's progress. ENCCs prior authorize home health and infusion therapy.

ENCCs authorize ancillary services on the basis of medical necessity. Services must be needed to help a person improve or prevent deterioration. Private duty nursing is only approved for skilled needs. Home health is covered only if there is also a skilled nursing need. If assistance with bathing is needed, but there is not skilled nursing need, a referral is made to the long term care system.

The OHP provides for 20 days of post-hospital extended care (sub-acute or skilled rehabilitative care). The benefit is similar to the Medicare benefit and requires a 3 day hospitalization which can be waived, however, it is used only when Medicare is not available. Facilities must be Medicare certified. MCOs are able to authorize the extended benefit "with input from the hospital, medical providers and, as appropriate, the (SDSD/AAA) case manager." The plan retains responsibility for physician services, drugs and ancillary services if the member remains in a nursing facility. If a member will require further care following the 20 day period, which is not covered by Medicare, plans are to request a nursing facility pre-admission screening from SDSD as soon as possible but no later than 48 hours before the transition. Plans are required to provide

notice when they are paying for the stay. Some plans notify the aging agency in all cases while others may not notify the aging agency if Medicare is the payer.

AAAs believe that plans utilize the extended care benefit without fully considering a return home with home and community based services, perhaps because they control extended benefit services and do not control home and community based services. As members approach the end of the covered service, a referral to SDSA or the AAA is made to determine eligibility for long term care benefits. In many instances, the member was receiving in-home services prior to the hospitalization. During the early phases of implementation, case managers indicated that they were not always contacted prior to the hospital discharge. On the other hand, health plan staff felt a temporary nursing home stay was usually appropriate when arranged by the ENCC. Regular meetings between case managers, ENCCs and hospital discharge planners have been instituted to improve communication and planning.

AAAs have initiated regular meetings with plans to establish channels for communication. In the Portland area, the three AAAs formed a task force that included 10 health plans, Disability Services Offices (3), County Mental Health/Developmental Disability Agencies, and state Offices of Services to Children and Families and Mental Health Organizations. The group initially met monthly during the initial implementation and now meet every two months. Plans are represented by government relations staff and other staff as appropriate. The agenda of this group is to expedite communication, to review how state policy is affecting the delivery of and access to services and to recommend changes in state policy. A subgroup was formed that includes ENCCs and AAA case managers. The agenda for the subcommittee is to facilitate staff working relationships, make recommendations to the task force and resolve less complex service delivery and/or coordination issues with specific members.

Plan and Provider Recruitment

Thus far, OMAP has contracted with MCOs that meet the state's criteria and which are willing to accept the capitation payment. However, OMAP is considering using a competitive bidding process in 1996 for the 1997 contract year.

Rate Setting and Capitation

Rates were developed based on 1992-1993 fee for service data in Oregon for both commercially insured groups and Medicaid recipients. The state contracted with Coopers and Lybrand to develop per capita data that was used to price the priority list for the legislature. The data was separated for each of 13 Medicaid eligibility groups including elders with and without Medicare coverage. Once calculated, the capitation data was converted to projected expenditures in a managed care environment using

billing amounts and cost to charge ratios. The conversion used managed care assumptions based on historical per member per month experiences for inpatient and outpatient services. Spending for inpatient services was reduced as much as 30%, however, projected Medicare spending was not reduced from historical averages.

Once the legislature has funded the priority list, Coopers and Lybrand sets rates for 9 categories of members:

- OHP recipients - < 100% of poverty except GA recipients;
- poverty related adults (pregnant women 100% - 133% of poverty);
- poverty related children (under 6, 100% - 133% of poverty);
- general assistance recipients;
- blind and disabled recipients with Medicare;
- blind and disabled without Medicare;
- foster children;
- aged recipients with Medicare; and
- aged recipients without Medicare.

The rates are adjusted for five geographic areas of the state. Adjustments are also made depending upon whether the MCO provides dental services and whether they purchase stop loss insurance⁶ through OMAP. Plans may purchase four levels of stop loss insurance - \$10,000, \$15,000, \$30,000 and \$50,000. If a plan chooses one of the four options, the capitation rate is reduced by a percentage that varies by the option selected and the eligibility category. OMAP pays a percentage of the expenditures above the stop loss threshold and 100% of the losses for costs that exceed \$100,000. At the end of 1995, 6 plans (mostly smaller plans) had purchased stop loss coverage through OMAP.

Both OMAP and health plan staff were sensitive to incentives for plans to underserve members. The consumer satisfaction surveys, the statewide ombudsman line and the complaint process were viewed as gross tools to protect members. Over time, OMAP plans to use analysis of encounter data to monitor over and underservice by comparing the data to the medical records. However, OMAP indicated that they need to further validate encounter data before conducting detailed analysis.

⁶ Stop loss coverage pays for care or a portion of the cost once the cost of care exceeds a specified threshold.

Quality Improvement

Health Plan Standards

Seventy five of the state's eligible population has enrolled in managed care plans.⁷ The shift to managed care has been promoted by four developments:

- controlling health care costs through two broad mechanisms: use of primary care practitioners and use of financial incentives, mainly limitation capitation or full capitation of services to control unnecessary utilization;
- improving access to health care because plans are accountable for finding and enlisting a sufficient number of providers to serve the plan's members; and
- improving coordination of care because it designates a primary care practitioner responsible for overseeing all care given to each clients.⁸

In addition to existing standards, OMAP has established a number of standards related to elderly and disabled members that health plans must follow. For example, the standards require that health plans have the ability to provide Exceptional Needs Care Coordination services. A number of measurement standards are used to determine compliance with the requirements. Plans must inform elderly or disabled members that ENCC services are available and they must submit to OMAP a description of how plans will inform members of the service system. OMAP staff review the submission and determine if the description was attached, review any information materials that will be used, or if not provided, the materials must be identified. Materials must be available in alternative formats that are appropriate to the populations served, eg., large type, or audio tape. PCPs have to establish written policies regarding the level of staffing for ENCC services and a description of the responsibilities for ENCCs. Skills in communication and sensitivity to the unique health care needs of members are required of ENCCs who must also attend initial training and continuing education offered by the Oregon Department of Human Resources. ENCC services have to be available during normal business hours and an initial response to any request for ENCC services has to be made by the next working day following the request. ENCC services may be requested by the physician, other medical personnel, or the SDSD/AAA case manager.

Another measure of the standard states that plans must have written

⁷ Education Brief. OMAP, 1995.

⁸ Ibid.

procedures describing how services will assist primary care practitioners and other medical providers in ensuring continuity of medical care as members transition from hospital settings to extended care settings.

A second standard governs the delivery of or arranging for accessible health care services. Plans are evaluated by the extent to which they have adequate practitioners with necessary expertise in treating medical conditions common to older people and people with disabilities. The plan's provider panel is reviewed by OMAP to determine whether there is sufficient detail to conclude that the members of a plan will have access to neurologists with interests in seizure disorders, access to suitable durable medical equipment and home health services and therapy providers with experience in swallowing disorders and to other sub-specialties.

OMAP also measures each plan's capacity to deliver services to members living in residential facilities, including nursing homes. Facilities are required to designate a staff member to ensure that members have timely and appropriate access to health plan services. A plan describing how health plans will implement this standard must be submitted to OMAP.

OMAP has developed safeguards in four areas: complaint process, hearing process, OMAP's ombudsman service, and the exceptional needs care coordination process.

Medicaid clients have a right to seek a hearing for any denial of service or coverage. Members are not required to use the Plan's grievance process before requesting a hearing although they are encouraged to do so because it is the quickest way to resolve a problem. Members may request an expedited hearing through OMAP if they cannot wait for the normal process to be completed as the result of an urgent condition.

An OHP ombudsman office has been created in OMAP. During the first 9 months, few people had filed formal complaints. OMAP's ombudsman may be used by the member or the member's representative concerning access to care, quality of care or limitations on care being provided. The ombudsman is available to receive complaints, research facts related to the complaint, advise clients of their rights and insure due process and refer complaints to the plans or to other agencies for resolution. The ombudsman also tracks complaints and their disposition to identify system problems that need to be addressed, to identify barriers to care for people with intense or complex needs, to identify common areas of grievances and recommend changes in rules standards or practices affecting member rights and access to care.

When complaints involve a denial of service, the PHP must comply with administrative rules. Members may use the complaint process outlined in OMAP rules

or seek a hearing with OMAP. Plans are required to have written procedures for accepting, processing and responding to all complaints. The procedures describe how members will be informed of the complaint procedure orally and in writing. Complaints may be made in writing or orally. Complaint forms must be available in all offices. A plan staff member must be designated to handle complaints. Plans must respond to complaints within 5 working days. However, plans may indicate that it will require up to an additional 30 days to resolve complaints and the reasons for the delay must be stated. Responses must be written and include a notice that the member has the option of requesting a fair hearing. OMAP conducts quarterly reviews of complaints logs which plans are required to maintain.

OMAP has developed a standard that requires that plans implement "an internal quality assurance program which is in accordance with accepted standard medical practices, professional standards, and Phase I measures" and with the additional Phase II requirements such as: PCPs shall monitor and evaluate clinical and service issues which reflect the populations served by age groups, disease categories and risk status. Methods and structures to identify the needs of members over 65 and people with disabilities have to be developed. The quality assurance committee has to have people who are qualified to review the care of people over 65 and people with disabilities. The QA committee is charged with reviewing the quality of ENCC services. Health plans are required to provide services that improve the health status of members that include health management protocols. The QA committee is charged with ensuring that this requirement is operating within the plan. Finally, the QA committee has to have procedures to review compliance of clinical care with the Americans for Disabilities Act, reviews of end of life decisions and do not resuscitate orders.

Role of the Aging Network

The Senior and Disabled Services Division is part of the Office of Human Resources, an umbrella agency which serves as the single state Medicaid agency. SDSD is responsible for setting policy and managing the state's long term care system, including nursing home, residential and home and community based services. The system includes pre-admission screening and assessment for nursing home admission, Medicaid home and community based services and state funded in-home services. The service package is flexible and seeks to provide the most appropriate and cost effective service for consumers. The agency is guided by a philosophy that stresses promoting independence and maintaining functioning, and promoting consumer choice. The program allows and encourages self-directed personal care in which the consumer hires and trains the provider. The system is managed through Area Agencies on Aging and SDSD field offices in areas where the AAA has decided not to operate as a single entry, case management agency.

SDSD was active in organizing a meeting of ENCCs, hospital discharge planners, nursing homes and AAAs to discuss implementation and training issues. The state agency has taken a position to remain flexible as implementation proceeds, to re-visit decisions made during the planning phase, to listen to people involved in implementation and to consult broadly when making decisions. This networking approach served the process well during the planning phase and was to be re-established to respond to implementation issues.

SDSD was involved in the planning process and staff identified several issues that were difficult to address. First, SDSD operates with a very decentralized management philosophy. SDSD determines what the anticipated outcome is and then allows their network agencies (state field offices and AAAs) to determine how those outcomes can be accomplished at the local level. Local offices develop and submit plans that describe how a goal will be accomplished. OMAP operates in a more centralized fashion with decisions made at central office being disseminated to state field office staff who are responsible for implementing a plan. OMAP staff indicated that this difference in approach required working through but agreement was reached and the outcomes have been achieved.

Second, differences between the long term care and acute systems basis for authorizing services was identified as a "cultural" difference between the two systems. The issue of medical necessity has two contexts: first in relation to the philosophy of independence and maintaining functions in the long term care systems, and second in relation to a managed care versus fee for service environment. Authorization of services based on medical necessity was seen by aging agencies as limiting the flexibility of Medicaid benefits to help people live independently. MCOs see excess utilization of services in a fee for service system which managed care is designed to control through financial incentives. These two perspectives can create conflict when the long term care and managed care systems meet to discuss member needs and service plans. SDSD and OMAP both encourage representatives of the local offices and plans to staff individual cases to better understand the member's situation and to jointly develop care plans that serve the member's needs without compromising either agency or plan standards. Local meetings between local office staffs and ENCCs of prepaid health plans serving each area are being held around the state. At the same time, SDSD and OMAP are meeting with plan representatives at the state level of identify and discuss issues. The goal is better understanding of the requirements and limitations of each system, eliminating as many barriers to cooperation as possible and developing ways of working together.

Examples of the issues that are discussed include:

- The member chooses to remain in their own home but the plan's home health agency thinks it is unsafe or that the client needs a higher level of care.

- The plan feels a member should be placed in a nursing facility, but the member prefers to remain in an assisted living facility and the agency feels that adequate care can be provided if the plan authorizes home health services.
- The member is used to seeing a podiatrist or having a provider make home visits for nail care but the plan will not authorize the service because it is not medically necessary.
- The mother of a disabled child has been accustomed to receiving a specified number of hours of therapy a week. The plan thinks the prior authorization was excessive and has the plan reviewed by one of its providers.
- A member wants Ensure. The plan says the member doesn't meet the criteria for Ensure and Instant Breakfast, which it will purchase, will meet the dietary needs.
- A member wants a lighter but costlier wheel chair because it is more mobile and more conducive to travel. The plan suggests that a less expensive but heavier chair is adequate.

The different "cultures" seem most apparent in the use of ancillary Medicaid services (private duty nursing, home health, hospice, durable medical equipment, physical therapy, and speech therapy occupational therapy). Prior to OHP, AAA and SDSA case managers authorized ancillary services. Case managers used ancillary services to support care plans geared toward maximizing functioning while MCOs followed "medical necessity" guidelines. AAA staff found it convenient to be able to order incontinence supplies and other items and they perceive the transfer as weakening the scope of their authority. The impact of the transfer is not clear. Some case managers feel access to ancillary services has decreased and clients are receiving fewer home health hours. Case managers documented reductions in the frequency and length of home health visits and a drop in physical therapy visits for chronic conditions. Plan staff indicated that authorizations are now more closely tied to medical necessity than they were under the fee for service system. In another AAA, staff felt access to primary care physicians has increased. In the fee for service system, some recipients previously had difficulty finding physicians who would accept Medicaid.

