The Hilltop Institute

analysis to advance the health of vulnerable populations

A Comparison of Managed Long-Term Care Programs

January 2009

A Comparison of Managed Long-Term Care Programs

The following tables compare managed long-term care programs in eight states. Table 1A (pages 2-6) examines programs in **Arizona**, **Florida**, **Massachusetts**, and **Minnesota**. Table 1B (pages 7-11) examines programs in **New Mexico**, **New York**, **Texas**, and **Wisconsin**. Both tables compare the programs along the same parameters:

- Implementation Date
- Mandatory/Voluntary
- Geographic Coverage
- Waiver Authority
- Eligibility
- Nursing Facility Level-of-Care Required
- Enrollment
- Medicare Integration
- Health Plans
- Covered Medicaid Services
- Risk for Nursing Home Care
- Capitation Rate Methodology
- Rate Cells

The Hilltop Institute researched and compiled the information in these tables. Information sources include published program descriptions, comparisons prepared by other researchers, waiver applications, and telephone interviews with state representatives. Comments and questions may be directed to:

Cynthia H. Woodcock
Director, Long-Term Supports and Services
The Hilltop Institute
410.455.6273
cwoodcock@hilltop.umbc.edu
www.hilltopinstitute.org

Table 1A. Arizona, Florida, Massachusetts, Minnesota

	ARIZONA	FLORIDA*	MASSACHUSETTS	MINNESOTA	
	Arizona Long-Term Care System (ALTCS)	**Nursing Home Diversion Program**	**Senior Care Options (SCO)**	**Senior Health Options (MSHO)**	**Senior Care Plus (MSC+)**
Implementation Date	1989	1988	2004	1997	2005
Mandatory/Voluntary	Mandatory	Voluntary	Voluntary Individuals can opt for fee-for-service.	Voluntary	Mandatory (if not enrolled in MSHO)
Geographic Coverage	Statewide	Limited Available in 30 counties	Limited. Currently: • 3 health plans in Boston/Merrimack Valley • 2 health plans in Springfield • 2 health plans in Worcester • 1 health plan in Taunton/New Bedford	Statewide	Statewide as of January 2009
Waiver Authority	1115	1915(a)(c)	1915(a)	1915(a)(c)	1915(b)(c)
Eligibility	Age 65+, physical disabilities, and developmental disabilities Exclusions: Native Americans on reservations	Age 65+, dual eligible, and meets NF level-of-care and one or more clinical criteria	All Medicaid members age 65+	All Medicaid members age 65+	All Medicaid members age 65+
Nursing Facility Level-of-Care Required	Yes	Yes	No	No	No

* Implementation of Florida Senior Care—the state's new managed long-term care program—is currently on hold while the program is reassessed. In 2006, CMS approved a combination 1915(b)(c) waiver for Florida Senior Care, which was to be piloted in two regions—one mandatory and the other voluntary. In 2007, at the request of the legislature, the waiver was resubmitted to CMS and later approved as a 1915(a) (c). The state planned to implement what was now a voluntary program in two pilot regions. However, because of concerns voiced by advocates, health plans, and consumers, Florida Senior Care is now "on hold."

	ARIZONA	FLORIDA*	MASSACHUSETTS	MINNESOTA	
	Arizona Long-Term Care System (ALTCS)	**Nursing Home Diversion Program**	**Senior Care Options (SCO)**	**Senior Health Options (MSHO)**	**Senior Care Plus (MSC+)**
Enrollment	46,000 in FY 08	10,000 in FY 08	10,600 in FY 08	36,000 in FY 08	11,000 in FY 08. The state expects enrollment to increase significantly when program goes statewide in January 2009.
Medicare Integration	No Health plans are encouraged, but not required, to be dual eligible SNPs.	No Health plans are not required to be dual eligible SNPs, although the state is looking to promote Medicaid-Medicare integration.	Yes. Integrated Medicare-Medicaid program with full Medicaid and Medicare benefits. All plans must be dual eligible SNPs.	Yes. Integrated Medicare-Medicaid program with full Medicaid and Medicare benefits.	No
Health Plans	9 health plans	14 health plans, with minimum of 2 plans in each participating county. Mix of non-profit and for-profit plans. Participating plans include Evercare, Universal, AMERIGROUP, Humana, some of the state's larger HMOs. Counties may participate, but none do so.	3 health plans, each operating in its own selected service areas (see "Geographic Coverage"): • Senior Whole Health (for-profit, approx. 3,000 enrollees) • Evercare (for-profit, approx. 2,000 enrollees) • Community Care Alliance (non-profit, approx. 2,000 enrollees)	Non-profit health plans	Non-profit health plans
Covered Medicaid Services	Acute and long-term care services	Acute and long-term care services	Acute and long-term care services	Acute and long-term care services	Acute and long-term care services

