Strengthening the Aging Network

Medicaid Managed Long-Term Care – Landscape and Key Features

Jointly Convened by n4a and NASUAD

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Strengthening the Aging Network

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First in a Series on Medicaid Managed Long-Term Care (MMLTC)

- Call 1: Medicaid Managed Long-Term Care (LTC) – Landscape and Key Features
- Call 2: Medicaid Managed LTC Market Landscape – April 20, 3-4 PM EDT
- Call 3: Medicaid Managed Care LTC Contracting and Capitation Payment Setting – April 26, 3-4 PM EDT

Speakers

- Sandy Markwood, n4a CEO
- Mike Cheek, NASUAD Senior Director
- State of Wisconsin
  - Donna Mcdowell, Director, WI Bureau of Aging and Disability Resources
  - Stephanie Sue Stein, Director, Milwaukee AAA
- State of New Mexico
  - John Lujan, Aging and Long Term Services Department
  - Ray Espinoza, Director, New Mexico's Indian AAA

Executive Summary

- Historically, Medicaid Managed Long-Term Care (MMLTC) struggled but…
- Innovations in program operations and the promise of budget predictability have increased interest …
- States with established programs receive generally have received positive consumer feedback, but evidence of cost savings is mixed
- Predictability of capitation keeps MMLTC an attractive option
- In past years, Medicare Advantage Special Needs Plans have fostered MMLTC
- Many states are interested in MMLTC

Agenda

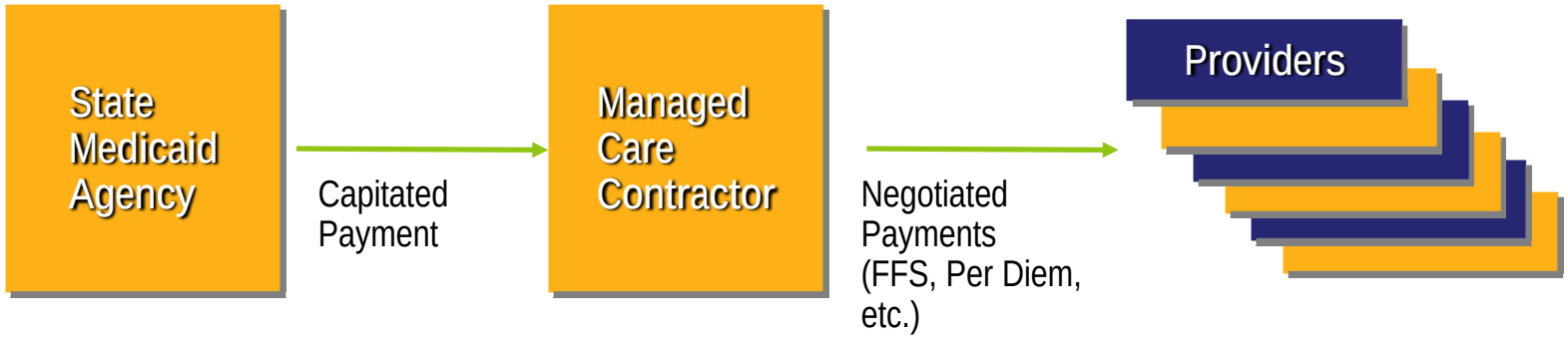
- Defining Medicaid Managed Long-Term Care
- Processes States Use to Adopt MMLTC
- Medicare Advantage Special Needs Plans
- Medicaid Managed Long-Term Care State Activity
- Models of Medicaid Managed Long-Term Care
- Overall Assessment of MMLTC – In the Literature
- Considerations for LTSS Network

Defining Medicaid Managed Long-Term Care

MMLTC Is a Delivery Model States Use in Lieu of Fee-for-Service

Capitated MMLTC

- Medicaid agency and contractors enter into agreement under which contractor accepts risk of providing defined Medicaid LTC services
- Alternative types of MMLTC capitation packages:
  - Medicaid-covered LTC services *only*
  - All Medicaid-covered acute and LTC services
  - All Medicare and Medicaid-covered services (additional *plan contract* with CMS required for Medicare portion)



[1] Source: AARP Public Policy Institute Issue Brief, Medicaid Managed Long-Term Care, 2005

Cost Savings Has Been the Historic Motivation Behind the Development of MMLTC Programs

- 1970s: Sharp rise in Medicaid-related nursing facility costs; sparked lawmaker concern
- 1981: Congress created Medicaid Home and Community Based Services (HCBS) waiver program
  - HCBS grew quickly, but did not slow growth of Medicaid nursing home expenditures
- 1990s: States adopted Medicaid managed acute care programs, leading a handful of states to create MMLTC programs

Source: Saucier, Paul, Brian Burwell, and Kerstin Gerst, *The Past, Present and Future of Managed Long-Term Care*, prepared for the HHS Office of the Assistant Secretary for Planning and Evaluation April 2005.