AAAs noted problems gaining access to transportation and interpreters. Medical transportation is part of the MCO benefit while non-medical transportation is available through the fee for service system. Over time, it is expected that access will increase as case managers and MCOs gain experience with the program, however, concerns about authorizations based on "medical necessity" may take longer to resolve. Already the term medical necessity has been replaced by "medically appropriate" as a means

of bridging the language and philosophy of the two systems. Operationalizing the distinction may take time to implement. Case managers in one AAA have begun to document problems gaining access to service in order to determine whether it is an isolated occurrence or a trend is emerging; to define issues that require clarification; and, to expedite discussion and resolution of problems experienced by members or their case managers.

While plans gain experience implementing a new benefit, case managers may have identified plans which are more flexible in their authorization practices and steer clients to those plans. This creates adverse selection which means that some plans will receive a higher than expected number of enrollees with extensive health needs. Plans with adverse selection may incur costs which exceed their average capitation rate. Plans with favorable selection, eg., a higher than expected number of enrollees with lower health care needs, may incur costs well below their capitation rate based on their pattern of authorizing ancillary services. However, this information was anecdotal and it was not possible to determine the extent of such practices. State officials will monitor the enrollment patterns and work to ensure that the counseling and enrollment process is neutral.

DHR staff felt the ENCC concept was essential to implementing a managed care plan for elders, especially for members who receive long term care services through Oregon's extensive home and community based service system. This function was particularly important as agencies and organizations serving the aged, mentally ill and developmentally disabled were concerned about the impact of managed care of these populations. The interaction of ENCCs and case managers has created a real learning environment in which case managers have better access to acute care providers and the managed care networks have a process for learning more about the long term care system, its services and philosophy of independence.

SDSD staff identified the fast paced changes taking place in the health care system and the workload impact of such a major undertaking as areas which should be examined closely by other states preparing for or considering managed care enrollment. AAAs found that the program added tasks to case managers, administrative and support staff. Case managers became involved in consumer managed care education, advocacy and problem resolution. The enrollment process added to the workload of support staff. Administrative staff had to learn the complexities of state managed care policy and state procedures as well as learning about the plans operating in their service area.

The OHP was not intended to deal with long term care during Phase II, however, state officials view long term care as an emerging issue. If long term care emerges as a future phase in the implementation, it will pose challenges for both state officials and the aging network. The primary issue looming for Oregon's aging network

is the future direction of managed care in relation to long term care benefits. While state agency staff are still focusing on implementation and responding to issues that need to be resolved, all the people we interviewed recognized long term care is the next logical step to address. As yet, no formal proposals have been developed nor have any steps been taken to discuss possible options.

An AAA briefing document cites a problem for members with chronic mental illness when such members move out of the metropolitan area for treatment reasons, they may have to change health plans. If the disenrollment and re-enrollment is not completed in a timely manner, the member returns to the fee for service system until the next month.

Implementation of OHP has highlighted difficulties for Medicare beneficiaries accessing Medicare mental health services through MCOs. Access to Medicare mental health services for dual eligibles was cited as a problem by one Area Agency on Aging. Prior to managed care, community mental health centers had billed Medicare and Medicaid on a fee for service basis. In 1995, the centers reported that they learned that Medicare rules do not allow Medicaid payments for mental health services provided by CMHCs to dual eligibles enrolled in an MCO for Medicare services. HMOs contracting with Medicare are required to provide services from psychiatrists, psychologists, clinical social workers and other qualified mental health professionals and for inpatient (180 days), outpatient and day treatment services. According to a briefing paper prepared by an Area Agency on Aging, OMAP has allowed a temporary exception and covers care with state funds to support delivery of care while a long term solution is sought. The state Office of Mental Health has initiated discussions with MCOs to resolve the conflict.

Conclusions

State officials noted that the high enrollment of elderly Medicare beneficiaries in private TEFRA HMOs, which cover 60% of the eligibles in metropolitan areas, made the transition easier for dually eligible Medicaid recipients entering a mandatory managed care program. Plans with TEFRA contracts may have an advantage over other plans since they have already assembled the provider panels needed to serve older people.

People interviewed cited the need for an effective structure and process to develop policy and respond to implementation issues, to overcome the different "languages" used by state agencies and health systems and to build trust in the people and organizations that are part of the system.

Plan representatives indicated that OMAP included health plans from the beginning of the planning stage and this contributed to the success of the program.

Medicaid managed care waivers to serve dually eligible elders and people with disabilities are more complicated because the proposals are reviewed by both the Medicaid and Medicare branches of HCFA. It is important to coordinate the review of the waiver by both branches to avoid raising Medicare issues after discussions and negotiations on the Medicaid component have been resolved.

Extensive communication, planning, and committees were created during planning period. A high level of formal communication needs to be carried over to implementation phase.

AAAs noted that there have been delays in notifying case managers, at least during the initial implementation period, when AAA clients are placed in a nursing home following a hospital admission. The plans tend to contact the AAA when the 20 day nursing home benefit is terminating and a PAS must be completed to transfer the member to the Medicaid long term care nursing home benefit. AAAs would prefer earlier notification, regardless of the payer, in order to participate in the discharge planning and perhaps avoid an interim placement in a nursing facility. As relationships between ENCCs and case managers develop, this problem should diminish, however, ENCCs will also have to develop good communication with the hospital discharge planners that are part of their network. Regional meetings of ENCCs, discharge planners and case managers have been implemented in the areas we visited to identify and resolve such coordination issues.

Case managers have complained about the added workload involved in providing choice counseling and enrollment for their clients. However, the workload has also been offset to some extent by the transfer of the authorization of ancillary services. A committee is being established to examine the net caseload affect to determine whether adjustments should be made in the caseload ratios.

Case managers continue to play a pivotal role with the clients and the managed care networks. ENCCs have been contacting case managers for assistance re-educating HCBS clients who use out of network providers. Case managers report that some providers have been balance billing clients who then call case managers for assistance. Case managers contact the plan, the OMAP ombudsman or OMAP Provider Services staff.

When asked if plans would consider contracting with a AAA for ENCC services, the MCO representative replied that it would not because of the National Council on Quality Assurance certification requirements and liability concerns. The health plans know what the benefit is, where the resources are and how to contract with vendors. AAAs may lack this expertise. In addition, most health plans do not contract out their services.

Planners and MCOs need to anticipate situations in which members in a nursing facility that is not part of the MCO network enter a hospital and require post acute care in a nursing facility. If the MCO does not make arrangements with the original nursing facility, the member may be placed in a new nursing facility for a temporary stay. When the post acute episode ends, a further move back to the original facility may be necessary as the member transfers to the Medicaid long term care benefit.

MANAGED CARE, MEDICAID & THE ELDERLY THE UTAH EXPERIENCE

Prepared by

ROBERT MOLLIKA

KIMBERLY IRVIN SNOW

Contents

Summary	97
Overview	97
History	99
Eligibility	100
Outreach and Enrollment	101
Benefits	104
Plan and provider recruitment	105
Intermountain Health Care	106
FHP	107
Linkages with long term care	108
Rate setting	110
Quality improvement	112
Role of the Aging Network	114
Conclusion	115

Summary

Utah's Medicaid program began converting from a voluntary to mandatory managed care system along the "Wasatch Front," the states' most populated areas, for AFDC and aged, blind and disabled recipients in October 1995. Two HMOs and a primary care case management program were available under the voluntary program. As a mandatory program, recipients must select from 5 HMOs. The primary care case management option is not available.

The program covers acute and ancillary services, including personal care. Long term care services remain fee for service. During FY 1995, savings of 10% were achieved.

Counseling and enrollment functions are performed by Health Plan Representatives of the Division of Health Care Financing which is the state Medicaid agency. Enrollment of elderly recipients rose from 2.24% in July 1994 to 3.6% of total enrollees in January 1996. Total enrollment will reach 85,000 when fully implemented in July 1996 of which elderly recipients are expected to comprise 8%. Mandatory enrollment of aged, blind and disabled recipients begins in March 1996 and these recipients must select a plan by June 1995. Those who do not make a selection will be automatically assigned to a plan. In 1995, disenrollment rates were higher for primary care case management members (16.5%) than HMO members (5.1%).

Because of the extensive penetration of managed care in commercial markets, most physicians belong to one or more plans and most Medicaid recipients will not have to change their physician or hospital when selecting a plan. However, recipients receiving home health service may have to change providers since many home health agencies do not have contracts with HMOs.

The Division of Aging and Adult Services administers a comprehensive home and community services system through Area Agencies on Aging using federal Older Americans Act, Medicaid HCBS waiver and state funds. Aging network agencies have received training about the managed care initiative. Discussions between HMOs and AAAs are beginning and a process for coordinating activities for HMO members who are also receiving home and community based services is seen as a priority.

Overview

The state of Utah implemented a voluntary Medicaid managed care program in 1984 for all categories of recipients including aged, blind and disabled recipients. The program offered a choice of a primary care case management option and HMOs. Governor Michael Leavitt implemented a health and long term care reform process in 1993. A Health Policy Options Commission drafted the "Utah HealthPrint" which was

adopted by the legislature in 1994 and involves a five year plan to phase in a range of reforms. In 1994 a long term care task force was established which will make recommendations to the Health Reform Commission in 1996. After review by the Commission, recommendations will be submitted to the legislature in 1997 and implemented in 1998.

HealthPrint also calls for expanding Medicaid eligibility over time and enrolling all recipients in mandatory managed care plans. Mandatory enrollment will include recipients receiving home and community based services, however, institutional and home and community based long term care services will remain fee for service and will not be part of the managed care benefit. Enrollment will not be required for Qualified Medicare Beneficiaries (QMBs) and Special Low Income Medicare Beneficiaries (SLIMBs) who do not receive full Medicaid benefits.

The Division of Health Care Financing, Department of Health, which is the state's Medicaid agency, submitted a Section 1115 waiver to the US Health Care Financing Administration in July, 1995. Expanded eligibility to aged, blind and disabled recipients with incomes below 100% of the federal poverty level was implemented beginning July 1995.

In 1992, 8.8% of the residents of Utah were aged 65 and over and 0.8% were over age 85. Nearly 26% of the people 65 and older live alone compared to 28.2% nationally.¹ Utah has invested \$550,000 in Medicaid home and community based waiver services in State Fiscal Year 1995. Expenditures per participant totalled \$3,808 for recipients in the home and community based waiver and \$17,214 for services to recipients nursing facilities during State Fiscal year 1995. The percentage of people 65 and over with incomes below the poverty level was 11.0%. The supply of nursing home beds is quite low among states, 50.2 beds per 1000 aged 65 and older, and the occupancy rate is 79.5%. Ladd² has measured demand for long term care in Utah using the number of severely disabled residents, 65 and older and 18-64 years of age, in relation to the total state population. Utah has a rate of 65.0 people 65 and older with severe disabilities, defined as impairments in 3 of 5 activities of daily living, and 4.7 people with disabilities aged 18-64. The national averages are 71.4/1000 and 5.6/1000 respectively. Utah provides long term care services to approximately 6,500 people through the Medicaid and Aging services programs with 5,000 receiving institutional care.

¹ Demographic and programmatic data taken from Richard C. Ladd, Robert L. Kane, Rosalie A. Kane, Wendy J. Nielson. "State Long Term Care Profiles Report." National LTC Mentoring Program. University of Minnesota. November 1995.

² Ibid.

In State Fiscal Year 1993, elders accounted for 4.7% of Medicaid recipients and 14.6% of expenditures while people with disabilities comprised 14.8% of all recipients and 33.3% of expenditures.³ Nationally, elders comprise 12% of Medicaid recipients and 28% of expenditure and people with disabilities account for 15% of the recipients and 31% of expenditures.

This report is based on interviews with state officials and key staff from the Utah Department of Health, Division of Health Care Financing, the Utah Department of Human Services, Division of Aging and Adult Services, Salt Lake County Aging Services, Intermountain Health Care (IHC) and FHP.

History

Utah has a well developed commercial managed care market. Between 35-40% of the people who are privately insured have joined HMOs. A voluntary Medicaid managed care program was implemented in 1984 that offered clients a choice of an HMO or primary care case management program (PCCM). Seventy-seven percent (97% in urban areas and 46% in rural areas) of the Medicaid recipients have enrolled in a managed care program. About 12% of the enrollees are elders or people with disabilities. While most recipients joined PCCM programs, the initiative was seen as a necessary step to develop interest in contracting with Medicaid and establishing managed care principles. The PCCM program, however, was intended to strengthen ties between recipients and specific physicians and to slowly familiarize recipients with the process of seeking referrals before seeing specialists. Although PCCMs do not receive an added fee for managing access, participation was high because it led to more permanent relationships with recipients.

In August 1995, the state received approval from HCFA to convert from a voluntary managed care enrollment to a mandatory program. Conversion of current Medicaid recipients and enrollment of new applicants in HMOs began in October 1995. All AFDC recipients and aged, blind and disabled recipients must select an HMO by March 1st and June 1st respectively.

DHCF plans to continue the primary care case management program as an optional program in rural areas and move more aggressively to develop managed care networks after July 1996 when the mandatory enrollment period has been completed in urban areas. Officials may initiate partial capitation options to stimulate development.

³ Utah Medical Assistance '93. "Annual Statistical Report of Medicaid and Utah Medical Assistance Program Fiscal Year 1993."

Currently, the state contracts with five HMOs: FHP, a staff and IPA model; Healthwise (a BC/BS of Utah subsidiary), an open panel model;⁴ United Health Care of Utah, an open panel model; Intergroup of Utah, an open panel model; and Intermountain Health Care (IHC) an open panel model. As the number of HMOs contracting with Medicaid has expanded, the primary care case management option was eliminated along the "Wasatch Front" or the urban areas of the state which account for 77% of the state's population. Total enrollment has increased from 20,000 members under the voluntary program to 56,000 by January 1996. As a voluntary program, approximately 12% of the eligible aged, blind and disabled recipients had selected an HMO. By July 1996, HMO enrollment will reach 85,000.