The Hilltop Institute

	ARIZONA	FLORIDA*	MASSACHUSETTS	MINNESOTA	
	Arizona Long-Term Care System (ALTCS)	Nursing Home Diversion Program	Senior Care Options (SCO)	Senior Health Options (MSHO)	Senior Care Plus (MSC+)
Risk for Nursing Home Care	Health plans are at full risk for nursing home care.	Health plans are at full risk for nursing home care.	Health plans are at full risk for nursing home care. To encourage NF transitions, if a plan transitions a member from an institution to the community, the plan continues to receive its institutional rate for 90 days. If a plan transitions a member from the community to an institution, the plan continues to receive its community rate for 90 days before shifting to the institutional rate.	Health plans are at risk for up to 180 days of nursing home care for members who are living in the community at the time of enrollment. Nursing home days per member are counted cumulatively (does not have to be a single nursing home stay). After 180 days, the nursing home is paid fee-for-service by the state and the nursing home add-on payment to the health plan ceases. However, the member remains enrolled with the health plan for all other Medicaid services while in the nursing home. Health plans are not responsible for nursing home care for members who are in a nursing home at the time of enrollment. The nursing home is paid fee-for-service by the state.	

	ARIZONA	FLORIDA*	MASSACHUSETTS	MINNESOTA	
	Arizona Long-Term Care System (ALTCS)	Nursing Home Diversion Program	Senior Care Options (SCO)	Senior Health Options (MSHO)	Senior Care Plus (MSC+)
Capitation Rate Methodology	Aged/physically disabled rates are based on financial and encounter data submitted by the MCOs. Cost categories "rolled up" into the capitation rate are: acute care, case management, HCBS, nursing facility, administration, and risk contingency (2%-3% profit margin). MCO-specific rates are weighted prospectively based on anticipated patient mix. There are no carve-outs. However, therapies are authorized and paid separately, outside the capitation rate. MCOs may negotiate with nursing homes to establish a rate for therapies. Rates are not based on acuity; cell sizes are not big enough.	A blended rate consisting of a fee-for-service capitated rate (50% weight) and a capitation rate based on encounter costs (50% weight). The state is moving to using 100% encounter costs. Under this voluntary program, the beneficiary may disenroll and revert to fee-for-service at any time. When an individual requires nursing home care, there is a strong incentive to disenroll because a limited number of nursing homes participate in the network, and nursing homes and hospital discharge planners frequently encourage disenrollment. In 2008, actuary Milliman recommended that the state charge the health plans a disenrollment fee since the capitation rate includes nursing home stays; otherwise, the plans are over-compensated.	24 rating categories differentiate members by setting of care (institution vs. community), level of care, eligibility status (dual vs. non-dual), and geographic location (Boston vs. outside Boston). To determine level of care, the state uses Management Minutes Categories (MMCs), a system established in the 1980s that counts actual minutes of care required by the individual.	Same Medicaid rates for MSHO and MSC+. For community members, health plans are paid a capitation rate equivalent to non-nursing home state plan services plus a "nursing home add-on" to cover the risk that a certain number of members will move into the nursing home in a given year. Fee-for-service per diem nursing home rates are the basis for calculating this add-on. If the member is eligible for Elderly Waiver services, the health plan receives an additional add-on payment. This separate rate cell for HCBS encourages community-based care.	