Processes States Use to Adopt MMLTC

Multiple Avenues for States to Create MMLTC Programs

- MMLTC Enrollment Authorities
  - Section 1115 Demonstration Waivers
  - Section 1915(a) Medicaid Managed Care State Plan Amendment (SPA)
    - With or without Section 1915(c) or Section 1915(i)
  - Section 1932(a) State Plan Amendment
  - Section 1915(b) Managed Care Waivers
  - Section 1915(b) and HCBS 1915(c) Combination Waivers
  - Program for All-Inclusive Care for the Elderly (PACE)

- MMLTC and Medicare-Medicaid Integration
  - Initially Social Health Maintenance Organizations (S/HMO) and Section 222 Medicare Waivers
  - Replaced by Medicare Modernization Act authority for Medicare Advantage Special Needs Plans (SNP)

Options for States to Use to Create MMLTC Programs (1)

1. Section 1115 Waiver
- Flexibility given to states to test policies not permitted under Medicaid statute
- Must demonstrate budget neutrality and must be statewide

2. Section 1915(a) Medicaid Managed Care State Plan Option (SPO)
- Typically used in combination with a Medicaid waiver
- Does not require states to demonstrate program cost effectiveness or budget neutrality
- States may use Medicaid managed care organizations or PCCM arrangements

3. Section 1915(b) Waiver
- Permits states to mandate enrollment into managed care programs
- Some services may be carved out of managed care
- Must demonstrate budget neutrality but does not have to be a statewide program

Source: Centers for Medicare and Medicaid Services Waiver Website, available at http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp

Options for States to Use to Create MMLTC Programs (2)

4. Section 1915(b) and HCBS 1915(c) Combination Waiver

- Permits states to provide LTC and HCBS in a managed care environment
- Must demonstrate cost effectiveness and cost neutrality but does not have to be statewide
  - States apply for two separate waivers, which may be burdensome to renew

5. Section 222 Waiver and Medicare Advantage Special Needs Plans

- Permited states to receive Medicare funding for the provision of services not typically covered under Medicare, such as LTC
- Some states combined 222 waivers with other waivers or state plan options to provide MMLTC to dual eligibles
- Phased out as of 2006 with establishment of Special Needs Plans (SNPs)

Source: Centers for Medicare and Medicaid Services Waiver Website, available at http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp

Options for States to Use to Create MMLTC Programs (3)

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

- Capitated managed care created in 1980s for dual eligibles over the age of 55 needing nursing facility care
- Balanced Budget Act of 1997 lets states implement PACE programs for Medicaid populations without a waiver
- Currently 46 PACE sites throughout US; providers include community organizations in conjunction with provider teams

7. Social Health Maintenance Organization (S/HMO)

- Created in 1984 to test whether providing coordinated care and some LTC benefits using capitation would be cost effective for Medicare HMO enrollees
- Congress authorized extension of S/HMOs in 1990, reinforcing importance of acute care management to delay need for LTC services
- S/HMOs received funding from Medicare, beneficiary premiums, and Medicaid
- S/HMOs either phased down or converted to SNPs by end of 2007

Sources: National PACE Association Website, available at http://www.npaonline.org/website/download.asp?id=1740.
State Coverage Initiatives, *Integrating Medicare and Medicaid: A Briefing Paper*, February 2001.

States Are Looking to New Ways to Run MMLTC Programs

- Deficit Reduction Act of 2005 (DRA) and Affordable Care Act State Plan Amendments (SPAs)
  - Option for states to modify Medicaid programs via state plan amendments
  - Modifications may include changes to prescription drug cost-sharing, premiums, and benefit packages
  - States permitted to target benefit packages to specific beneficiary populations
  - SPAs approved more rapidly
  - Less administratively burdensome than waivers
- Special Needs Plans (SNPs) Created by the Medicare Modernization Act of 2003 (MMA)
  - The MMA expanded the availability of Medicare/Medicaid integrated care by authorizing SNPs, which differ from standard managed care offerings
  - SNP enrollment among dual eligible individuals has grown

Special Needs Plans

SNPs are MA-PD Plans but With Special Requirements

- SNPs are similar to MA-PDs because they
  - Must be an MA-PD plan and use the MA-PD application process
  - Offer all MA services including the Part D drug benefit
  - Generally must follow MA plan marketing guidelines
  - Paid using the same risk-adjusted payment system as MA-PD

- SNPs differ from regular MA-PD because they
  - Have been reauthorized by Congress several times but with additional requirements
  - Must provide services tailored to their special needs population that go beyond standard Medicare services
  - May limit enrollment to certain populations
  - Have a variety of Part D Special Election Periods (SEP) that allow Medicare beneficiaries to enroll throughout the calendar year

Some States Using SNPs To Deliver Integrated Medicare and Medicaid Services

Current Delivery System

Medicare and Medicaid administered by different units of government

No vehicle for beneficiary health care information exchange

Medicare and Medicaid cover some of same services but with different service definitions and limits

Medicaid covers key services Medicare does not

Integrated SNP Delivery System

- Plans contract with CMS for Medicare Advantage services; state contracts for Medicaid MCO services
- Care coordination provides assistance with service access, tracking, utilization management
- SNP gets capitated payments for duals from both Medicare and Medicaid

