



MANAGED LONG-TERM CARE IN NEW JERSEY

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Introduction

New Jersey's Fiscal Year 2009 Budget included the following language:

On or before April 1, 2009, the Commissioner of the Department of Health and Senior Services shall report to the Governor, the State Treasurer, the President of the Senate and Speaker of the General Assembly on, the department's plan for the conversion of the Medicaid fee for service long-term care benefit to managed care. The report shall include but not be limited to timeframes for implementation per county, plan design, included and excluded populations and projected savings in related Medicaid expenditures relative to fee-for-service projections for Fiscal Year 2010 through 2014.

This report fulfills that requirement. In this report, we begin by describing the current state of re-balancing efforts in New Jersey. We provide a detailed overview of the major decisions that New Jersey must make regarding the rollout of managed long-term care. We survey the planning activities that have taken place to date and the decisions that the Department of Health and Senior Services has made based on those planning activities. We conclude with an estimated timeline for a pilot of managed long-term care.

Managed long-term care has been tried to varying extents in several Medicaid programs. It is a model with great promise but also with real risks for what is a particularly vulnerable group of Medicaid beneficiaries. Managed long-term care is still a relatively new phenomenon and in need of careful study.

New Jersey has already made significant progress in transforming long-term care from institutional to home and community-based settings, as detailed in the background section below. However, progress in "rebalancing" the long-term care system has been uneven, with some counties and some populations progressing faster than others. Our recommendation, therefore, is to proceed with a pilot managed long-term care program and to include a rigorous third-party evaluation of the program before making a decision on a statewide managed care model in New Jersey. This report lays out a plan for **a pilot of managed long-term care in a small number of**

counties, focusing on the elderly and those with physical disabilities. This would be a pilot of managed long-term care as a new delivery system for entire long-term care eligible populations, and we propose that enrollment into managed long-term care would be mandatory in the pilot counties. We also propose a focus on counties with a large Medicaid long-term care population in order to provide sufficient enrollment for participating plans.

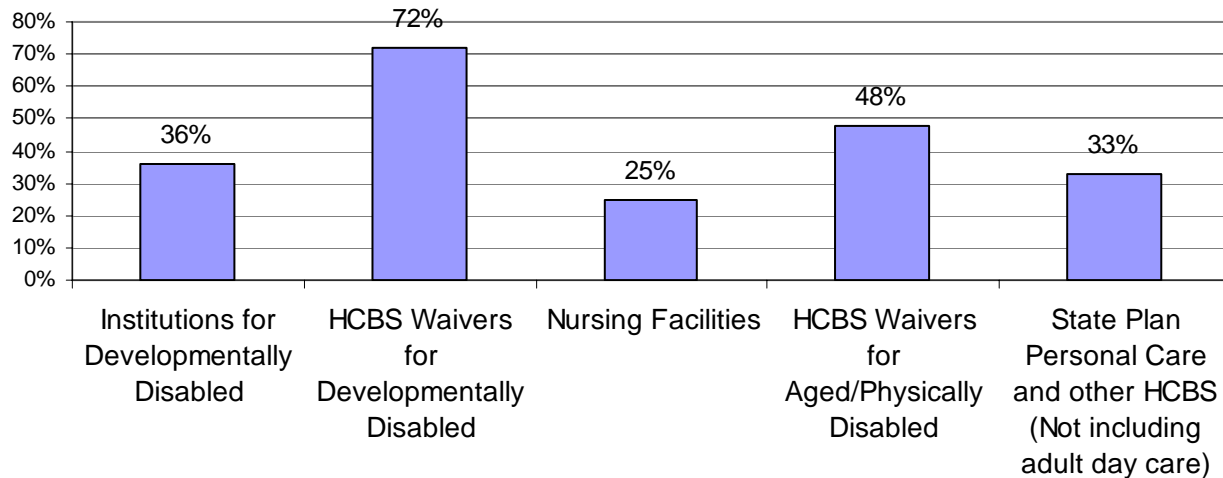
There are multiple time-consuming administrative processes involved in establishing a pilot managed long-term care program. We anticipate these processes taking until SFY 2011—at which point a pilot program could begin enrollment.