	ARIZONA	FLORIDA*	MASSACHUSETTS	MINNESOTA	
	Arizona Long-Term Care System (ALTCS)	**Nursing Home Diversion Program**	**Senior Care Options (SCO)**	**Senior Health Options (MSHO)**	**Senior Care Plus (MSC+)**
Rate Cells	2 rate cells: • Developmentally disabled. Single capitation rate; no risk adjustment. • Aged/physically disabled. Capitation rates are MCO-specific; three rates: with Medicare, without Medicare, and acute care only.	One rate cell for all levels of care. Average FY 09 PMPM is $1,624. Rates are county- and plan-specific.	6 Medicaid rate cells: • Community Other • Community Alzheimer's Disease • Community Nursing Home Certifiable • Institutional Tier 1 • Institutional Tier 2 • Institutional Tier 3	3 Medicaid rate cells: • Community dwelling/non-nursing home certifiable • Community dwelling/nursing home certifiable • Institutionalized at enrollment or afterwards for at least 30 days There are various rates within each rate cell based on age, sex, region, and Medicare status.	

Table 1B. New Mexico, New York, Texas, Wisconsin

	NEW MEXICO	NEW YORK		TEXAS	WISCONSIN	
	Coordination of Long-Term Services (CoLTS)	**Medicaid Advantage Plus**	**Partial Capitation**	**STAR+PLUS**	**Family Care**	**Family Care Partnership**
Implementation Date	2008	2007	1998	1998	2000	1999
Mandatory/Voluntary	Mandatory	Voluntary	Voluntary	Mandatory	Voluntary	Voluntary
Geographic Coverage	Statewide	Limited	Limited	Limited	Limited (but rapidly expanding) Currently in 29 counties	Limited Currently in 15 counties
Waiver Authority	1915(b)(c)	1915(a)	1915(a)	1915(b)(c)	1915(b)(c)	1915(c) and 1932(a) Medicare Advantage SNP
Eligibility	"Healthy" dual eligibles and individuals assessed at NF level-of-care (NF residents, D&E waiver participants, PCO participants, certain persons with brain injury, children <21 with physical disabilities). Excludes DD population.	Age 18+, dual eligible, and meets NF level-of-care. Not eligible if in a NF.	Age 18+ and meets NF level-of-care. Not eligible if in a NF.	Mandatory for Medicaid members and individuals age 21+ with SSI; voluntary for individuals under age 21 with SSI. Residents of NFs are not eligible unless they were enrolled while still in the community.	Frail elders, persons with physical disabilities, and persons with developmental disabilities with long-term service needs.	Dual eligibles and Medicaid-only members certified for NF level-of-care
Nursing Facility Level-of-Care Required	No for dual eligibles; Yes for waiver populations	Yes	Yes	No	No	Yes
Enrollment	Projected enrollment 38,000 by July 2009	216 in FY 2008	21,408 in FY 2008	165,000 in FY 2008	22,000 as of 12/08; 55,000 expected by 2012.	3,100 as of 12/1/08
Medicare Integration	No. Health plans are required to become dual eligible SNPs	Yes. Benefits through Medicaid and a Medicare Advantage SNP.	No	No. Health plans are not required to be SNPs, but most are.	No	Yes. Benefits through Medicaid and a Medicare Advantage SNP.