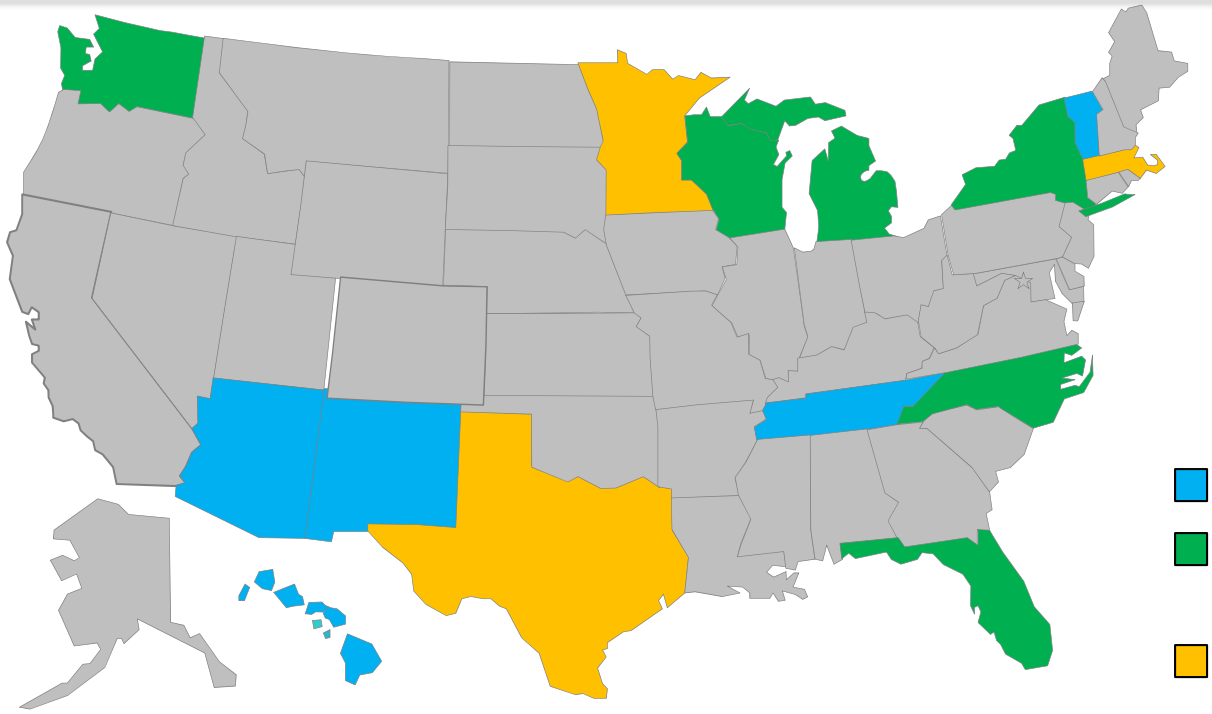
SNP Marketplace has a Mixed Outlook

- SNPs with no or limited Medicaid experience appear to have difficulty
  - Distinguishing themselves from other MA plans
  - Understanding and building relationships with LTC providers
  - Building care coordination programs expert with high need populations
  - Collecting Medicare cost-sharing assistance from Medicaid for duals
  - Providing prescription drug services to nursing home residents
  - Coordinating with Medicaid-financed services with Medicaid-only providers
  - Developing marketing and outreach strategies that reach target audiences and differentiate SNPs from other MA plans
- Affordable Care Act Changes
  - Pending changes in MA-PD Reimbursement

Source: MEDPAC report

Medicaid Managed Long-Term Care State Activity

MMLTC Market has Grown but is Less Prevalent Than Primary/Acute Managed Care



Notes: 1) Does not include PACE; 2) Rhode Island's program includes managed primary and acute care LTC remains fee-for-service; 3) Wisconsin also operates a Medicare-Medicaid Integration program called the Wisconsin Partnership Program; and 4) Some states require their Medicaid managed care plans to also be SNPs -- only historical integration state program are noted above

Sources: CMS Waiver database at http://www.cms.gov/MedicaidStWaivProgDemoPGI/MWDL/list.asp ; Saucier, Paul, Brian Burwell, and Kerstin Gerst, The Past, Present and Future of Managed Long-Term Care, prepared for the DHHS Office of the Assistant Secretary for Planning and Evaluation, April 2005; NASUAD Research

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Generally Voluntary for Beneficiaries and Serve Only a Portion of a State

	Beneficiaries Served	Type of Services Managed	Authority and Program Type
Program for All-inclusive Care for the Elderly (PACE), 1983	Nursing facility (NF)-eligible individuals over age 55 who are eligible Medicare and Medicaid	All Medicaid and Medicare covered services	▪ PACE State Plan Option (SPO) ▪ Voluntary program
FL Frail Elder Option program, 1987	Medicaid beneficiaries eligible for NF care	All Medicaid covered services	▪ 1915 (a) SPO and 1915 (c) Waiver ▪ Voluntary program
AZ Long-Term Care System (ALTCS), 1989	Medicaid beneficiaries eligible for NF care	All Medicaid covered services	▪ 1115 Waiver ▪ Mandatory program
WI Partnership Program, 1995	Dual eligibles eligible for NF care	Began providing both Medicaid and Medicare covered services in 1999	▪ 222 and 1115 Waivers – Now SNP ▪ Voluntary program
MN Senior Care, 1997	Aged dual eligibles	All Medicaid and Medicare covered services	▪ 1915 (a) SPO & 1915 (c) Waiver and SNP ▪ Mandatory program

Programs Mostly Cover Subsets of Individuals In Need of Nursing Facility Level of Care