In July 1994, 19,098 Medicaid recipients had enrolled in an HMO. Aged, blind and disabled recipients accounted for 12.12% of the total enrollment as follows: aged, 428 (2.24%), blind, 6 (.03%), and disabled 1,880 (9.84%). By January 1996, aged, blind and disabled recipients accounted for 9,681 of the total 56,210 recipients enrolled and the number of aged had risen to 2,025 or 3.6% of total enrollees. Enrollment of people with disabilities rose to 7,628 or 13.57% of total enrollment. DHCf expects that elders will comprise about 8% of enrollment and people with disabilities will constitute about 15% of enrollment. Among the plans, FHP has 16,000 members; Intermountain Health Care (IHC), 17,000; Healthwise (Blue Cross/Blue Shield), 6,000; United Health Care, 10,000 and Intergroup, 7,000.

The long term care service system operates independently from Medicaid managed care program. The Division of Aging and Adult Services administers a home and community based services system using a range of funding sources that includes the Medicaid Home and Community Based Waiver Services program.

Eligibility

In July 1995, eligibility for aged, blind and disabled persons was expanded to 100% of the federal poverty level. The change did not generate a large increase in the number of recipients although many recipients converted from the medically needy and QMB category to full eligibility.

The managed care program covers all Medicaid recipients except those who are receiving institutional long term care services. Financial eligibility is determined by staff at the Office of Family Services. The same staff also perform eligibility functions for AFDC cash assistance and food stamps. Because the Medicaid component has become so specialized, the cash assistance and Medicaid eligibility functions will be separated and staff continuing to perform Medicaid eligibility determinations will be

⁴ Open panel models contract with providers comprising the network.

transferred to DHCf effective February, 1996. Creating Medicaid specialists will improve workers' knowledge of the complexities of Medicaid policy, rules and regulations and managed care networks. Workers are outstationed at hospitals, clinics and health centers.

Only one plan, FHP, currently has a cost contract with HCFA to serve Medicare beneficiaries however, two plans have applications for TEFRA risk contracts pending and FHP is seeking to convert its cost contract to a risk contract. As HMOs obtain risk contracts, state officials plan to require that Medicaid recipients who select an HMO for their Medicare services select the same HMO as their Medicaid plan.

Since the inception of the managed care program as a voluntary option, Medicaid has been able to refuse payment of Medicare copayments and deductibles for members of an HMO who use out of plan providers. However, HCFA has not approved continuation of the practice under a mandatory managed care plan. State officials have requested a change in this provision and further negotiations are anticipated as part of the 1115 review process.

Outreach and Enrollment

Outreach, enrollment and advocacy functions are performed by Health Program Representatives (HPRs) employed by DHCf. HMOs are responsible for educating members about their network following enrollment. Materials, which must be approved by DHCf, are available from each HMO but the plans are not allowed to conduct direct marketing. New Medicaid applicants are informed about the mandatory conversion to health plans and most applicants choose an HMO upon certification rather than wait to select an HMO later (within 30 days).

Outreach is conducted by the Medicaid program. Fifteen HPRs are assigned to 10 locations along the Wasatch front. Many of the HPRs have 10 or more years of experience in the position which has created a stable and skilled workforce to implement these activities.

In October 1995, aged, blind and disabled recipients received a letter from DHCf informing them that mandatory enrollment would be required. Enrollment of all existing aged, blind and disabled recipients will be completed by July 1996. In February, recipients were mailed a second letter asking them to contact a Health Program Representative and select an HMO by June 1, 1996. Recipients who do not make a selection will be automatically assigned by the HPRs, effective July 1, 1996. Medicaid officials are preparing contingency plans depending upon the number of people who fail to make a selection. If the number is relatively low, HPRs will contact recipients individually and make further attempts to assist them in making a selection. If the number is large and exceeds the staff's capacity to make individual contacts by

the conversion deadline, automatic assignments could be made without further contact. Once an HMO is selected, members may change plans every month. This minimal lock in has created difficulties for plans in tracking enrollment and establishing continuity of care. Pending 1115 waiver changes will require a one year lock-in and an annual two month open enrollment period in May-June.

DHCF has developed a professionally produced video for recipients to view before meeting with an HPR. Information is presented in a game show format with different "categories" such as basic services, rights and responsibilities, after you choose an HMO and the five HMO options. Each plan presents itself on the video. One plan describes coverage of mammograms and prostate screening and another pictures an elderly couple receiving their prescription drugs but the content focuses primarily on families and children and does not present information directed at elders or people with disabilities. After viewing the video, recipients meet with the HPR who again reviews the managed care program, describes the HMOs and provides information about the plan affiliations of physicians, hospitals and other providers. HPRs use materials provided by each of the HMOs to explain each of the plans. HMOs also place materials, approved by DHCF, at providers' offices, fairs and other locations. HMOs are not allowed to contact recipients directly prior to selection.

Since enrollment is performed by DHCF staff, HMOs are not allowed to "selectively" enroll healthier recipients. HMOs send representatives weekly to each Medicaid office to receive lists of enrollments and disenrollments and to meet with HPRs to discuss individual member issues or other changes related to the program. The HMO representative contacts each client by phone, mail or home visit to orient them to the plan, answer questions and conduct a risk screening. The Medicaid contract requires that HMOs provide each member with a handbook, reviewed by DHCF, which describes the scope of benefits, the location of providers, how to receive emergency care and the grievance process. Enrollments completed before the 20th of the month are effective in the following month. Enrollment completed after the 20th are delayed until the subsequent month.

During the enrollment process, the recipient generally first checks the affiliations of their current physician followed by the hospital they prefer to use. Decisions are made based primarily on physician and hospital affiliation, however, home health and durable medical equipment providers are also important in the selections made by people with disabilities. IHC staff indicated that recipients often make a selection decision based on the affiliation of their current home health agency provider. It appears that recipients choose a plan based on the membership of the health care provider they see most frequently. Recipients receiving home care often have more contact with their home health agencies than their physicians or hospitals. IHC staff noted that many of the recipients who had a relationship with a home health agency in one plan and a physician in another plan chose the plan based on the home health

provider and changed their physician instead of the home health agency. IHC indicated that it is willing to make arrangements to have a member receive services from a non-plan home health provider if IHC cannot serve the person within its network. Such exceptions, however, are not routine.

The transition to a mandatory managed care system is now occurring and Area Agency on Aging staff reported that recipients receiving home and community based services frequently contact AAA case managers when they receive information concerning the initiative. An information and training session was held for AAA staff and case managers, however, the aging network has no formal role in the program, and no formal working mechanisms among Medicaid, HMOs and aging agencies have been established.

An HMO representative recommended that plans be able to conduct their orientation at the time of enrollment in the welfare office. On site orientation would be more cost effective and eliminate both the delay in reaching new members and the time required to make appointments. It would also increase the face to face orientation sessions among younger members who have been difficult to reach and often receive the orientation over the phone.

IHC representatives indicated that RNs providing services to clients of the network's home health agency always check the member's Medicaid card during the first visit of the month to make sure the person is still a member of the plan and has not switched to another plan. Electronic enrollment is being examined as a means of facilitating communication between the HPRs and plans.

During 1995, 7,981 recipients, or 10.6% based on average monthly enrollment, disenrolled from managed care programs both HMOs and PCCM programs. This figure does not include recipients who disenrolled due to loss of eligibility. Seventy five percent of those who disenrolled had initially enrolled with a PCCM provider. Based on average monthly enrollment, the disenrollment rate was 16.5% for PCCM providers and 5.1% for HMOs. DHCF records the following reasons for disenrollment: location of provider, quality of care, access to care, personal choice and other. Of those who disenrolled, 77.8% cited "personal choice" as the reason, 11% cited access, 7.2% disenrolled because of the location of the provider and 3.8% left because of quality of care. Disenrollment figures included both AFDC and ABD recipients. Figures for elderly disenrollment rates were not available.

FHP representatives indicated that 16% of members left FHP to join another plan in December. IHC is developing a system to track disenrollment. The health plans preferred a longer lock-in period to stabilize enrollment, payment and delivery of care. Plan representatives felt that disenrollment to switch plans was more frequent among younger members than elderly and disabled members, however, data to validate this

observation was not available. State officials noted that they had received only 3 cases in which HMOs sought to disenroll a member because of behavior or non-compliance with treatment plans.

One plan representative felt that HPRs did not always make an attempt to understand why a member is requesting transfer to another plan and, if the reason is related to the plan itself, the plan prefers an opportunity to remedy the problem. State officials indicated that HPRs do fulfill an advocacy function and call plans to remedy problems raised by members prior to switching plans. At a minimum, plans would be interested in receiving reports on the reasons for disenrollment as a quality improvement tool that will enable them to identify problems and determine what steps, if any, the plan might take.

Benefits

The managed care benefit includes physician, hospital, ancillary services, DME, skilled nursing (30 days or less), home health, emergency transportation and personal care services. Dental services are covered by some plans and are available fee for service for recipients whose plans do not cover dental care. Regular medical transportation is also provided fee for service. Mental health services are carved out of the HMO plan and are provided through a separate managed care network comprised of community mental health centers. Elderly nursing home residents needing mental health services are covered by the carve out Prepaid Mental Health Plan (PMHP). While few elderly recipients living in the community are using mental health services, Medicaid may be paying the copayments and deductibles for recipients who are using Medicare mental health benefits. Coinsurance is paid by the Medicaid program outside the PMHP contract.

By state law, pharmacy services are only included in the two original HMO contractors, FHP and Healthwise. These services are available fee for service outside these two plans. The legislature adopted provisions in 1994 that do not allow the Division of DHCF to include pharmacy benefits in the capitation rates for new HMO contractors. Legislation to repeal the exclusion is expected to be considered by the Legislature.

The HMO benefit includes 30 days of care in a nursing home. HMOs are required to provide coverage if the plan of care includes recovery and discharge within 30 days. If the plan of care projects a length of stay of more than 30 days, the HMO must notify the member, the hospital discharge planner and the nursing facility that the stay will not be covered and the person is referred to the DHCF. The stay is covered as a long term care services. If, during the 30 day stay which is covered by the HMO, it appears a longer stay will be required, the HMO notifies DHCF and the member is disenrolled the beginning of the month following notification.

State officials indicated that coordinating services between the mental health (PMHP) and the acute care plans (HMOs) has been difficult. For example, an HMO member may enter the hospital for an acute care episode and develop mental health needs during the stay creating confusion in determining which plan should be responsible for payment. To clarify which system has payment responsibility, HMO plans covering prescription drugs are now defining which ones are associated with mental health conditions and which are covered by the acute care plan.

DHCF has asked that all plans designate a staff person to be responsible for coordination with mental health contractors and to develop procedures for coordinating care. Plan representatives cited difficulty coordinating mental health and acute care benefits. While the mental health contractor in Salt Lake City has created case manager positions to coordinate with HMO utilization review staff, the communication sometimes lags decisions being made in one system or the other. The plan indicated that improvement in coordination is expected over time. Officials indicated that few elderly people are served in the mental health plan.

DHCF staff noted a dramatic shift from inpatient to outpatient use of mental health services in both the managed care and fee for service mental health areas which can be attributed in part to hospitals closing psychiatric beds and more managed behavioral care programs such as PMHP. For those who do enter a hospital, the average length of stay is increasing because only the sickest people are admitted.

While personal care is included as a covered service in the capitation payment to HMOs, none of the member handbooks included it in their descriptions of covered services. DHCF materials describe personal care aide services to include home health aide care for ADLs, meal preparation, homemaker services and incidental housekeeping as "one step lower in level of care, than traditional HHA service, that require additional skill requirement to delivery services."

Plan and provider recruitment

DHCF has developed a model contract and will contract with any health plan that has a certificate of authority from the state Division of Insurance and is willing to contract with the state. DHCF staff review plan provider panels to determine whether they are adequate to serve the population to be enrolled. Federally Qualified Health Centers have not received special protection, however, FQHCs are located in areas in which established HMOs do not have as many providers as are needed. FQHCs serve approximately 4,000 Medicaid recipients and have been able to negotiate contracts with the HMOs to be part of their networks. As in other states, FQHCs have considered forming their own health plan but have not done so.

FHP has contracted with Medicaid since 1976 and Med Utah since 1984. In 1994, Governor Leavitt's health reform initiative, Utah HealthPrint, proposed to enroll all Medicaid recipients in managed care plans and to expand eligibility. The plan was adopted by the state legislature. At the same time, national health reform had captured the national attention and health plans that had not previously contracted with Medicaid were interested in doing so. Three plans entered negotiations with DHCF in 1994 and two new HMO contracts were signed in 1994, a third HMO in early 1995. All five Medicaid contracting HMOs also serve the commercial, employer based market.

Unlike the experience in other states, most physicians in Utah contract with at least one managed care plan. When beneficiaries must choose a plan, it is likely that their primary care physicians belong to one of the plans with a Medicaid contract.

Opposition to the expansion of the managed care program has been minimal and limited to home health providers. Thirty five home health agencies operate in Utah including six in the Salt Lake City area. Many agencies do not have affiliations with the five plans that contract with DHCF. As a result, home health agencies have complained when their clients select an HMO and must change providers. To facilitate the transition, DHCF has issued a bulletin that places responsibility on the HMOs and home health agencies to check each recipient's Medicaid card at the beginning of each month. The card lists whether the recipient has selected an HMO. HMOs are responsible for assessing the needs of their members at the time of orientation. HMOs must notify the home health agency that the recipient has enrolled in the HMO and, to facilitate the transition, HMOs can be responsible for payment to the home health agency for care delivered up to 7 days following the notification of enrollment. While this policy does not address the long term issues facing agencies that do not belong to a network, it does clarify the payment policies needed to facilitate the transition and, more importantly, to avoid disruptions in service.