Background

Medicaid long-term care benefits are delivered to a diverse set of beneficiaries, including most notably: the frail elderly; people with physical disabilities; people with developmental disabilities; and people with severe mental illness. The State of New Jersey has made substantial progress in shifting the delivery of long-term care from institutional to home and community-based settings. According to the AARP, between, 2002 and 2007 New Jersey spending on HCBS grew substantially faster than spending on institutional services.¹

¹ AARP, *Across the States 2009*. Because AARP does not count Adult Day Care in its calculations, growth in “State Plan Personal Care and other HCBS” is under-stated.

Change in Medicaid Spending on Institutional vs. Home and Community-Based Services, New Jersey 2002-2007. (Source AARP)



More recently, New Jersey has initiated a multi-faceted effort to rebalance long-term care for the elderly and physically disabled. On June 21, 2006, Governor Jon S. Corzine signed the Independence, Dignity and Choice in Long-Term Care Act to create a process to reallocate Medicaid long-term care expenditures and develop a more appropriate funding balance between nursing home care and other home and community-based care services (HCBS). The State is now legislatively charged with rebalancing its Medicaid long-term care system to include more community care and greater consumer choice, and to ensure that “money follows the person,” allowing maximum flexibility between nursing homes and home and community-based settings.

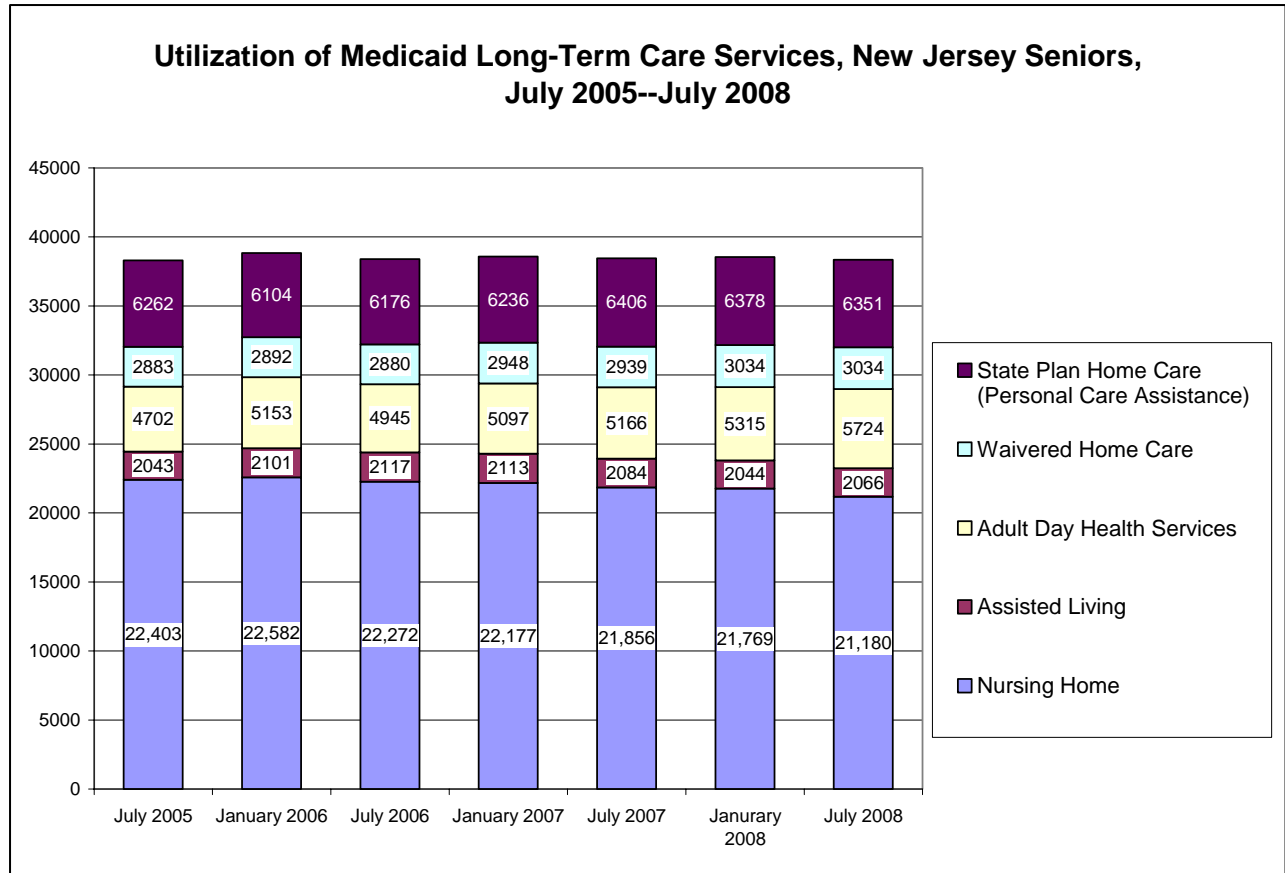
The centerpiece of this effort is the Aging and Disability Resource Connection (ADRC). ADRC, with a focus on community residents and consumer direction, was initially implemented in the pilot counties of Atlantic and Warren in 2007 and is recently expanded to seven counties. In the ADRC model, consumers are informed about appropriate long-term care options as part of a comprehensive assessment and care management approach administered at the county level. Based on their eligibility criteria, consumers are counseled on appropriate home and community based services. This model is paired with nursing screening and diversion programs that coordinate with the ADRC.