	Beneficiaries Served	Type of Services Managed	Authority and Program Type
NY Managed LTC, 1997	Medicaid beneficiaries eligible for NF care	Medicaid covered long-term care services, only	▪ 1915 (a) SPO & 1915 (c) Waiver ▪ Voluntary program
TX STAR+, 1998	Medicaid beneficiaries NOT residing in NFs, but at high risk of institutionalization	All Medicaid covered services	▪ 1915 (b)/ (c) Waiver ▪ Mandatory program
FL Diversion, 1998	Aged eligible for NF care	All Medicaid covered services	▪ 1915 (a) SPO & 1915 (c) Waiver ▪ Voluntary program
MI Specialty Services and Supports, 1998	Persons with developmental disabilities	Medicaid financed behavioral health, developmental disability, and substance abuse services	▪ 1915 (b)/ (c) Waiver ▪ Mandatory program
WI Family Care, 2000	Medicaid beneficiaries with any LTC needs	Medicaid covered long-term care services only	▪ 1915 (b)/ (c) Waiver ▪ Mandatory program
MA Senior Care Options (SCO), 2004	Aged dual eligibles	All Medicaid and Medicare covered services	▪ SNP and MassHealth Section 1115 ▪ Voluntary program
North Carolina, Piedmont Care, 2004	Persons with developmental disabilities	Medicaid financed behavioral health, developmental disability, and substance abuse services	▪ 1915 (b)/ (c) Waiver ▪ Mandatory program

Several States Recently Have Adopted MMLTC

	Beneficiaries Served	Type of Services Managed	Authority and Program Type
Vermont MMLTC, 2005	Medicaid beneficiaries eligible for NF care	Limits long-term care services to beneficiaries in the highest need group – others will be served if funding is available	▪ 1115 Waiver ▪ Mandatory
Washington State MMLTC, 2006	All Medicaid beneficiaries residing in Snohomish County	All Medicaid covered services	▪ Amendment to State Plan ▪ Voluntary
Hawaii QExA, MMLTC, 2008	Older adults, person with disabilities including spend-down population	Medicaid acute and long-term care services (HCBS and facility)	▪ Section 1115 ▪ Mandatory
New Mexico CoLTS, MMLTC, 2008	Currently targeted to duals, people who meet a NH level of care and certain individuals with brain injury	Medicaid acute and long-term care services (HCBS and facility) but includes participant direction	▪ 1915 (b)/ (c) Waiver ▪ Mandatory program
RI Global Consumer Choice Compact, 2009**	All Medicaid categorically eligible aged, blind and disabled population **Program encompasses entire Medicaid program	Managed Medicaid primary and acute services ; Fee for Service long-term care services (HCBS and facility) with a self-directed option	▪ Section 1115 ▪ Mandatory
Tennessee Choices, MMLTC, 2010	Medicaid beneficiaries who meet a nursing home level of care Special targeting to people at risk of NH placement	Medicaid acute, long-term care services (HCBS and facility), behavioral health	▪ Section 1115 ▪ Mandatory

Three Models of Medicaid Managed Long-Term Care

There Are Three Basic MMLTC Models

	MODEL 1: Medicaid LTC Only	MODEL 2: Medicaid-Only	MODEL 3: Medicaid-Medicare Integration
Medicaid Services for Which Managed Care Contractor is at Risk	Home and Community Based Services (HCBS) Nursing Home Care	HCBS Nursing Home Care Medicaid-Covered Primary Care Services Medicaid-Covered Acute Care Services Medicaid-Covered Pharmacy	HCBS Nursing Home Care Medicaid-Covered Primary Care Services Medicaid-Covered Acute Care Services Medicaid-Covered Pharmacy
Medicare Services for Which Managed Care Contractor is at Risk	None	None	Medicare Acute Care benefits Medicare Prescription Drug Benefit

Dual eligibles may also be enrolled in Medicare managed care and receive Medicaid LTC services in either FFS Medicaid, or in MMLTC Models 1 or 2

Source: AARP Public Policy Institute Issue Brief, Medicaid Managed Long-Term Care, 2005.

Two State and Local Experiences

1. Wisconsin
   - Family Care
   - MMLTC
   - http://www.dhs.wisconsin.gov/LTCare/
   - http://www.dhs.wisconsin.gov/LTCare/Reports/PDF/2009annualreport.pdf

Family Care

* ADRC and Benefit
* Capitated and Risk Based
* No Acute or Primary Care

* Five pilots- Including Milwaukee County Department on Aging-AAA for Milwaukee County-2000
* Statewide Expansion by 2013
* New Operators- Non-profits-Districts
* Options-Family Care-Partnership-PACE-IRIS

Eligibility

* Adults 18 and Over
* Functional Need determined by Screen
* Financially Medicaid Eligible
* Includes Cost Sharing
* Family Care County

Benefit

* All Traditional Supports and Services
* Card Services-Medical Equipment-Therapies Etc.
* Residential Service Costs
* All Nursing Home Costs

Payments

* Actuaries determine Capitation
* Adjusted for Savings
* Risk Reserve- Solvency Reserve- Working Capital
* Cost Sharing Room and Board

Issues

* Freeze on Enrollment
* Audit
* New Administration
* Fiscal Health
* Separation

Two State and Local Experiences

2. New Mexico
   - Coordination of Long-Term Services (CoLTS)
   - Medcaid Acute, Coordination with Medicare and MMTLC
   - http://www.nmaging.state.nm.us/COLTS_overview.html