Intermountain Health Care

IHC's Medicaid network includes 8 hospitals and over 1,500 physicians that serve 16,000 Medicaid recipients. The IHC hospital and provider network services over 500,000 commercial or privately insured members. In addition, IHC offers "Senior Care," a Medicare health care prepayment plan. Medicare beneficiaries who join select a primary care physician in a multi-specialty clinic. The Medicare plan is a capitated group HMO model. About 10% of the Medicaid enrollment are elders or people with disabilities. The plan began enrolling Medicaid recipients in February 1995. IHC uses Plan Orientation Specialists to inform new members about the services covered and procedures for utilization care. A specialist contacts each new enrollee to conduct the orientation and to administer a health evaluation survey. Members receive a booklet explaining how to use services, a list of providers and a magnetic card that lists IHC's

800 number, and reminders to always see the primary care physician before seeking specialty or hospital care, except in emergencies. A card containing the magnetic card charts the access process and highlights the member's financial responsibility for seeing specialists without a referral and using out of network providers.

For elderly and disabled members, the orientation is conducted in the member's home. During the visit, the specialist will note any environmental or functional indicators that require further assessment and follow up by a case manager or other medical staff.

Some of IHC's physicians serve Medicare beneficiaries but have been closed to Medicaid recipients. However, dually eligible members have access to the full panel of providers.

IHC representatives found that elders and people with disabilities who frequently use health and long term care services tended to enroll during the voluntary phase of the program rather than recipients who are healthier. They believe that these recipients seek to establish or maintain a pattern of care while healthier recipients can delay selection and enrollment until required to do so by DHCF.

IHC staff believe they have experienced biased selection, primarily among children with more extensive medical needs, because of the nature of their network and their plan design. The network includes more specialists than other plans. In addition, members are not required to select a primary care provider. Members can schedule appointments with any plan provider, however, referrals to specialists must be made by a primary care physician. IHC also does not require pre-authorization of emergency room visits.

IHC expects a 10,000 member increase in enrollment during the next six months and is developing strategies to expand its network, particularly its home health capacity, to meet the expected increase in demand. IHC plans to develop more preventive and psycho-social programs for older people and hopes to see an increased emphasis on home and community based services from state agencies, especially an expansion of respite care, for services that are outside the Medicaid capitation payment.

FHP

FHP serves over 16,000 Medicare beneficiaries through a cost based contract with HCFA. The plan submitted an application to convert to a risk based contract in November 1995 and has stopped enrolling new members until a decision is made. The plan operates a staff model panel and an IPA panel. The staff model has operated for 15 years and serves Medicare beneficiaries and Medicaid members and

includes medical, hospital, ancillary services, dental and pharmacy. Mental health care is provided through a separate carve out plan. As the Medicare market has expanded, FHP has developed and expanded a senior specialty clinic and recruited physicians with specialties in geriatrics to work exclusively with senior members.

Two IPA programs are offered, one which includes dental care which has been available since July 1994, and one which excludes dental care. About 50% of the physicians in the IPA model are open to new Medicaid recipients, based primarily on the rates negotiated by FHP with their providers.

The FHP staff model has enrolled 14,100 members of which 1,985 are disabled and 575 are elderly. The IPA program, which was offered in July 1994, serves 1750 members of which 210 are disabled and 45 are elderly and the IPA select option, offered in October, 1995, serves 350 members of which 43 are disabled and 4 are elderly.

FHP's marketing representatives are expected to make at least one group presentation a month about FHP to groups of elders. Sessions are held, often by request, at senior centers, meal sites and elderly housing buildings. FHP staff make weekly visits to the Medicaid offices to pick up new enrollment and disenrollment information and information from the HPR concerning special care needs. New enrollees are contacted by FHP staff for orientation. FHP marketing staff meet with HPRs about three times a year to review Medicaid policy changes, HMO changes and the overall operation of the process. FHP representatives indicated that staffing patterns have been stable in both the HMO and Medicaid which has helped to build relationships and communication channels. These informational sessions have been directed at Medicare beneficiaries as FHP cannot enroll Medicaid recipients.

FHP has created a grievance committee to handle complaints and to review cases of abusive or non-compliant members. If disenrollment is recommended by the committee, DHC has 30 days to make its decisions. The committee considers about 3-4 cases a year for disenrollment.

Linkages with long term care

The Utah State Division of Aging and Adult Services (DAAS) administers the Older Americans Act programs, the Medicaid Home and Community Based Services waiver program and two state funded in home services programs, The Alternatives Program (TAP) and the Homemaker/Personal Care program. TAP was created in 1978 and provides in home services to adults and elders who meet financial criteria and are at risk of entering a nursing facility within 90 days. The homemaker/personal care program serves people who are not at risk of entering a nursing facility. Up to 25% of the funding in the alternatives and homemaker/personal care program can be

used to serve adults age 18-59 who qualify for the program.

The services are administered through contracts with 12 Area Agencies on Aging (AAAs) and serve a total of 1,873 people (TAP and personal care/homemaker programs). The Medicaid HCBS program operates in six AAAs and serve 258 participants.

Discussions to establish formal linkages specifically for aged Medicare beneficiaries are beginning between the AAA and IHC. For Medicaid recipients, aging and health plan representatives indicated that coordination and linkages are similar to the fee for service system in which case managers would contact physician's offices and work with hospital discharge planners concerning home care clients who are enrolled in managed care plans.

While the AAA indicated that there is no process for ensuring that primary care physicians or plans identify members who are receiving home and community based services, IHC has developed a system for coordinating services for elderly and disabled recipients who are more likely to be higher utilizers of multiple services. IHC is developing the position of "systems case manager" which will be staffed by registered nurses. The case managers will be responsible for monitoring and

Summary of DAAS Programs				
Program	Number served	Funding	Services covered	Eligibility
Alternatives	842	\$1.9 million	Homemaker, personal care, home health aide, RN, respite, home delivered meals, adult day care, transportation	At risk of NF admission in 90 days
Homemaker/personal care	772	\$1.1 million	Homemaker and personal care	
HCBS	259	\$1.2 million	Case management, homemaker, home health aide, emergency response, home delivered meals, respite, transportation	Meet NF criteria
OAA, Title IIIB	33,650	\$1.6 million	I&R, outreach, transportation, legal, chore/maintenance, telephone reassurance, respite, advocacy, letter writing, interpreting, recreation, and others.	60 +

coordinating services across providers within the IHC network. In addition, the case manager will be able to evaluate the need for durable medical equipment and home care services and to initiate and authorize home care services when appropriate. This position would also be responsible for coordinating services with the aging network and other community agencies. When home visits are made, IHC staff asks about other formal and informal services being received by the member. Services plans are developed which supplement existing services. In some instances, home health aide services may be cut back from 5 to 3 days a week if the plan is able to develop other resources, eg., family or friends. The assessment, care planning and authorization process used by IHC is similar to that used by many home and community based case management systems operated by the aging network.

IHC has used its capitation payment, which includes personal care and home health benefit, very flexibly, based in part on their philosophy of care. While the contract does not cover long term care, IHC representatives indicated that they review member needs and authorize services to promote and maintain independence in the member's home. Services are not authorized by a strict application of medical necessity or limited to the post acute period until the member has been restored to the previous level of functioning. IHC authorizes home care as provided as a substitute for nursing home care even if needed after the post acute episode has been completed. In addition, representatives indicated that terminating services may lead to more frequent use of acute services and the HMO believes it should serve a broader role. The IHC home health staff will contact family members to let them know the schedule for making visits as a means of coordinating formal and informal care.

IHC representatives indicated that staff have not indicated instances in which IHC members are receiving services from both the plan's home health agency and the Area Agency on Aging.

Rate setting

DHCF uses two approaches to setting capitation rates. Payment rates for the two plans that have contracted with the program since 1984 are adjusted based on their cost experience and utilization with adjustments for profit and inflation. DHCF compares the data from the two plans to the PCCM fee for service data base and the data from the plans is lower than the PCCM fee for service comparison.

For the three new plans, DHCF used PCCM fee for service upper limit data and reduced it by 10% as a starting point for negotiation with plans. Data files are created from paid claims history data and eligibility files. The state contracts with Coopers and Lybrand for rate setting assistance in analyzing claims data by eligibility category. The eligibility files are grouped by category and age: under age 21 male and female; age

21-65 male and female; aged blind and disabled male and female; medically needy children; and medically needy adults. Creating categories for aged with and without Medicare are being studied. Coopers and Lybrand is also developing data to build rates that reflect risk among subgroups, eg., HIV/AIDS cases, cerebral palsy and other diagnostic categories.

Paid claims data is then matched by rate group. Expenses for SOBRA eligible women and institutional long term care costs are removed. Claims data is reviewed against the eligibility file and claims prior to the certified eligibility date are removed. Rates are developed based on the population that is expected to enroll and only data for claims paid for recipients in the areas covered by the mandatory managed care program are included. Finally, an adjustment of 2-3% is made for third party liability collections.

Rates for SOBRA eligible women are calculated separately. Because of the large expenditures for this group, the cost of deliveries is excluded. Physician hospital services and pre-natal service costs are reviewed and a community rate is determined which is paid to the plan. Upon delivery, a lump sum payment of \$3824 is paid to cover the delivery costs for the mother and child.

Effective July 1995, the average rates for aged and disabled recipients were \$129.73 and \$198.69 a month respectively. DHCF has calculated that managed care has resulted in savings of \$2.5 million in SFY 1994 and \$3.5 million in SFY 1995 or 10% of expenditures for services covered by HMOs. The DHCF analysis also found that the healthier recipients remained in the fee for service system. The average fee for service cost was \$120.99 per member per month in 1994. Costs were expected to rise to \$126.92 per member per month in 1995, but instead, dropped to \$113.76. Savings data was not differentiated by category of eligibility and expenditures and savings data for elderly recipients was not available.

DHCF staff advised that states closely monitor the way recipients are assigned to eligibility categories. If policy or practice changes occur and recipients are assigned differently from paid claims data, the cost experience will vary from the rate calculations. For example, when Utah raised eligibility to 100% of poverty, new applicants were assigned to categorical eligibility groups rather than medically needy groups. Non-institutional medically needy recipients were less expensive than categorically eligible groups which could have resulted in overpayments to plans for these newly eligible members.

DHCF develops risk sharing arrangements with plans during the first few years of contracting. Plans receive stop loss protection for hospital claims exceeding \$15,000 per admission. DHCF pays 90% of the claims over \$15,000. Based on stop loss experience, \$5.43 per member per month is taken out of the rate and paid to the

plans as claims occur. DHCF is considering raising the payment threshold and lowering the percentage.

DHCF staff recommended use of risk sharing to facilitate the rate negotiation process. MCOs that are entering Medicaid contracts for the first time tend to believe the rates developed by the agency are too low. The plan's actuaries develop expected rates based on worst case assumptions that are much higher than the state rates. The risk sharing approach allows plans more flexibility and assurance that facilitates negotiation of an acceptable rate. Staff also felt it helps build a working relationship with plans.

DHCF staff indicated that improvements in the state's reporting system are being developed. HMOs currently submit aggregate cost and utilization data by service and eligibility category. While the data is acceptable for rate setting purposes, it must be validated. Beginning in July, 1996, DHCF will require member specific encounter data and will use the HEDIS data when it is implemented. Plans have stated their concerns to DHCF about how it will be used. State officials indicated that when requiring and collecting member specific encounter data, states should be clear about how it will be collected, entered into the system and, most importantly, how it will be used. Development of a risk adjustment methodology, quality assurance and focus studies were the areas cited for application of the data. State officials also indicated that they would work with HMOs to develop a common understanding on the use of the data which will help ensure its accuracy and reliability. DHCF is developing a separate system for maintaining managed care data to avoid system conflicts between managed care, eligibility and fee for service claims processing systems.

Quality Improvement

The state's quality improvement program focuses more on processes than chart reviews. All grievances are reviewed and those involving medical complaints can be referred to the PRO for review as indicated. HEDIS data will also be reviewed to measure delivery of preventive services including physical exams, mammograms and immunizations. The state has contracted with the PRO to conduct focus studies. The topics for the studies have not been determined as yet.

Eighteen quality assurance standards were published by DHCF on March 1, 1995. The guidelines require that HMOs have a written quality assurance plan that includes goals and objectives which are developed annually and contain timetables for implementation. The plan should address the quality of clinical care and non-clinical aspects including availability, accessibility, coordination and continuity of care. The review has to cover all demographic groups, care settings and types of services. The HMO's plan also includes descriptions of studies that will be undertaken and the methodologies and arrangements for carrying them out. Provider reviews are required

by physicians and other professionals of the process followed in delivering services including feedback on performance and outcomes.

A second standard addresses monitoring and evaluation of the quality and appropriateness of care and service to members through quality of care studies including areas determined to be priorities by the state and federal government. The plan describes the clinical or health services areas to be studied, the indicators used to measure quality, the practice guidelines that will be used, the analysis of clinical care by clinicians and multi-disciplinary teams for systems issues, a plan to implement corrective actions, and a plan to assess the effectiveness of corrective action.

State officials, the PRO and plans meet periodically to identify issues that would be most beneficial to study such as prenatal visits and diabetes. The subjects studied can be drawn from a priority list established by HCFA and DHCF that cover 29 clinical areas (eg., hip fractures, breast cancer/mammography, coronary artery disease, diabetes and cholesterol screening), 6 health service delivery areas (access, coordination, utilization, continuity, health education and emergency services).

The quality assurance monitoring guidelines include a reviewer work sheet on which compliance with each standard and the indicators can be recorded.

An active quality assurance committee has to be established; and the plan specifies the membership, meeting schedule, role, structure and function of the committee and the lines of accountability. Providers have to be kept informed about the written plan and must cooperate in its implementation. Functions of the plan may be delegated to other organizations but the plan remains responsible for its implementation and results. A method for reviewing and maintaining the credentials of providers is also included.