A number of other reforms have taken effect in parallel with the ADRC:

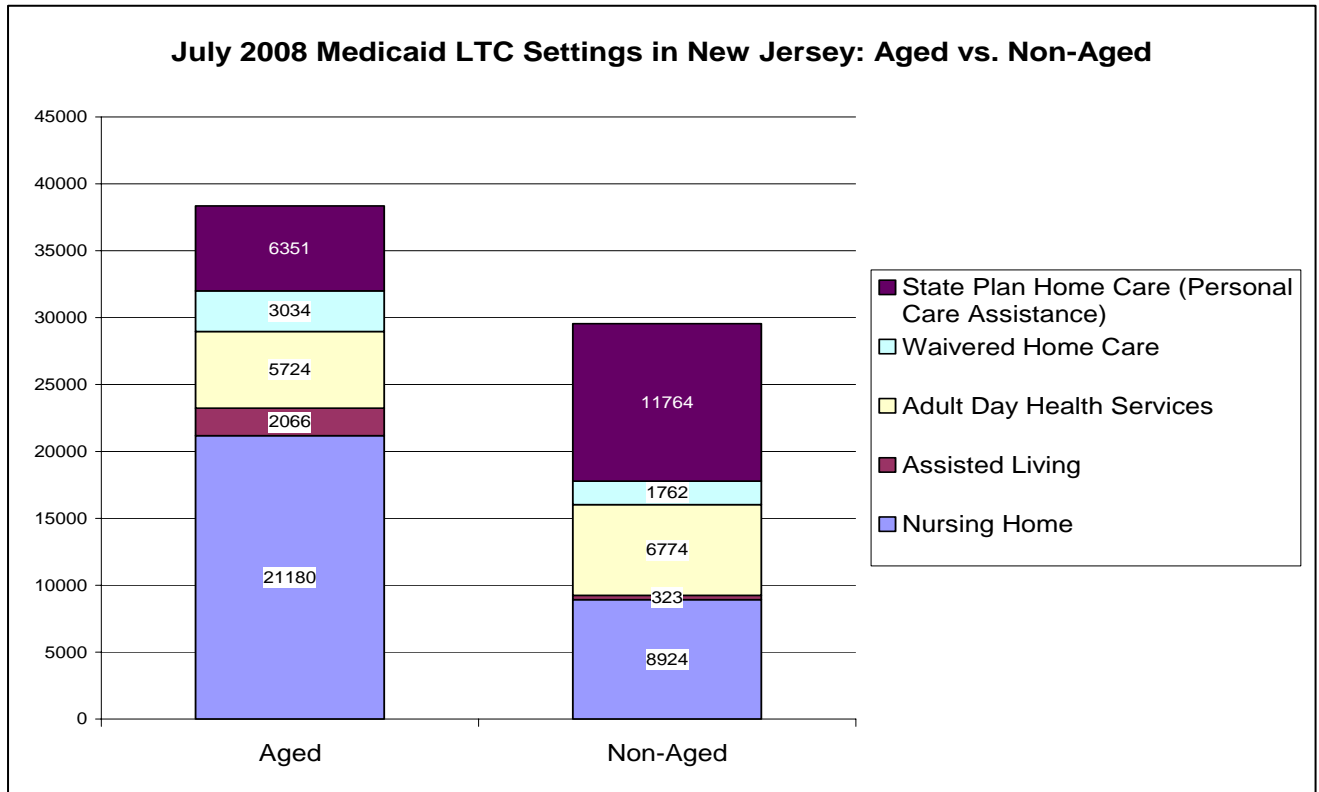
- Under a new Medicaid Eligibility Fast Track Determination (Fast Track) process available statewide, consumers who are clinically eligible for nursing home care and meet the Medicaid financial criteria can receive HCBS for up to 90 days while they complete the full Medicaid application and eligibility determination process.
- A Nursing Home Transition program has increased available funding, expanded HCBS options, and provided more flexibility for nursing home residents to control and direct their services.
- A new budget process is under development in the DHSS to support the rebalancing of the State's long-term care budget.
- The three Medicaid waiver programs for home and community-based services have been consolidated into one Global Options waiver and a web-based client tracking system is being implemented.
- New Jersey has begun operating the first of several anticipated PACE (Programs of All-inclusive Care for the Elderly) programs. PACE incorporates managed long-term care with Medicare managed care, using both funding streams to support an intensive care management model housed in a medical adult day center. PACE provides a full range of preventative, primary, acute, rehabilitative, pharmaceutical and long-term care services at a pre-determined Medicaid and Medicare capitated rate.