Overall Assessment of MMLTC – In the Literature

MMLTC Program Evaluations Have Not Generated Conclusive Cost Savings

- MMLTC where 1) Medicaid LTC services are capitated, or 2) both Medicaid acute and LTC services capitated has been shown to:
  - Reduce costs in some states with established programs, such as AZ
  - Reduce use of higher cost services such as ER, hospital and nursing facility
  - Increase HCBS access
- States value predictability of capitated LTC payments
- Evidence of cost savings from integrated Medicare and Medicaid programs is mixes due to apparent induced demand for health care services
  - Duals often have many unmet health care needs
  - Managed care for such populations provides services they have difficulty accessing in fee-for-service arrangements

Sources: AARP Public Policy Institute Issue Brief, Medicaid Managed Long-Term Care, 2005. Master, R. and Eng, C. (2001). Integrating Acute and Long-Term Care for High-Cost Populations. Health Affairs, Vol. 20, No. 6.; Kane R., et. al. (2005) The Quality of Care Under a Manage-Care Program for Dual Eligibles. The Gerontologist, Vol. 45, No. 4.

MMLTC Consumer Satisfaction Is Generally High

- MMLTC quality received neutral to favorable evaluations
- Consumer satisfaction generally high among all types of MMLTC participants
  - Utility of care coordination
  - Emphasis on HCBS
  - Ease of access
- Quality outcomes are strong in PACE, but mixed for other integrated care models
  - Nursing home utilization has not been significantly reduced
  - No changes in mortality
  - Hospital admissions have been reduced, primarily in EverCare programs

Sources: Master, R. and Eng, C. (2001). Integrating Acute and Long-Term Care for High-Cost Populations. Health Affairs, Vol. 20, No. 6.; Kane R., et. al. (2005) The Quality of Care Under a Manage-Care Program for Dual Eligibles. The Gerontologist, Vol. 45, No. 4.

Depending Program Structure, Certain Elements of MMLTC May Be Prove Challenging to Providers

- Selective contracting may be unfavorable to certain LTC providers
  - Only certain facilities may have access to the population enrolled
- Administrative burdens may be created for LTC providers if:
  - MMLTC contractors pull out of service area
  - Plans have varying quality measurements and data/reporting requirements
- Potential exists for plans to establish insufficient provider payments rates
- It may take longer for a managed care plan to reimburse providers than it does the state FFS Medicaid program
- Staffing and protocols of LTC provider and MMLTC plan may not be consistent
- Diversion of NF-eligible Medicaid beneficiaries into community may hurt LTC facilities

Pending Congressional Action, Continued SNP Roles is Unclear

- CMS likely to continue to foster SNP growth to improve care coordination
  - However, CMS guidance may become increasingly prescriptive, requiring SNPs to better differentiate themselves from other MA-PD plans
- New SNPs must partner with states via contractual agreements
- Plans offering PDPs, MA-PDs and SNPs may develop information systems to take advantage of special enrollment rules, spur movement from PDP to SNP
- MA-PD rates and new quality requirements may pose challenges

Considerations for States and Localities

Several Actions are Necessary When MMLTC is Under Consideration

Strategic Options

- LTC provider and consumer advocate perspectives
- Study State Medicaid Managed Care landscape
  - Current plan marketplace
  - Penetration rates
  - Enrollment of ABD populations
- SNP
  - Same as above but also state contracts with SNPs

Required Decision Points/Actions

- Mandatory versus Voluntary
- Scope of Capitated Benefits
- Target Populations
- Geographic Coverage
- Payment Methods
- Enrollment Authority
- Quality Oversight
- Contract development
- Operational resources

For More Information

Suggested Resources

- NASUAD Strengthening the Aging Network Web Pages
  - http://www.nasuad.org/san/strengthening_the_aging_network.html
- CMS “Your Guide to Special Needs Plans”
  - http://www.medicare.gov/Publications/Pubs/pdf/11302.pdf
- CMS Promising Practice Brief on MMLTC
  - http://www.cms.gov/communityservices/hcbsppr/itemdetail.asp?itemid=CMS030841
- CMS Overview on MMLTC Enrollment Authorities
  - http://www.hcbs.org/files/191/9510/ManagedLTSS.pdf
- SCAN Foundation-Funded Roadmap for Managing Long-Term Services and Supports
  - http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf

Questions

Advocacy. Action. Answers on Aging.