Standards for enrollee rights and responsibilities is described in the state requirements, including access to a grievance process. Member satisfaction surveys are required that include appropriate representation of Medicaid members, requests to change practitioners, disenrollment by Medicaid members and an analysis of complaint and grievance data. The requirements also include standards for medical records, utilization review, continuity of care, QA plan documentation, coordination with management activity, data collection and solvency.

Each plan is required to have a grievance process and the State also has its own grievance process. State officials indicated that most problems are resolved in a few days and never become formal grievances. State reports indicated that 56 complaints were filed in 1995 including complaints about billing. Most of the complaints concerned billing to the recipient for out of plan utilization. Only 1 complaint was referred to the PRO for review of quality of care. Complaints call

attention to problems which are addressed in HMO coordination meetings, by offering a transition period for some services, changes in contracts or policy.

HPRs receive complaints filed by members. Supervisors review the complaint and determine whether the issue can be resolved or if a further referral is needed. Interventions on behalf of the member are made by the DHCF staff most capable of resolving the complaint. Complaint categories include: medical, surgical, OB, pharmacy, ancillary, case management, pediatrics, dental, vision, medical supplies, provider, positive comments, unprofessional conduct, marketing by HMO, access to care, insufficient, unclear explanation, home health, non-compliant client and other.

Role of the Aging Network

The aging network is not directly involved in the Medicaid managed care program. However, DAAS administers a Health Insurance Information Program, funded by Medicare, which provides information and counseling to elders concerning Medicaid, Medicare, and supplemental insurance through AAAs. It was reported that one plan, United Health Care, had proposed creating a role for DAAS in the complaint process, however, limited staff capacity prevented DAAS from pursuing such a role.

In order for AAA staff and case managers to be prepared for the transition of elderly Medicaid clients to HMOs, they participated in a two hour training session organized by the Division of Health Care Financing. Case managers receive calls from their clients concerning the Medicaid managed care program. As a case management function, AAA case managers may refer clients to the local HMO representative to assist clients with obtaining necessary information.

The Salt Lake County Aging Services agency, a unit of county government, has a waiver under the Older Americans Act to provide services to older people directly. The AAA administers an \$8.5 million budget through 150 staff members, many of which are part time. The AAA operates 17 senior centers, meals on wheels, in home services, foster grandparents, senior companions and RSVP programs, transportation and healthy aging programs. The Healthy Aging Program includes clinic services, preventive care (stress management, nutrition, exercise, alcohol and drug prevention), flu shots and mammograms.

AAA staff participated in a managed care training program in the fall of 1995 as the program conversion was initiated. Staff noted that while they have no formal role, case managers receive many calls from HCBS clients who have received information about the program and seek information from their case manager before contacting either DHCF or an HMO. Agency officials also cited service delivery obstacles created by parallel systems. The AAA administers the Medicaid HCBS waiver which covers

case management, home health aide, homemaker, emergency response, senior companion, respite, a second meal and non-medical transportation. The waiver does not cover personal care because it is covered as a state plan service and is part of the HMO benefit package. Case managers have reported instances in which personal care rather than home health aide services were more appropriate for waiver clients. Because clients would have had to switch providers, clients continued to receive more expensive home health aide services. AAA staff did not have data to describe the extent of these situations, however, a process that builds regular communication between HMOs and AAA case managers and joint care planning might be effective in addressing coordination of care. AAA staff indicated that they would like to see a process developed that assures that primary care physicians, or other HMO staff members, are informed about members who are receiving HCBS services and a contact point established to facilitate coordination.

As a provider of services, the initial confusion about membership and out of network use has posed problems for the AAA during the transition to mandatory managed care. The AAA provided flu shots to 5,700 older people but 30 claims were rejected by Medicare for members who had joined an HMO since the service should have been provided by the HMO. The AAA has contacted the HMOs to discuss a contract for the next flu season.

AAA officials felt they would benefit from more discussion about managed care and the roles of HMOs and AAAs. Case managers in particular need better training about managed care and a process for developing working relationships with staff in each of the HMOs to improve case planning and coordination for HCBS clients.

Conclusion

Utah has a well developed managed care infrastructure with a considerable private sector penetration. The state also has a relatively small number of elderly people who receive Medicaid. The combination of factors has allowed the state to enroll aged, blind and disabled recipients in managed care more easily than it would have in a different environment. Because of its history managing a voluntary managed care program that includes aged, blind and disabled recipients, the implementation of a mandatory program enrolling elderly recipients is seen as transitional rather than a major reform. Except for home health providers that are not part of particular networks, representatives from state agencies and health plans did not identify issues that are specific to serving ABD recipients. Plans have not developed procedures to coordinate acute and long term care with the aging network beyond the coordination that occurs in the traditional fee for service network. HMOs have the flexibility to address the functional needs of elders without referral to the aging HCBS programs because of the inclusion of personal care and home health services in the capitation payment and, at least in one HMO, a philosophy that emphasizes members needs

rather than strict "medical necessity."

Use of commercial HMOs, rather than Medicaid only plans, make implementation of Medicaid managed care more acceptable. DHCF officials recommend a phase-in of managed care by type rather than by eligibility category. Enrolling AFDC and aged, blind and disabled recipients in primary care case management programs and fully capitated plans was seen as easier than starting with fully capitated plans for AFDC recipients first and aged, blind and disabled recipients at a later date. Use of PCCM programs, especially in rural areas with established networks, helps introduce managed care principles and risk sharing arrangements facilitate the transition from fee for service to PCCM to risk based arrangements.

DHCF officials recommend that states implementing managed care programs consider the impact of the changed role on the organization and staffing of the state Medicaid agency. Managed care programs require more attention to customer service and client focused management as well as additional financial expertise developing rates. Monitoring and auditing staff need to focus on profitability, data validation and evaluation rather than provider records. Quality assurance and contract monitoring activities require more attention. Managed care is more of a partnership between the state Medicaid agency and health plans.

Managed care also requires an attitudinal change from management of a fee for service system. Management shifts from developing rules, setting rates and implementing regulations to negotiation, problem solving, coordination, monitoring and evaluation which requires a period of adjustment for staff. A third area of change for state Medicaid agencies is the collection and use of data. Data collection under managed care programs is needed to monitor and adjust capitation payments, to identify areas quality improvement

Dual eligibles pose a potential problem for out of network utilization. As a voluntary program, DHCF was able refuse to pay for copayment and deductibles incurred by members using out of plan providers for their Medicare services. While a request is pending to extend the practice, HCFA has not thus far approved its continuation. The extent of out of plan use may be limited as HMOs obtain Medicare risk contracts. In view of the extent of managed care in Utah, Medicaid recipients may be more likely to select an HMO for their Medicare services since nearly all physicians and hospitals have affiliations with one or more HMOs.

State officials stressed the importance of collecting data that is useful in analyzing all different aspects of the managed care program from utilization to rate setting to quality improvement. Having appropriate data collection systems in place prior enrollment can improve the effectiveness and responsiveness of the program

The extent of overlap among Medicaid recipients in HMOs and clients receiving HCBS services is not known. Since the counseling and enrollment is done by Medicaid HPRs and long term care remains a fee for service benefit, the aging network has not been asked to assume a role in the implementation of the program. However, as changes are implemented in the health delivery system, older people are likely to contact the person they have the most established relationship with to ask questions about the changes. An informed case management and aging network could be an important ally in providing information and resources to people.

The inclusion of personal care in the HMO benefit adds important flexibility to the care provided to elderly members. HMOs, like IHC, which have a commitment to providing care to maintain independence and see the connections between acute and long term care needs, have a mechanism to bridge the gap between these systems and to be more flexible when serving the needs of its members.

MANAGED CARE, MEDICAID & THE ELDERLY
THE FLORIDA EXPERIENCE

Prepared by
TRISH RILEY
ROBERT MOLLIKA

18

Contents

Summary	121
Overview	121
Acute care	121
Long term care	124
The Frail/Elderly option	125
CAC-United HealthCare Plans (ElderCare)	125
PacifiCare (Independence Plan)	126
Eligibility	126
Enrollment	128
Disenrollment	128
Benefits	130
Rate setting	131
Plan recruitment	132
Care Management/Geriatric Focus	134
Linking Acute and long term care	136
Quality improvement	137
Aging Network	139
Conclusions	141

BLANK PAGE

120

Summary

Florida was selected for a case study because of its contracts with two HMOs to provide Medicaid acute and long term care services to recipients who meet the nursing home level of care criteria. However, the state has developed a statewide network of HMOs and primary care case management program to enroll AFDC and SSI recipients. As of March 1996, HMOs were available in 51 of the state's 67 counties and primary care case management providers are available statewide. While the report focuses primarily on the frail/elderly option, the statewide initiative is also summarized.

Overview

Florida's population age 65+ comprises 18.6%, 2.7 million people, of the total population and will rise to over 3.6 million people by the year 2000. The state spent \$1.7 billion on long term care services for 48,000 elders in FY 95¹ of which 78% was spent on nursing home care. However, 2.5% of the state's population 65+ resides in a nursing home compared to 5% nationally. The state's Department of Elder Affairs operates two Medicaid home and community based services programs and two general revenue home care programs that serve 53,495 people at a cost of \$81.4 million. In addition, DOEA operates the Older Americans Act programs, an Alzheimer's respite program and other smaller programs.

Managed care has a significant presence in Florida. Nearly 500,000 beneficiaries, or 19% of the Medicare population, have enrolled in HMOs. In addition, 19% of Florida residents insured through other means have enrolled in HMOs for a combined penetration of 25% of the population. Florida ranks tied for fourth with Minnesota among states in Medicare enrollment after California, 32%, Oregon, 30%, and Arizona, 26%. HMOs in parts of Florida have a significant incentive to participate in Medicare because of the above average reimbursement rates. The Adjusted Average Per Capita Cost (AAPCC) in Palm Beach, Florida, with 21% of the Medicare beneficiaries enrolled in an HMO, is 126% of the national per capita cost.

Acute care

The primary goals of Florida's Medicaid managed care efforts are to achieve greater access to medical care for recipients and to reduce costs. Florida has adopted two approaches to Medicaid managed care:

¹ "Managing Florida's Future." Final Report from The Commission on Long Term Care. December 15, 1995.

- Contracts with commercially licensed HMOs or Medicaid Prepaid Health Plans using a monthly capitated payment to provide covered Medicaid services.

- A primary care case management program, MediPass, which reimburses primary care physicians \$3 a month to manage recipient care. Medical services are reimbursed fee for service.

The first Medicaid prepaid health plan began in January 1981 in the Palm Beach County Health Department. In 1984, Florida was one of five states selected by HCFA to implement a prepaid program on a broader scale. The program's objectives were to:

- Reduce the annual growth rate of Medicaid expenditures.
- Reduce the rate of increase in per capita costs.
- Reduce inappropriate use of care.
- Increase the participation rate of high quality providers.
- Reduce the proportion of Medicaid funds spent on claims processing.

Managed care plans were initially selected through a competitive bidding process. However, the process became so time consuming and cumbersome that Medicaid replaced competitive bidding with negotiated, fixed rate contracts and agreed to contract with any plan that met federal and state requirements. Until 1995, plans were paid 95% of the historical fee-for-service costs per recipient per month by county. In September, 1995, rates were set for 11 geographic regions (rather than 67 counties), seven eligibility groups² and five age bands.³ Enrollment was slow for many years due to lack of experience among plans with low income populations and concerns that Medicaid recipients had more health problems and utilized more services than commercially enrolled members. As a result, by 1991, 11 prepaid health plans in 5 counties had signed contracts with Medicaid and 100,000 recipients had enrolled. Four of the 11 plans were commercially licensed and the remaining 7 were Medicaid only plans.

MediPass was developed in 1991 under a section 1915(b) waiver as a demonstration program for AFDC recipients in the Tampa Bay area. In 1992, MediPass was amended to enroll SSI recipients who were not eligible for Medicare and in June 1993, the program was expanded statewide. Eligible Medicaid recipients must select a primary care provider or enroll in an HMO. Recipients who do not select

² Rate cells were developed for AFDC, Foster Care, SOBRA, Medically Needy, SSI-No Medicare, SSI-Medicare B only, SSI-Medicare A and B and A only.

³ In 1996 the age bands were increased to 6: < 1, 1-5, 6-13, 14-20, 21-54 and 55+.

a participating primary care provider are automatically assigned. MediPass enrollees have 24 hour access to care and coordination of specialty services. Care of 508,000 recipients who have selected MediPass is coordinated by over 4,500 primary care physicians who participate in the program

Several categories of recipients are exempt from MediPass: Medically needy, dual eligibles⁴, including QMBs and SLMBs, home and community based waiver participants, and others. SSI recipients who are not eligible for Medicare are required to participate in MediPass or select an HMO. In 1996, the Agency for Health Care Administration had signed contracts with 22 HMOs and prepaid health plans. Of the 1.5 million Medicaid recipients in Florida, 508,000 are enrolled in MediPass, the (PCCM) program, 397,000 have enrolled in HMOs and 547,000 remain in the fee-for-service system. Over 91,000 SSI recipients who are not eligible for Medicare participate in MediPass (40,646) or have joined an HMO (54,441). However, the number of elderly SSI recipients was not available.

Enrollment of dually eligible elderly recipients in Medicaid managed care is limited. Of the 232,483 dually eligible aged recipients, about 8%, 18,600, have enrolled in Medicaid managed care. About 15,000 have joined an HMO for Medicaid acute care services and 3,500 (about 13% of these recipients are under 65) are enrolled in the frail/elderly option described below.