These efforts have led to demonstrable results for long-term care delivery to elderly people. As shown in the chart below, despite growing populations of frail elderly and people with physical

disabilities, Medicaid nursing home use among the elderly has gone down steadily over the last three years while use of home and community-based services has increased.



However, progress in “rebalancing” the long-term care system has been uneven, with



some counties and some populations progressing faster than others. Although nursing home use is declining among the elderly, over 50% of elderly users of Medicaid long-term care are still in nursing homes in New Jersey, a number that is higher than the United States average.²

How Managed Care Could Help to Rebalance Long-Term Care in New Jersey

Medicaid managed long-term care is similar to the existing Medicaid managed care program for primary and acute care in New Jersey (and most states) in that an insurance company receives a fixed monthly amount per person (a capitation) from the state in return for delivering a range of Medicaid services. However, managed long-term care involves capitation for Medicaid long-term care costs, typically including both nursing home care and home- and

² AARP, Across the States 2009.

community-based services (“HCBS”), rather than physician and hospital costs. In some states plans cover both Medicaid long-term care and conventional primary and acute care Medicaid benefits.

Beginning with a small pilot in California in the late 1980s and with Arizona’s statewide system in the early 1990s, a number of states have employed capitation as a tool to encourage efficiency and in particular to encourage the substitution -- where possible -- of HCBS for nursing home care.³ States also expect managed long-term care to provide comprehensive case management and coordination services. **Table 1** below summarizes the history of managed long-term care in Medicaid.

From the state’s perspective, the primary objective of managed long-term care is to incentivize insurers to allocate resources cost-effectively and appropriately. Because HCBS are typically less expensive than institutional care, managed care organizations have an incentive to maintain people with disabilities in the community if possible.

Both fee-for-service and managed care Medicaid programs have two primary mechanisms for changing where a given consumer receives long-term care. The first is the authority to approve or disapprove a given service. The second is the capacity to work directly with consumers in a care management capacity to maximize their independence and well-being.

Managed long-term care can strengthen both of these mechanisms, because capitation gives plans a strong financial incentive to hold down the high cost institutional services. Managed long-term care plans can be expected to reduce nursing home utilization through the process of approving or denying services. Managed long-term care plans also have financial incentives to limit high cost services by investing in a care management program. Some states

³ “The Past, Present and Future of Managed Long-Term Care” Paul Saucier, Brian Burwell and Kerstin Gerst Thomson/MEDSTAT and University of Southern Maine, Muskie School of Public Service April 2005, Department of Health and Human Services.

have made a robust, “high-touch” care management program a specific requirement in managed care contracts. In New Jersey, where there are both state-level and county-level care management systems already in place in the fee-for-service system, managed long-term care could either replace those care management entities or work in concert with them.

Many of the established programs are still relatively small pilots, and the state with the most mature program, Arizona, has never had a Medicaid fee-for-service system as a basis for comparison. Medicaid officials in states such as Minnesota and Wisconsin believe strongly that managed care has been successful in their states. But a cautious, step-by-step approach in implementing managed care in New Jersey would be best for New Jersey.