Appendix
Three Additional State Models

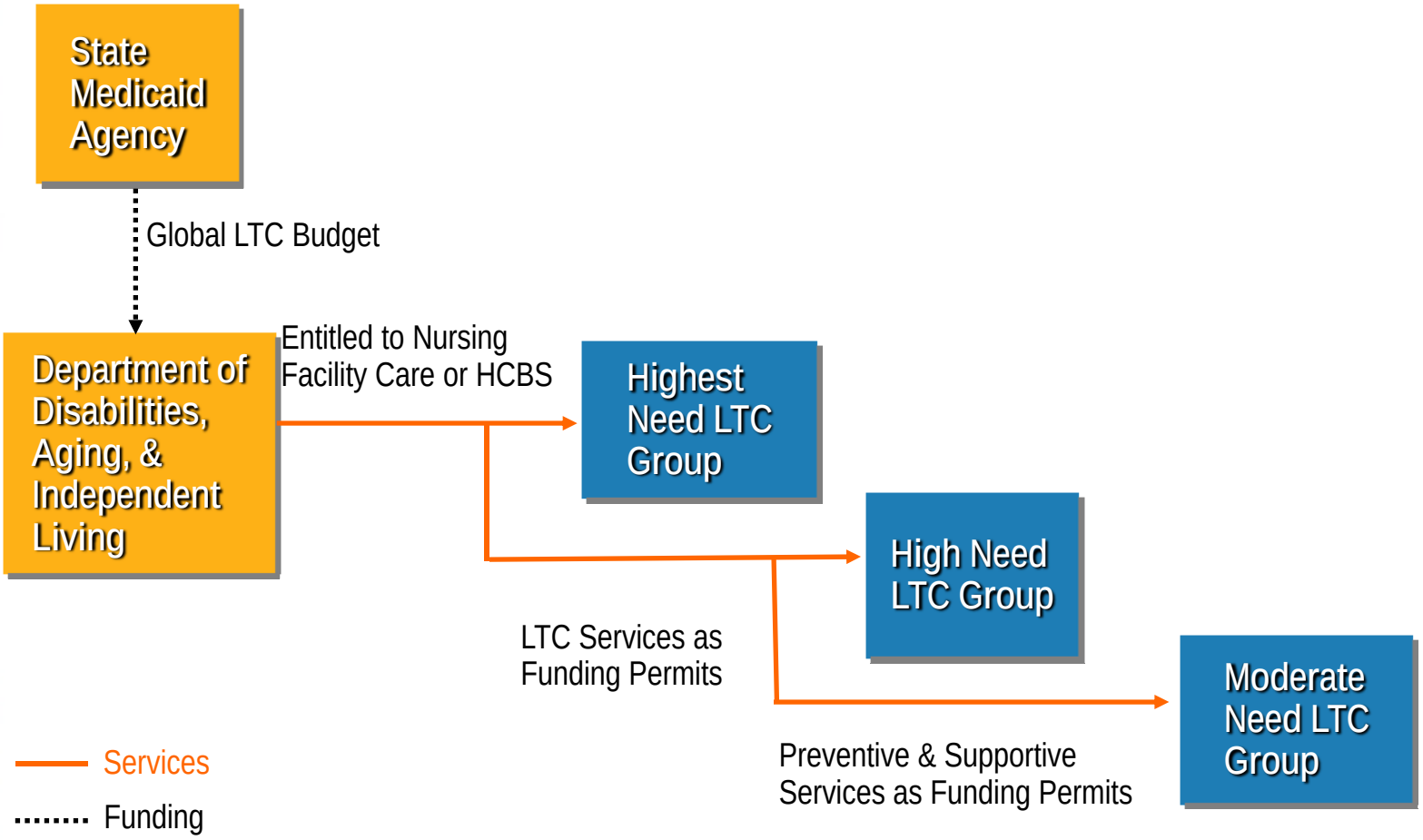
Model 1:
Medicaid LTC Services Only
Vermont

Vermont Has Historically Embraced HCBS, As Reflected in Its Waiver Design

Historical Context

- June 2005 – Vermont received federal Section 1115 waiver
  - Made substantive changes to its Medicaid long-term care program
- The waiver, “Choices for Care,” gives residents equal access to care either in nursing facilities or via HCBS
- Program design, however, seeks to control costs for LTC services by limiting access to NF care and increasing availability of HCBS

Vermont Department of Aging and Disabilities Services Acts as Capitated MMLTC Plan



Enrollees Grouped and Services Covered as Appropriate and as Permitted by Capped Funding

Program Structure

- Individuals are assigned to one of three groups based on their LTC needs:
  - *Highest Need* – Requires extensive or total assistance with at least one activity of daily living (ADL) and requires assistance with any other ADL
  - *High Need* – May not require any of the care needed by the "highest need" group but has extensive needs for personal care and rehabilitation services
  - *Moderate Need* – Do not qualify for an institutional level of care
    - Includes 1115 expansion population previously not served by Medicaid
- Only those in the *Highest Need* group are guaranteed access to LTC services

Sources: "The Vermont Choices for Care Long-Term Care Plan: Key Program Changes and Questions." Kaiser Commission on Medicaid and the Uninsured. July 2006. Choices for Care: 1115 Long-term Care Medicaid Waiver Regulations. State of Vermont Agency of Human Services Department of Disabilities, Aging and Independent Living, Division of Disability and Aging Services. October 2005.

Program Has Capped Funding Over a Five Year Period

Program Structure

- Program operated through the Department of Disabilities, Aging and Independent Living which serves as a capitated LTC managed care plan under the waiver
  - Medicaid provider payments stay FFS; providers take no new risk
- Medicaid agency gives a 5-year, $1.236 billion global budget to DA&D, based on estimates of the demand for, and cost of, LTC services
- State must continue to provide NF and HCBS services to beneficiaries receiving these services at time of initial implementation

Sources: “The Vermont Choices for Care Long-Term Care Plan: Key Program Changes and Questions.” Kaiser Commission on Medicaid and the Uninsured. July 2006. Choices for Care: 1115 Long-term Care Medicaid Waiver Regulations. State of Vermont Agency of Human Services Department of Disabilities, Aging and Independent Living Division of Disability and Aging Services. October 2005.