Conflict with Medicare payments to HMOs has resulted in obstacles to enrolling dual eligibles in a single HMO for both Medicare and Medicaid. HMOs with Medicare risk contracts in Florida receive payments based on the AAPCC and do not receive payments from Medicaid. HMOs must develop an adjusted community rate (ACR) which estimates the cost of all services that are expected to be utilized by Medicare enrollees. HCFA compares the ACR to the AAPCC. If the ACR is lower than the AAPCC, the HMO may reduce premiums, expand benefits or both or receive a lower rate. Based on 1991 data, HCFA calculated that on average, HMOs offered \$115 a month in additional benefits or reduced premiums. Because of the high AAPCC and lower ACR in parts of Florida, HMOs usually offer zero premium plans with expanded benefits. Medicaid would typically cover premiums, and be billed for deductibles, copayments, if applicable, by providers for dual eligible recipients enrolling in managed care. In addition, Medicaid typically covers services that are not part of the Medicare benefit. Most Florida HMOs therefore do not charge premiums and offer benefits that, as a result, need not be covered by Medicaid. As a result HCFA has precluded dual eligibles from simultaneously enrolling in Medicaid and Medicare managed care plans to prevent duplicate payment until a methodology is developed that adjusts Medicaid capitation rates. State agencies are seeking Medicare HMO enrollment data and

⁴ Dual eligible means a person eligible for both Medicaid and Medicare.

Medicare utilization data to explore methodologies for developing an appropriate capitation rate for dual eligibles.

Long term care

Florida is pursuing several planning and program initiatives to serve elders. The Medicaid program has contracted with two HMOs to offer a frail/elderly option which provides Medicaid medical and long term care services. The state Department of Elder Affairs has received a grant from the Robert Wood Johnson Foundation to develop an integrated model for serving dually eligible beneficiaries in selected counties of the state. The legislature created a Commission on Long Term Care in Florida in 1994 to study and make recommendations on the current programming and financing of long term care and to develop a framework for planning. The Commission issued its final report December 15, 1995.

The final report of the Commission on Long Term Care in Florida recommended that acute and long term care be integrated in a managed care system. The report states that:

"the system would be designed to apply management principles to the acute and long term care systems in order to assure that consumers receive the care that they need, when they need it, in a setting that is medically, socially and economically appropriate and that these goals are accomplished through the use of a capitated payment system which removes incentives on the provider, the supplier and the consumer to over-charge, over-supply and over-utilize care."⁵

The Commission recommended that Florida phase in a program that integrates acute and long term care for all Medicaid recipients between 1997 and 2001. The recommended system would serve all populations: elders, people with disabilities, persons with developmental disabilities, people with AIDS and people with severe and persistent mental illness. Eligibility would be based on financial need, disability status or severity of functional impairment regardless of the origin, and the availability of family, social and community supports. The Commission preferred partnership networks formed by managed care organizations and existing long term care providers.

As part of its plan, the Commission supports a modification of the certificate of need program to further limit the supply of nursing home beds and expand the supply of home and community based alternatives to divert people seeking nursing home

⁵ Ibid.

admission. Recognizing the continuing need for nursing homes, the Commission supported their use for people whose cost of care in the community exceeds the cost of the nursing home. The Commission's recommendations would utilize all sources of federal and state financing including Medicaid, Medicare, state general revenue programs and the Older Americans Act.

The state of Florida has received a grant from the Robert Wood Johnson Foundation to develop a pilot project to integrate acute and long term care services through Medicaid and Medicare. DOEA and the Agency for Health Care Administration (AHCA), which is the Medicaid agency, have signed an interagency agreement to develop the program design and waiver application.

The Frail/Elderly option

Florida has developed the frail/elderly option which allows Medicaid HMOs to assume risk for long term care services. Capitation rates are based on a combination of community and institutional experience for a comparable fee-for-service population. The two frail/elderly options are the ElderCare Plan, offered by CAC-United HealthCare Plans of Florida, Inc. in Dade and Broward counties and the Independence Plan offered by PacificCare of Florida in Dade and Palm Beach counties.

CAC-United HealthCare Plans (ElderCare)

ElderCare began in 1987 as a federal demonstration project at Mount Sinai Medicaid Center in Miami Beach. The demonstration was intended to determine whether a Medicaid capitated program providing a comprehensive set of medical and personal support services could effectively delay entry of frail elders into nursing homes. The results of the project showed that an intensely case managed program of care could delay nursing home entry, thus improving the quality of life for enrollees, and reduce the cost of the state while providing a profit to the prepaid health plan. The demonstration project was folded into the Mount Sinai Medical Health Plan contract in 1990. In 1992 CAC/Ramsey purchased the ElderCare Plan. CAC/Ramsey was acquired in turn by United HealthCare in 1995.

CAC-United HealthCare Plans of Florida, of which United HealthCare Plans of Florida (ElderCare) is a subsidiary, is a combination staff and IPA model HMO. The plan is a Medicare risk contractor and a Social/HMO II site. CAC-United serves over 240,000 enrollees including 49,000 Medicare beneficiaries. The Medicaid plan enrolls 10,000 SSI recipients of which 1,870 participate in the frail/elderly component. Forty seven percent of the frail/elderly participants are 65-85 years of age, 34% are 86 or older, 9% are under 50 and 10% are between 51 and 65.

PacifiCare (Independence Plan)

Independence Plan, formerly know as Lourdes Medical Plan, began as part of Advantage Health Plans in 1992 and was purchased by PacifiCare in 1993. PacifiCare has received provisional NCQA accreditation and has submitted an application to become a Medicare risk contractor (TEFRA HMO). PacifiCare covers approximately 45,000 commercial members and 6,000 Medicaid enrollees of which 1,100 recipients participate in the Independence Plan.

Eligibility

To be eligible for the frail/elderly Medicaid Managed Care option, clients must be Medicaid/SSI recipients and have functional impairments that make them eligible for nursing home placement as determined by the state's preadmission screening program, The Comprehensive Assessment and Review for Long Term Care (CARES). However, nursing home eligible Medicaid recipients who participate in the Aged/Disabled Home and Community Based Services Waiver program, the Assisted Living Waiver and the Project AIDS Care Waiver are not eligible. Unlike waivers, this program cannot serve persons to 300% of poverty nor does it serve medically needy recipients. Participation in the program is voluntary and enrollment is capped.

PacifiCare limits the program to SSI recipients 21 and over while CAC United serves all ages. Members who enter a nursing facility on a permanent basis are disenrolled at the end of the contract year (state fiscal year). To minimize incentives to disenroll high cost enrollees, plans are required to cover nursing home care and all services not included in the nursing home rate until the end of the contract year (the state fiscal year), or the HMOs contract with the nursing facility, whichever is greater.

The CARES program, which was transferred from the Department of Health and Rehabilitative Services to the Department of Elder Affairs in 1995, is responsible for determining Medicaid eligibility for nursing home placement or a nursing home diversion program. The state hires and trains assessors and certifies them to conduct the assessment. A standardized assessment tool and scoring system has been developed to determine eligibility. Screening is required prior to admission to a nursing facility or diversion to a waiver program or the frail/elderly option, with several exceptions. Notably, hospitals may admit directly to a nursing facility and CARES assessors conduct a desk review within 90 days of placement. Plans expressed concern that the ability of hospitals to directly place members in a nursing home made it difficult to arrange home care alternatives. CARES screening is not required for private pay or Medicare reimbursed nursing home admissions.

CARES completes all initial assessments for the level of care determination for ElderCare and Independence Plan in Dade and Broward counties. In Palm Beach

county, Independence Plan completes the assessment which is reviewed by CARES staff. Both plans complete an annual reassessment which is submitted to CARES for a desk review. Statewide, CARES performs about 9,000 in home assessments a year and an equal number of desk reviews of assessments completed by other providers including nursing facilities. AHCA staff have concerns about the self-interest plans have in qualifying members for the frail/elderly capitation payment and are exploring options for validating the assessments. DOEA is currently undertaking an evaluation of the CARES instrument and process in an effort to develop an instrument that would predict risk of nursing home placement and make scoring more objective and reliable. However, a study conducted for the Long Term Care Commission by the Florida Policy Exchange Center on Aging and the Southeast Florida Center on Aging found that elderly Medicaid HMO members were as impaired as, or more impaired than, recipients in nursing homes and four other programs, the Medicaid Home and Community Based Services Waiver, the Home Care for the Elderly program, Community Care for the Elderly and the Channeling program. (See Table 1).

Table 1
Percentage of Medicaid Recipients with Impairments by Program

	NFs	HMOs	Waiver	HCE ⁶	CCE ⁷	Channeling
No or mild cognitive impairment, no ADLs	1.8	4.0	14.5	5.2	25.6	3.4
1-2 ADLs	7.2	12.7	30.7	8.3	26.9	20.3
3 ADLs, or moderate cognitive impairment	10.2	15.1	20.3	18.8	21.9	16.1
4-5 ADLs, no or mild cognitive impairment	29.9	13.5	9.3	9.4	7.9	10.2
Moderate cognitive impairment and 4-5 severe ADLs or severe cognitive impairment	50.2	54.8	25.2	58.3	17.8	50.0
Severe cognitive impairment	22.9	48.8	17.8	45.9	14.5	37.8
Dementia diagnosis	54.8	34.6	14.2	31.6	11.6	37.2
Chronic incontinence	50.0	42.5	24.0	22.4	18.7	39.7

⁶ Home Care for the Elderly.

⁷ Community Care for the Elderly.

Enrollment

The two program sites are responsible for marketing and enrollment. Plans must use a Statement of Understanding (which a client must sign) developed by the state and must provide enrollees a handbook. Plan marketing staff must be licensed as insurance brokers by the state and trained and certified in the CARES assessment in order to enroll recipients. However, they do not conduct the CARES assessment. For clients referred from CARES, the plans use the completed CARES assessment for clinical decision making. Plans have five days after membership begins to visit the client and develop a plan of care. The majority of clients are referred directly by provider agencies and most HMO marketing is directed to these agencies. Once a provider makes a referral to an HMO, the client completes an application and a physician completes a form, and the client is assessed by CARES. In both plans, a new referral receives a home visit from a state licensed "enrollment representative," who conducts a preliminary assessment, secures a physician's order for nursing home-level care and refers to CARES for a comprehensive assessment and an official eligibility determination. If CARES determines the client eligible, the plans send enrollment information to the state and, upon receipt of an enrollment effective date, a care coordinator develops and implements a plan of care.

Disenrollment

Plans are required to submit monthly reports on voluntary and involuntary disenrollment by reason. The reasons for voluntary disenrollment are:

- Expects to move,
- Wishes to see a private MD or practitioner at clinic,
- Dissatisfied with plan policies or procedures,
- Enrolled/enrolling in MediPass (PCCM),
- Marketing representative compliant or misrepresentation of plan, and
- Other with a listing of the reasons.

Involuntary requests for disenrollment include:

- Missed 3 consecutive appointments in a continuous 6 month period,
- Moved out of service area,
- Admitted to long term care facility (non frail/elderly),
- Fraudulent use of plan or plan identification,
- Death,
- Loss of Medicaid eligibility, and
- Other with the name of the recipient and the reason cited.

Disenrollment rates have generally been low. Both PacifiCare and CAC/United

reported a disenrollment rate of about 4% a month or less. The program is voluntary but plans are required to accept all clients deemed eligible through the CARES assessment. Both plans cite death as the single greatest reason for disenrollment. In ElderCare, approximately 18% of disenrollments are due to loss of Medicaid eligibility. Others disenroll to assure access to providers (e.g., a local pharmacy) which may not be in the HMO's network.

Independence Plan noted its unique arrangement with board and care and assisted living sites.⁹ The plan contracts with assisted living facilities to assist in maintaining members' independence in residential settings in order to prevent or delay nursing home placement or hospitalization. Assisted living providers meet periodically with HMO care managers to discuss member needs, provide space for care managers to interview members, and provide access to member records. Assisted living facilities are also required to notify the plan of address changes, hospital or nursing home admissions/discharges, death and significant changes in health conditions. They also assist with the dispensing, storing and tracking health supply inventories, provide additional assistance to people who are incontinent and verify service delivery by other subcontractors such as home health agencies, durable medical equipment, consumable supplies, over the counter drugs and prescription drugs. Facilities that meet the plan's standards receive an administrative fee of \$50 per member per month for assisting with these responsibilities.

Independence Plan provides nurses aides to deliver services to members in ALFs rather than contracting with the facilities. For example, an ALF with 16 residents who are members may have two full time aides assigned to the facility by the Independence Plan. This arrangement helps the plan address liability, supervision and quality of care in settings which vary in size and capacity to provide services. While ALFs are used as permanent housing for members, the plan does not pay for room and board and does not contract with ALFs to substitute for a nursing home level of care. Most ALF residents receive the Optional State Supplementation to the federal SSI payment. This payment covers room and board, personal care and other services including case management. The case management function can overlap with or duplicate what is provided by the HMO.

ALFs can potentially influence decisions by residents to join an HMO and ALFs are recognizing their emerging leverage. One facility discovered that 15 of their residents were members of one HMO. The ALF offered to make office space available

⁹ Assisted living in Florida includes adult congregate living facilities and extended congregate care. Recent legislation refers to both models as assisted living. ALFs provide meals, housekeeping and limited personal care. ECC provides a higher level of service and includes some skilled services.

and the HMO agreed to send a physician to the site on a regular basis. HMO representatives also noted that ALFs can sometimes create pressure for disenrollment. For example, if the ALF staff seeks health services for a resident which are denied by Independence Plan, the staff may encourage the client to disenroll and seek services through the fee-for-service system.

Benefits

In its regular HMO contracts for acute care, plans are required to cover 45 days of inpatient hospital services annually, outpatient hospital and emergency services, physician services, lab and x-ray, prescription drugs, family planning, home health and durable medical equipment, and therapies. In 1996, AHCA is adding transportation, community mental health and targeted case management as mandatory services. Plans may provide vision, hearing, dental and nursing facility services. Plans may also offer expanded services which include adult dental and over the counter products. Plans offering expanded services must identify the amount, duration and scope of each service. Plans also cover Medicare co-payments and deductibles for medical services provided to dual eligible enrollees through fee-for-service Medicare.