	NEW MEXICO	NEW YORK		TEXAS	WISCONSIN	
	Coordination of Long-Term Services (CoLTS)	**Medicaid Advantage Plus**	**Partial Capitation**	**STAR+PLUS**	**Family Care**	**Family Care Partnership**
Health Plans	Two health plans that operate statewide: AMERIGROUP and Evercare	Currently 17 health plans for the state's 3 models: PACE, Medicaid Advantage Plus, and Partial Capitation. Some plans offer multiple products in the state. Membership in 3 models is growing about 20% per year.		4 health plans: AMERIGROUP, Molina, Superior, Evercare.	MCOs in cooperation with ADRCs are currently operating in 22 counties. One MCO operates in each county. There are currently 8 different MCOs operating in the state. The state anticipates eventually contracting with 12-15 MCOs when Family Care is statewide. MCOs are local entities (not national companies). As Family Care expands, the state is seeking contracts with regional entities. Some MCOs are looking to offer just Family Care; others want to offer other products.	3 of the 8 MCOs operating in the state have SNP contracts and participate in the Partnership program.
Covered Medicaid Services	Acute and long-term care services	Long-term care, ancillary, and ambulatory services	Long-term care, ancillary, and ambulatory services.	Acute and long-term care services	Long-term care only; no acute care	Long-term care and acute care

The Hilltop Institute

	NEW MEXICO	NEW YORK		TEXAS	WISCONSIN	
	Coordination of Long-Term Services (CoLTS)	**Medicaid Advantage Plus**	**Partial Capitation**	**STAR+PLUS**	**Family Care**	**Family Care Partnership**
Risk for Nursing Home Care	Health plans at full risk for nursing home care	Health plans are at full risk for nursing home care. Rates do not change if a client moves from the community to a NF or vice versa.		***Methodology thru January 2009 (after this, the state will begin carving out nursing home care from MCO capitation rates in response to a CMS review):*** Health plans are at risk for nursing home care for four months only (cumulative over two years); after four months, the member is disenrolled and becomes fee-for-service. A member may be re-enrolled after s/he returns to the community. During nursing home stays, the MCO's service coordinator must visit and assess the individual at 30 days and at 90 days to determine the individual's ability to move back to the community.	Health plans are at full risk for nursing home care.	Health plans are at full risk for nursing home care.

The Hilltop Institute

	NEW MEXICO	NEW YORK		TEXAS	WISCONSIN	
	Coordination of Long-Term Services (CoLTS)	**Medicaid Advantage Plus**	**Partial Capitation**	**STAR+PLUS**	**Family Care**	**Family Care Partnership**
Capitation Rate Methodology	Blended rate based on historical cost data	Rates are based on historical MCO capitation rates, trended forward. The rates take into account the MCO's assumptions about the percentage of clients in the community versus a NF. MCOs negotiate NF rates directly with the NFs.		***Methodology thru January 2009:*** PMPM is about $3,500 while member is in the community. PMPM is about $300 during a member's four-month nursing home stay. This covers the cost of the MCO's service coordinator. The nursing home bills the state directly for the member's nursing home costs. Inpatient hospital is carved out of the capitation rate. Inpatient behavioral health is included in the capitation rate.	Rate is developed each year by compiling projected costs for all clients (based on historical costs, adjusted for inflation and anticipated case mix). Use functional screen-based regression model.	Originally a PACE-like rate methodology, but being phased out by CMS

	NEW MEXICO	NEW YORK		TEXAS	WISCONSIN	
	Coordination of Long-Term Services (CoLTS)	**Medicaid Advantage Plus**	**Partial Capitation**	**STAR+PLUS**	**Family Care**	**Family Care Partnership**
Rate Cells	5 rate cells: • NF level of care—dual eligibles • NF level of care—Medicaid only • Mi Via—dual eligibles • Mi Via—Medicaid only • Healthy dual eligibles	2 Medicaid rate cells: • Under age 65 • Age 65+		8 Medicaid rate cells: • Medicaid only OCC (acute and LTC) • Medicaid only CBA (acute and LTC) • Dual eligible OCC (LTC) • Dual eligible CBA (LTC) 4 rate cells above are calculated for “Harris County” and “non-Harris County” to arrive at 8 rate cells. CBA: Community-Based Alternatives OCC: Other community care	2 rate cells: • Comprehensive Level-of-Care (LOC) • Intermediate LOC	

The Hilltop Institute

University of Maryland, Baltimore County
Sondheim Hall, 3rd Floor
1000 Hilltop Circle
Baltimore, MD 21250
410-455-6854
www.hilltopinstitute.org