Model 2 : Medicaid Acute and LTC Services Arizona

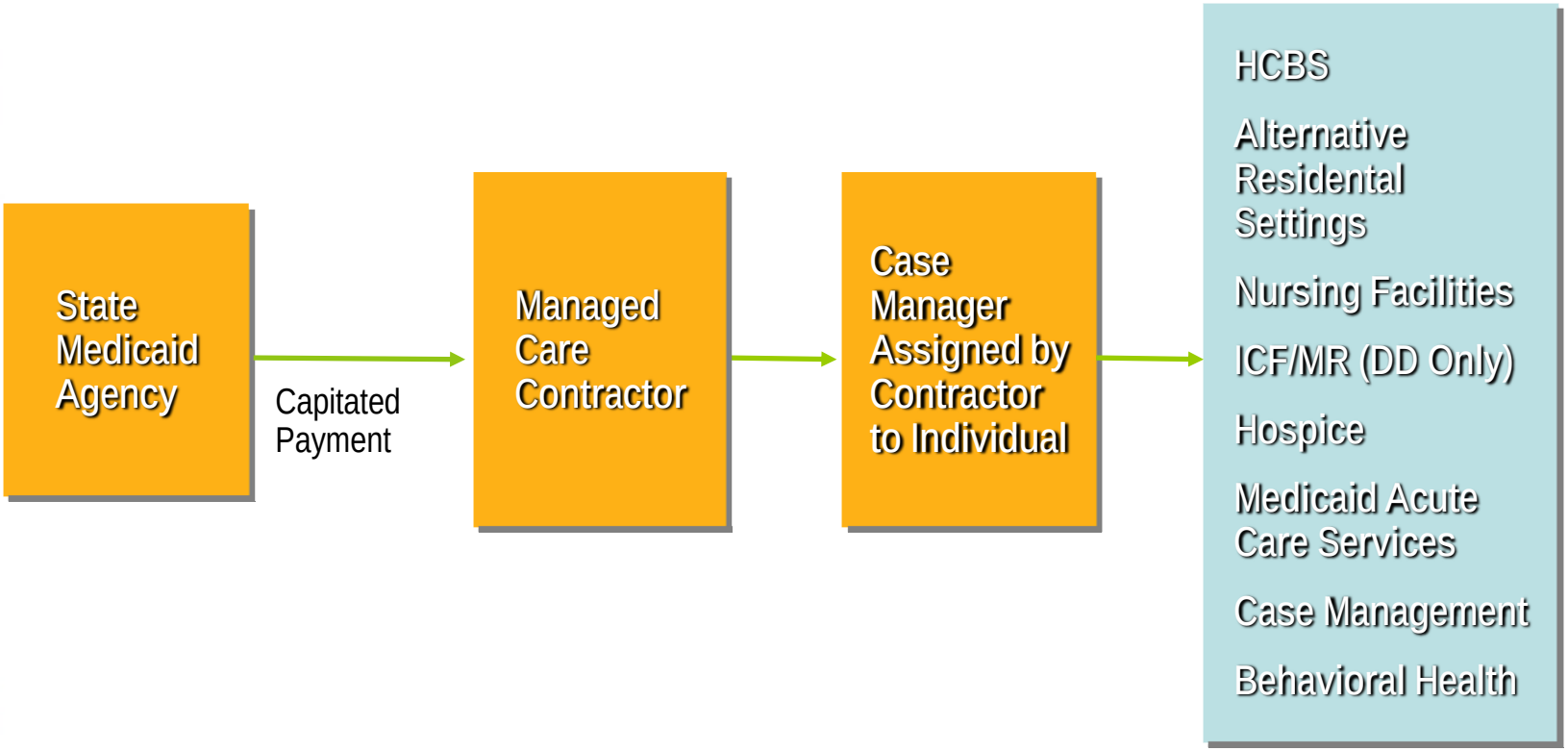
Arizona was the first State to Operate a Statewide, Mandatory MMLTC Program

Historical Context

- Arizona was last state to adopt a Medicaid program and last state to incorporate LTC services into Medicaid benefit package
- Arizona was first state to mandate all Medicaid beneficiaries enroll in capitated managed care
- 1983 – Arizona Health Care Cost Containment System (AHCCCS) created to provide capitated Medicaid managed care
- 1989 – In response to preliminary success with AHCCCS, the state added the Arizona Long-Term Care System (ALTCS)
  - Medicaid beneficiaries eligible for NF level of care enrolled into ALTCS
- Program operates under Section 1115 waiver

Sources: Sparer, Michael, Managed Long-Term Care: Limits and Lessons, Journal of Aging and Health, February 2003; and Weissert, William, et al, Cost Savings from HCBS: Arizona's Capitated Medicaid LTC Program, Journal of Health Politics, Policy, and Law, December 1997.

Each County Has, On Average, One ALTCS Contractor for Elderly and Physically Disabled



Majority of ALTCS Contractors Are Not-for-Profit Organizations

Program Structure

- MCOs responsible for care plans, determining appropriate levels of care, and paying for all types of care
- Aged and physically disabled enrolled in county-specific plan
  - Developmentally disabled are enrolled in statewide plan run by State Department of Economic Security
- Currently one contractor per county — except for Maricopa County (Phoenix area), which has 3 participating plans
  - United's EverCare plan is only for-profit plan in ALTCS
    - Currently serves 7 counties, including Maricopa
  - Remaining 8 counties served by non-profit entities
- All beneficiaries receive acute care services coordinated via case managers

Sources: Weissert, William, et al, Cost Savings from HCBS: Arizona's Capitated Medicaid LTC Program, Journal of Health Politics, Policy, and Law, December 1997; Sparer, Michael, Managed Long-Term Care: Limits and Lessons, Journal of Aging and Health, February 2003; Kronick, R. and Dreyfus, T., Capitated payments of Medicaid Long Term Care for Older Americans, AARP 2001; and ALTCS Annual repor; ALTCS 2005 report issued by the state of Arizona.