In the frail/elderly option, the Medicaid medical services, primarily cost sharing for dually eligible recipients, are also covered. Recipients eligible for Medicare receive Medicare services fee-for-service and have full choice of providers whether or not they are in the HMO's network. In addition, plans offer coordination of services, adult day health care, homemaker/personal care, adaptive equipment, and supplies. Other services deemed necessary by the multi-disciplinary team must also be covered such as emergency alert response services, identity bracelets, expanded home health, financial education, respite, caregiver training and pharmaceutical management.

Both frail/elderly plans provide enhanced benefits to enrollees. PacifiCare provides dental care, vision and hearing, personal care, nursing home (up to one year), homemaker/chore, home delivered meals, adult day care, respite care, drug/nutritional assessments, companions, specialized home management services, minor adaptation and adaptive technologies, caregiver training and escort services. PacifiCare provides a \$10/month benefit for over the counter drugs and consumable supplies (including incontinence supplies). One pharmacy receives a capitation payment of \$10 per member/per month and provides a list of items enrollees may receive.

ElderCare provides hospital, physician, diagnostic, prescription drugs, care management, hearing, vision and dental care, nursing home, personal care/homemaker, home health nurses and therapists, respite, heavy cleaning, adult day care, transportation, escort nutritional assessments, companion, pharmacy review, minor adaptation and adaptive technologies, durable medical equipment, consumable

supplies and \$10 a month for over the counter drugs. They also have physicians in their network who conduct home visits.

Medicaid "carves out" community mental health services, however, institutional mental health is included in the HMO benefit. PacifiCare has subcontracted with a behavioral health management company to deliver these covered services.

The plans are also at risk for nursing home care until the end of the contract year which coincides with the state fiscal year. Plans may place an enrollee in a nursing home without an additional CARES assessment. When members are placed in a nursing home, the state reviews each nursing home placement at the end of its fiscal year and if long term placement seems likely, that client is disenrolled and the nursing facility will be reimbursed fee-for-service in the next year. Because this process occurs in the state's contract year and not a year from admission to a nursing facility, the plan's liability is not usually a full year but only from the date of admission until the end of the state contract year. Such a provision could create an incentive for plans to place high cost clients in a nursing facility and limit their liability, especially since CARES' review occurs in a desk audit 90 days after admission.

Plans note that they are designed specifically to avoid nursing home placement. As a discrete program within an HMO, the frail/elderly option was created to address the needs of a high risk population. Since all members are at risk of nursing facility placement and the program is designed to provide home care options, members would not join or stay in these voluntary programs if they perceived a bias toward institutionalization. Moreover, the program cannot place enrollees in a nursing facility without the approval of enrollees or their families and clients are reluctant to enter a facility. Finally, the rates paid to the plans assume little nursing facility use and reflect the fact that Florida has the lowest ratio of beds per thousand elderly in the nation (28.6/1000). Florida's nursing home occupancy rate during the last six months of 1995 was 90.3% and the comparable rate for Dade county was 89.7%. The supply of Medicaid nursing home beds may be more limited.

One plan noted that liability for all nursing facility care is complicated by the dual eligibility status of many enrollees since Medicare covers hospital admissions, limited skilled nursing facility stays, sub-acute care and rehabilitation services. Since members remain in the Medicare fee-for-service system, the plan may not be aware of or agree to the nursing home placement and the plan's liability begins after the expiration of the Medicare benefit.

Rate setting

Capitation rates for the frail/elderly option include payment for Medicaid acute care services, including Medicare cost sharing (cross over payments) and an

additional component for long term care services. The plans are paid a capitation rate for each enrollee who has been determined eligible through a CARES assessment. Rates were developed based on a blend of the Medicaid fee-for-service claims experience for nursing home eligible recipients residing in the community and the rates for nursing home care to reflect the expected utilization of nursing home and community services. Since their development, rates have been recalculated periodically. Because the original methodology was developed in the mid-1980s, Medicaid officials are re-evaluating the rate and examining options for constructing a rate that reflects a population more comparable to the participants currently served in the frail/elderly option.

The plan receives 95% of the capitation rate for each enrollee for as long as the enrollee remains a member and continues to meet the minimum nursing home level of care. If the enrollee, upon reassessment by CARES, no longer meets the nursing home level of care, the plan receives the standard community capitation rate applicable to the member's eligibility group.

The two plans currently receive approximately \$2000 per month for Medicaid only members, \$1500 per month for Medicaid recipients who are eligible for Part B only and \$1100 a month for those eligible for Medicare Parts A and B.

PacificCare pays its contracted nursing homes at the Medicare rate or at a higher rate than Medicaid. The plan does not have contracts with all nursing facilities in the area. Some facilities do not meet the standards set by the plan. Other facilities prefer not to contract because of perceived intrusions and oversight by the plan (e.g., quality assessments).

Plan recruitment

By July 1996, managed care plans contracting with Medicaid must be commercially licensed and therefore accredited by a nationally recognized organization. Health plans must receive 2 certifications to operate in Florida. AHCA is responsible for reviewing quality of care and issuing a health care provider certificate while the Department of Insurance reviews the plan's financial condition and issues a certificate of authority to conduct business in Florida. AHCA contracts with 22 HMOs including the two plans that offer a frail/elderly option. Nineteen plans are commercially licensed and three contract as prepaid health plans. One Federally Qualified Health Center has applied for commercial certification. The number of contractors has dropped from 29 due in part to cancellation of non-performing plans and the merger of other plans. A rule requiring all commercially licensed HMOs to serve Medicaid recipients has sunset. One plan, Humana, dropped its Medicaid program when the requirement was dropped because of the difficulty developing an appropriate network and a preference for focusing on the more lucrative Medicare

market.

To assure access, the AHCA contract requires that plans maintain staffing/provider ratios that include one FTE primary care physician per 1500 members for non-staff model HMOs. The ratio can be increased 500 members for each nurse practitioner or physician assistant. Plans cannot assign members to primary care physicians who have a patient load of more than 3000 active patients. Active patient is defined as a person who has been seen three times per year. Plans must also assure the availability of 19 specialists for adults and pediatrics identified in the contract. However, a geriatrician is not required. Plans must have one acute care hospital bed per 275 members, one pharmacist per 2500 members in a staff model, a designated emergency facility within 30 minutes travel time, available 24 hours a day, seven days a week, and a medical consultant for each nursing facility with 60 beds or less. Other requirements apply to the plan administrator, support staff, medical records manager, marketing, quality assurance and other areas.

Health plans are required to assure the availability of specialists who are appropriate to the population enrolled. Among the specialists listed are: cardiologist, orthopedist, dermatologist, otolaryngologist, chiropractic physician, urologist, podiatrist, ophthalmologist, optometrist, neurosurgeon, gastroenterologist, oncologist, radiologist, pathologist, anesthesiologist, psychiatrist, oral surgeon, physical therapist, and a specialist in AIDS care. Members must be offered a choice of primary care physicians and plans must notify AHCA monthly when physicians are no longer accepting new patients.

Plans are also required to be responsible for case management and continuity of care. Written protocols must be developed describing how the process works and how the following functions are performed: referral and scheduling assistance, arranging transportation, documentation of referral services, monitoring of ongoing medical conditions, documentation of emergency medical encounters, hospital discharge planning, determining the need for non-covered services and referring members to appropriate resources.

Plans are required to contact members within 90 days to complete an initial health risk assessment, obtain a medical records release and identify members who are more than 2 months behind in their periodicity screening schedule.

Plans are not allowed to routinely deny emergency room use. Criteria for authorization and denial have to be submitted to AHCA.

In addition, the frail/elderly option sites both contract with a range of home and community providers and nursing facility providers. Both programs contract with most area nursing homes and about a dozen home health agencies who refer clients and

subcontract with them to provide care. Enrollees referred from a home health agency almost always continue to be served by that agency once eligible for Independence Plan. Service plans develop care plans that combine Medicare and Medicaid plan services as appropriate. Many enrollees are residents of assisted living facilities and generally continue to receive care from those facilities.

Care Management/Geriatric Focus

The site visit included a review of ElderCare and Independence Plan and the United Home Care Services (UHCS), a case management and direct service provider agency which subcontracts with both plans. Both ElderCare and the Independence plans provide care management and specialized geriatric care but use different models. PacifiCare reviewed all its Medicaid members, recognizing that dually eligible recipients received physician services through Medicare, and identified all enrollees' physicians who were not PacifiCare providers. These physicians were actively recruited to join PacifiCare's network to enhance continuity of care and 12 were actually enrolled as primary care providers.

The ElderCare Plan formed care management teams composed of a case coordinator, nurse, clerical support staff, supervisor and manager. Care coordinators have social work, medical or other social service backgrounds. The role of care coordinators and/or nurses includes:

- visiting clients,
- conducting assessments and reassessments,
- developing care plans,
- authorizing services delineated in the care plan, monitor client status,
- communicating with the primary care physician, and
- managing transitions across settings.

The nurse's role is to implement intervention strategies to reduce risk and functional decline. These activities include home visits to assess health status and changes, educate members, review medications, nutrition, home safety and advance directives, ensure discharge plans are implemented and understood and to recommend care plan changes. Each week a geriatrician meets with care coordinators to review problem cases. Like Independence Plan, ElderCare care coordinators refer to contracted agencies for explicit units of service as defined in their care plans.

PacifiCare's Independence Plan assigns each member to a care manager who is responsible for assessment, care planning and monitoring on a monthly basis. These care managers have social work backgrounds. The care management responsibilities include:

- identification of member problems, resources and needs,
- care plan development and implementation,
- coordination with the primary care physician, utilization management and other providers, and
- reassessment.

The role of the care manager also includes an advocacy function as "an overriding responsibility of the care manager, particularly when dealing with impaired members who cannot negotiate the system on their own behalf." The care manager plays a role in resource management and cost effectiveness. Care managers are responsible for a caseload of about 90 which is viewed as high by program managers but is manageable because the caseload includes multiple residents at the same address in assisted living facilities. The plan has subcontracts with a host of providers. An RN coordinator works closely with the care managers and provides oversight for hospitalizations and skilled nursing facility placements. Health care coordinators from the HMO's utilization management section follow Medicaid only institutional placements.

United Home Care Services, UHCS, is a home and community service provider which subcontracts with both frail/elderly option HMOs. UHCS has been designated by the Area Agency on Aging as a Community Care for the Elderly "lead agency" or single entry point in Dade County. It also provides Medicaid Aged and Disabled Waiver and Older Americans Act services. UHCS is one of two lead agencies statewide that is a licensed home health agency and is seeking certification as a Medicare home health agency provider. Because it is a home health agency, the frail/elderly plans subcontract with UHCS to provide personal care and home health aide services. Currently, UHCS has a waiting list of about 1000 people seeking services from the community care and waiver programs. UHCS refers people on the waiting list to the frail/elderly plans, if they meet the income and level of care criteria.

UHCS serves as one of the service providers for Independence Plan. UHCS provides home health services under a modified capitated reimbursement arrangement. A per person capitation rate is established, but the agency is only at risk for 30 days. Currently, they are providing home health services to 64 members of PacifiCare and 43 ElderCare members. The remaining enrollees are served by the dozen or more other home health agencies with which the plans subcontract.

UHCS provides a nutrition risk reduction service to frail/elderly enrollees when referred by a case manager. The service is paid under a "fee for service" reimbursement arrangement. This service, in part, assists in the appropriate use of nutritional supplements. They report receiving an average of eight referrals per week from PacifiCare's Independence Plan. The intervention usually is for an initial assessment and three follow up visits.

UHCS believes, based on its own nursing assessment, that the Independence Plan sometimes order too many nurse visits when no skilled care is being ordered and too few personal care hours. UHCS contends that they are able to substitute less costly care for program enrollees referred to them by the ElderCare Plan for whom they develop a home health care plan under a subcontract. The health plan disagrees with this interpretation and noted that the HMO emphasizes routine RN monitoring in order to prevent more costly hospitalizations. They contend that community programs which are not liable for medical care, such as UHCS, may not fully appreciate the importance of nursing in preventing institutionalization.

Currently ElderCare is experimenting with UHCS for care plan development and coordination of home health (not medical or pharmacy) services. UHCS care managers develop and submit the home health care plan to ElderCare Plan but UHCS does not receive an additional payment from ElderCare other than the capitation rate. If there is disagreement, the two programs discuss it and agree on a resolution.

Independence Plan notes that it has considerable flexibility to design creative, non-medical services to avoid or delay institutionalization. For example, they recognize that incontinence frequently precipitates admission to a nursing home. They are currently seeking an incontinence expert to help them develop better preventative services. They also note that the highly competitive marketplace has both advantages and disadvantages. To keep clients enrolled, plans are encouraged to market extra services elders need and want. But because the program is voluntary and must provide maximum client choice to Medicare clients through fee for service, the program cannot require a "lock in." Without a lock-in, there is no guarantee that the enrollee will be a long term member, and this can be a disincentive to invest in creative alternatives. For example, a plan may spend considerable resources to modify a home to accommodate a member's disability, which may allow a person to move to the community from an institutional setting. If the member disenrolls, the investment becomes a significant loss. Thus, case managers may not always be able to implement care plans which might be most appropriate. AHCA is submitting a waiver to require a 12 month lock-in to address this concern.

Linking Acute and long term care

The frail/elderly plans link Medicaid acute and long term care services which provides incentives to use home care alternatives. Care managers coordinate and monitor care plans to assure linkage. However, because the elderly are also eligible for Medicare and can select providers outside the frail/elderly option, true integration cannot be achieved. Because CAC-United HealthCare Plans of Florida is a TEFRA HMO, it would be possible to improve coordination between Medicare and Medicaid except that frail/elderly option enrollees are not allowed to join a Medicare HMO. Continuity of care is interrupted when dual eligibles transition from home to hospital to

nursing facility, since home care may be paid by Medicaid but hospital care and post-hospital nursing home care is typically a Medicare responsibility. The two HMOs included in this site visit have done much to improve the coordination of acute and long term care. Both plans have significant enrollment and contract with most local hospitals, which also participate in Medicaid. These comprehensive networks help prevents out of network use.

The hospitals are informed of a person's HMO status through a Medifax system, an electronic system that allows direct access to the state's Medicaid eligibility system. Hospitals inform HMOs of the admission and status of their enrollees, and they include information about Medicare recipients as well. Because a dual eligible enrolled in the frail/elderly option has an eligibility card noting their participation, hospitals alert the plans to the admission of these enrollees.

A problem cited by many informants is the tendency for hospitals to discharge frail/elderly enrollees to home health agencies or nursing facilities, especially since placement can be made without prior approval from the CARES staff. Since more hospitals operate their own home health agencies and nursing home facilities, and refer discharges for skilled care to them, the frail/elderly plans have been hindered in their ability to integrate medical and long term care.

Quality Improvement

Beginning in late 1995, Medicaid required plans to submit quarterly utilization reports that include the aggregate number of hospital inpatient days, outpatient visits, emergency center visits, physician office visits, non-physician (PA, NP, Podiatrist, Dental, Optometrist/Optician, Otologist, Audiologist) visits, number of prescriptions and refills, and nursing home days. The data are reported by eligibility category (AFDC/SOBR/A/Foster Care, SSI without Medicare, SSI with Part B, SSI with Part A&B). Plans also report monthly by eligibility category the dates of hospital admissions and discharge with the primary diagnosis. Emergency center visits are also reported by diagnosis code and eligibility category. By July 1996, plans will be required to use selected Hedis 2.0 measures to facilitate reporting of required data.

The standard Medicaid contract requires written quality assurance policies and procedures. The plan must identify a person responsible for quality improvement activities, assure that activities occur in all plan areas, direct task forces in the review of focused concerns, publicize findings to appropriate staff and departments and direct and analyze periodic reviews of service utilization patterns.

The procedures include a review to determine the acceptability of medical care under current standards through a quarterly review of 10% or 50 enrollee records, whichever is less, of members who have received services during the quarter. The

reviews must cover management of specific diagnosis, appropriateness and timeliness of care, comprehensiveness and compliance with the plan of care and evidence of special screening for and monitoring of high risk individuals or conditions. Quality assurance programs must have a peer review component.

The Medicaid HMO contract includes requirements for information that must be included in medical records, such as dated entries, provider/author identification, personal/biographical data, allergies, past medical history, immunization record, diagnostic information, ID of current problems, smoking/substance abuse, consultations, referrals and specialist reports, emergency care, hospital discharge summaries, advance directive and patient visit data.

AHCA performs comprehensive annual reviews of each plan, including medical and financial audits, and a focused review each quarter of provider networks, cash flow and solvency. AHCA uses a 70 page survey form which parallels the contract requirements to record information. An annual medical record review by an external peer review organization is also required.

Finally, commercial plans are required to establish a grievance procedure that includes:

- designating a grievance coordinator,
- providing information to members about the grievance process,
- assigning staff with the authority to solve problems to participate in the process, and
- involving physicians other than the member's primary care physician in medically related complaints.

Plans must maintain adequate records of each grievance and submit quarterly reports on the number filed, reasons and a listing of the number and nature of all grievances that have not been satisfactorily resolved. Members may appeal unsatisfactory resolutions to AHCA's statewide Provider and Subscriber Assistance Program.

PacificCare has received preliminary accreditation from NCOA and comments that this creates some overlap with the current system. Some informants reported that NCOA appears to hold plans to a higher standard than traditional Medicaid fee-for-service requirements. NCOA holds plans accountable for all services they delegate which may have future implications about how and to whom plans may subcontract services.

ElderCare Plan is considering a study of the use of prescription medications. Improving such use will be difficult to achieve due to the large number of prescribing physicians and enrollee choice of physician. They also conducted in 1995 a member

satisfaction survey through the University of Miami. Key findings include:

- 86% of those receiving home care found the service to be good or excellent.
- 93% reported no difficulty contacting ElderCare if they had a question or concern.
- 69% reported that ElderCare had arranged transportation for them and 82% of these respondents rated the service as good or excellent.
- 91% were satisfied with their case manager.
- 95% reported that they thought the plan helped them avoid admission to a nursing home.

Aging Network

The Florida Department of Elder Affairs (DOEA) is a separate cabinet level agency created by legislation in 1991. DOEA is responsible for administering the Older Americans Act, two general revenue programs (Community Care for the Elderly and Home Care for the Elderly), the Medicaid Aged and Disabled waiver, an Alzheimer's Disease initiative, the nursing home preadmission screening programs (CARES), and the Assisted Living Waiver. DOEA channels funds for these programs through contracts with 11 Area Agencies on Aging (AAAs). The AAAs, in turn, contract with "lead agencies" which act as single entry points in their service area.

The state received \$60.5 million under the OAA in FY 1996 and will serve 359,481 elders through supportive services (Title IIIB), congregate (IIIC1) and home delivered meals (IIIC2), in-home services (IIID) and other titles of the Act.

The Community Care for the Elderly program serves people 60 years of age and older who have functional impairments. While there is no income limit, participants pay a portion of the cost of services based on their income. Priority is given to individuals at risk of entering a nursing home or those who have been abused, neglected or exploited. The program provides adult day care, case management, chore, counseling, emergency alert response, emergency home repair, homemaker, respite, medical transportation, home delivered meals, personal care, physical therapy, occupational therapy, speech therapy, home nursing and mini-day care.

DOEA operates two of the state's Medicaid home and community based services waiver programs. In FY 95 the Aged and Disabled Waiver spent \$20.9 million and served 8,108 recipients. Spending will rise to \$23.9 million in FY 96 to serve 9,250 recipients. The waiver has an approved cap of 15,128 recipients, however, state

matching funds are not available to expand participation. Services covered by the waiver include adult day health, case management, case aide, chore, consumable medical supplies, caregiver training and support, counseling, emergency alert response, environmental modifications, homemaker, home delivered meals, personal care, risk reduction, therapies, companionship, health support, escort and respite services.

The Assisted Living Waiver supports 225 recipients in residential settings. Services covered include personal care, attendant and companion, medication administration and oversight, homemaker, therapeutic social and recreational programming, therapies, intermittent nursing services, specialized medical supplies, specialized approaches to behavior management, emergency call system and case management. This program was started in February 1995. Eligibility is limited to people 60 and older who meet one or more of the following criteria:

- Require assistance with four or more activities of daily living (ADLs) or three ADLs plus supervision or administration of medications.
- Require total assistance with one or more ADLs.
- Have a diagnosis of Alzheimer's Disease or other dementia and requires assistance with two or more ADLs.
- Have a diagnosed degenerative or chronic medical condition requiring nursing services that cannot be provided in a standard ALF but are available in an ALF that is licensed for limit nursing or extended congregate care.
- Are Medicaid eligible awaiting discharge from a nursing facility who cannot return to a private residence because of a need for personal care, supervision, periodic nursing services or a combination of the three.

The Home Care for the Elderly program provides a cash subsidy for care of elders in family type living arrangements in private homes as an alternative to nursing home or other institutional care. The subsidy program has two components. A basic subsidy of \$106 a month, on average, covers support and maintenance. A special supplement may be approved for additional services or supplies such as incontinence items, medications, medical supplies, wheelchairs, assistive devices, ramps and home modifications for accessibility, nutritional supplements, home health aide, home nursing and other services that help the person stay at home. Eligible applicants must have income below the institutional care program standard (\$1410) and be at risk of nursing home admission. The participant must also have an approved caregiver residing with the participant who is willing and able to provide or assist in arranging for services. The program serves 8,500 elders and the average subsidy is \$1,272 a year.

Major Programs and Funding, FY 1996		
Program	Funding	Number served
Older Americans Act	\$60.5 million	359,481
Community Care for the Elderly	\$41.5 million	35,494
Home Care for the Elderly	\$13.7 million	8,500
Medicaid Aged & Disabled Waiver	\$23.9 million	9,250
Medicaid Assisted Living Waiver	\$ 2.3 million	225
Alzheimer's Disease Respite	\$ 3.8 million	2,272
Total (excluding OAA)	\$85.2 million	55,741

DOEA had not been created at the time the frail/elderly option was implemented as a demonstration program. DOEA and AHCA are developing a federal waiver application that will build upon the frail/elderly option and integrate acute and long term care services for dually eligible elders.

At the local level, HMOs have contracted with the single entry point or lead agency to perform a range of functions. Lead agencies in Florida are also direct service providers which accounts for the contracting interest. However, in Dade County, the lead agency, UHCS, is subcontracting with ElderCare Plan and works in collaboration to develop care plans for home health services. This model could provide useful information as a potential model for other aging network case management providers.

Conclusions

Florida has useful experience enrolling nursing home eligible aged Medicaid recipients in managed care plans.

The frail/elderly option highlights the conflicts and difficulties serving dual eligibles. Lack of adequate adjustments to the Medicaid and/or Medicare capitation payment for dual eligibles have prevented the state from enrolling dual eligibles in an HMO for both programs. However, since members often use Medicaid HMO's providers for their Medicare services, coordination can be addressed indirectly. The new managed long term care initiative will attempt to address these issues.

As a state with a very large elderly population and extensive HMO penetration in commercial and Medicare markets, Florida has been a testing ground for managed

care initiatives. Florida has encouraged the development of managed care as a tool for improving access to health care and controlling Medicaid expenditures. Important lessons have been learned. Initially, AHCA relaxed regulations of Medicaid HMOs to encourage their expansion. HMOs were able to conduct their own marketing and enrollment functions. Recently, state officials have tightened contract provisions and require that Medicaid HMOs comply with all regulations that apply to commercial HMOs. State officials have also indicated their interest in implementing a third party or non-biased counseling and enrollment process but have been hindered by lack of additional funding. Now that most of the AFDC and SSI-non Medicare population is enrolled in either Medicaid managed care or the MediPass program, the state is turning its attention to applying managed care principles to the health care problems of special need populations, including the frail elderly.

Despite concerns about the ability of CARES staff to conduct face to face assessments to determine eligibility for every enrollee, the program does most of the in-person assessments in the counties served by the frail/elderly option. State officials are concerned that recipients may be entering the program who may not be at risk of entering a nursing facility. However, data from a special study conducted for the Long Term Care Policy Commission found that frail/elderly members are quite frail and compare favorably with the population served by other programs designed to serve people who qualify for or are at risk of placement in a nursing facility.

Some frail/elderly members live in assisted living facilities that are similar to board and care facilities in other states. Group residential settings offer opportunities to improve the delivery of care by bringing physicians and other providers to the residential environment. Contracting arrangements and definition of mutual roles is necessary to reduce potential conflict between the managed care plan and the residential facility.

When capitated to provide long term care services, HMOs can develop the home and community based services networks needed to overcome a perceived reliance on medical and institutional resources.

HMOs providing acute and long term care to frail elders require good procedures and an understanding of the perspectives of health and community based services providers to develop appropriate, cost effective care plans.

The state's Medicaid managed care contracts have a number of provisions directed at ensuring adequacy of HMO networks and the provision of quality care. Collection and analysis of utilization or encounter data is an important aspect of contract monitoring and quality assurance. This aspect of the frail/elderly option would benefit from further attention. However, until the limitations serving dual eligibles are resolved, enrolling elders in managed care is not likely to be major priority. Work on a

demonstration program to enroll dual eligibles may allow the state to build on programs that have been successful developing appropriate provider networks to serve a frail population.

NATIONAL ACADEMY FOR STATE HEALTH POLICY

FACT SHEET

The National Academy for State Health Policy (NASHP) was formed in 1987 to provide a multi-disciplinary forum for the timely examination of complex health policy issues affecting states. The Academy provides a non-profit forum for leading state health policy officials to exchange insights, information and experience, and to develop practical solutions to problems confronting states.

The Academy recognizes that responsibility for health care does not reside in a single state agency or department and provides a unique forum for productive interchange across both department and agency and executive and legislative lines of authority. Steering committees of volunteers from various executive branch agencies, state universities and legislatures play a key role in identifying the Academy's agenda and in developing innovative and effective strategies to improve the delivery and financing of health care. The Academy links policymakers with practical and useful policy research through affiliation with three universities, University of Southern Maine's Muskie Institute, Brandeis University's Institute for Health Policy and University of Minnesota's Long Term Care Center.

The Academy convenes forums and workshops; provides technical assistance to states; and develops and distributes publications and analysis. Current programs include:

Annual State Health Policy Conference

Held each August, the conference is a unique collaboration of key policy makers examining cutting edge issues and best practices.

Health Reform Initiatives

The Academy analyzes state and Federal health reform, works with the academic community to help expand primary care capacity and provides support to states in implementing reform. Through a subcontract with the Research Triangle Institute, the Academy assists HCFA and states with 1115 waiver programs.

National Long Term Care Resource Center

Co-sponsored with the University of Minnesota and funded by the Administration on Aging, the Center provides technical assistance and policy analysis to states in all areas of long term care policy and practice.

Center for Vulnerable Populations

Co-directed with Brandeis University, and funded by the Henry J. Kaiser Family Foundation, the Center conducts research and policy analyses, examines best practices for vulnerable populations and aggressively disseminates the results.

Medicaid Managed Care Resource Center

Supported primarily by The Pew Charitable Trusts, the Resource Center places special emphasis on the needs of key groups of Medicaid enrollees: women, children, the elderly and people with disabilities. The Center creates a centralized source for technical assistance to states.

For more information about the Academy or to order publications, please contact the Academy at 50 Monument Square, Suite 502, Portland, Maine 04101, 207-874-6524, fax: 207-874-6527.