Few Recent ALTCS Evaluations — Past Reports Indicate Cost Savings and Consumer Satisfaction

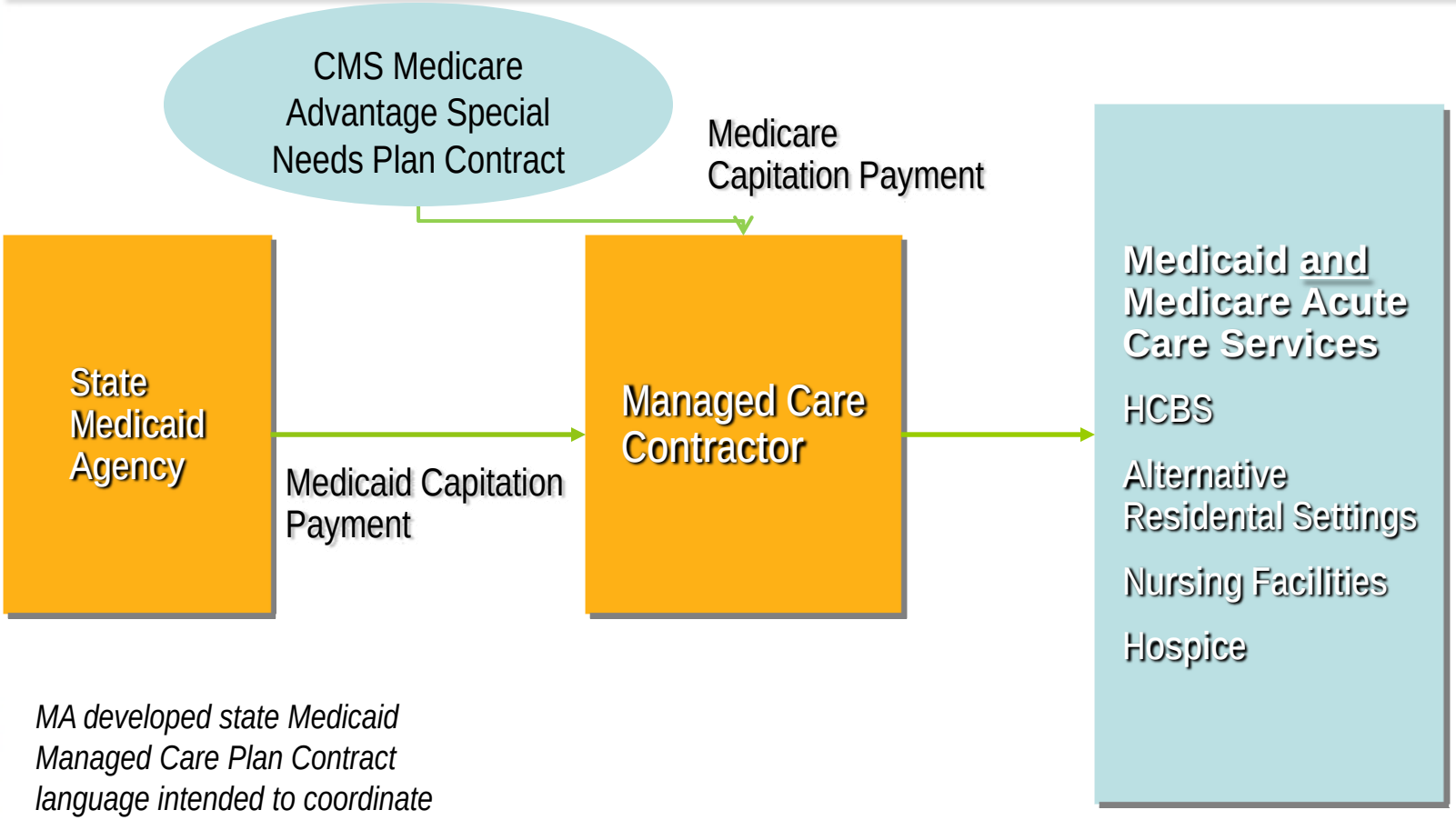
Program Evaluation

- Effort by state to use capitation to encourage HCBS
- ALTCS costs less than LTC services furnished under Medicaid FFS
  - AZ saved 18 percent on medical services and 16 percent overall
  - Cost savings likely due to state administrative infrastructure, rigorous preadmission screening process, and the push toward HCBS
- Depending on the ALTCS plan serving them, consumers were either very satisfied or satisfied with their plan 91 to 95 percent of the time

Sources: McCall, Nelda, et. al, *Evaluation of AHCCCS Demonstration– Final Report*, 1996; Weissert, William, et al., *Cost Savings from HCBS: Arizona's Capitated Medicaid LTC Program*, Journal of Health Politics, Policy and Law, December 1997; and Arizona AHCCCS Report, *ALTCS Consumers Speak Out*, 2002.

Model 3:
Medicare and Medicaid Integration
Massachusetts

Massachusetts Programs Are Fully Integrated SNPs for Dual Eligibles



MA developed state Medicaid Managed Care Plan Contract language intended to coordinate with CMS Medicare requirements to reduce administrative burden on plans and the state