TABLE 1: Characteristics of Selected Managed Long-Term Care Programs⁴

Program	Implementation Date	Population Eligible	Voluntary/Mandatory for Medicaid	Geographical Coverage	Medicaid Payments	Must enroll in Medicare Managed Care
PACE (includes "pre-PACE)	1983 (On Lok)	55+ with NF-level LTC needs	Voluntary	40 urban programs in 17 states	Capitated primary, acute and LTC; rate structure varies	Yes
Florida Frail Elder Option	1987	Aged and disabled; NF-level LTC needs	Voluntary	2 urban counties in Southeast Florida	Capitated primary, acute and LTC; three rate cells	No
Arizona Long Term Care System (ALTCS)	1989	Aged and disabled; NF-level LTC needs	Mandatory	Statewide (urban and rural)	Capitated primary, acute and LTC; single blended rate	No
Wisconsin Partnership Program	1995 ²	Aged and disabled; any LTC needs	Voluntary	6 counties (rural and urban)	Capitated primary, acute and LTC; multiple rate categories	Yes
Minnesota Senior Health Options (MSHO)	1997	All aged	Voluntary	Initially 7 urban and 3 rural counties, now expanding statewide	Capitated primary, acute and LTC (NF limited to 6 mos.); multiple rate cells	Yes
New York MLTC Plans	1997	Aged and disabled with NF-level LTC needs (aged/ disabled varies by plan)	Voluntary	Multiple counties (rural and urban, but mostly urban)	Capitated LTC only (primary and acute FFS); multiple rate cells	No
Texas Access Reform (Star) + Plus	1998	All aged and disabled	Mandatory	Initially 1 urban county; now statewide urban expansion	Capitated primary, acute and LT (NF limited to 1 mo.; Rx not in cap); multiple rate cells	No
Florida Diversion	1998	Aged with NF-level LTC needs	Voluntary	25 urban and contiguous counties	Capitated primary, acute and LTC; single rate	No
Wisconsin Family Care	2000	Aged and disabled; NF-level LTC needs	Mandatory	Initially 5 counties, now expanding state wide	Capitated LTC only (primary and acute FFS); two rate cells	No
Minnesota Disabled Health Options	2001	All physically disabled	Voluntary	Initially 4 urban counties, now expanding state wide	Capitated primary, acute and LTC (NF limited to 6 mos.); multiple rate cells	Yes

⁴ Adapted from "Past Present and Future of Managed Long Term Care", DHHS 2005.

Mass Health Senior Care Options (SCO)	2004	All aged	Voluntary	Nearly statewide (rural and urban)	Capitated primary, acute and LTC; multiple rate cells	Yes
New Mexico (CLTCS)	2008	All aged and disabled	Mandatory	Initially 6 counties, expanding statewide	Capitated primary, acute and LTC, but mostly seniors who receive FFS Medicare	No

Options for New Jersey:

There are several basic decisions that New Jersey must make regarding managed long-term care program design:

1. Which Populations: Medicaid long-term care benefits are delivered to a diverse set of beneficiaries, including most notably: the frail elderly; people with physical disabilities; people with developmental disabilities; and people with severe mental illness.

2. Relationship with Medicare and other Medicaid benefits: Managed long-term care has been combined with capitation for other Medicaid or Medicare services in some states. Texas has integrated managed long-term care with capitation of managed care organizations for the whole Medicaid benefit package including acute care costs, and has expanded the program on a mandatory basis to much of the state. Massachusetts has gone further, integrating the entire Medicaid benefit with Medicare managed care for dual eligibles.

Table 2 below lays out these options:

Table 2: Options for Integration of MLTC and Other Managed Care Benefits	Medicaid Long-Term Care Only	All Medicaid	Medicaid-Medicare
Contractor at risk for:	Medicaid HCBS and Nursing Home	Medicaid HCBS and Nursing Home	Medicaid HCBS and Nursing Home
		Medicaid Primary and Acute	Medicaid Primary and Acute
		Medicaid Rx	Medicaid Rx
			Medicare Primary and Acute
			Medicare Rx

3. Starting in one county, a group of counties, or statewide: Although managed long-term care has a great deal of promise, it also requires careful evaluation, which indicates that a pilot in a small number of counties is advisable. However, it is also important to have enough Medicaid enrollment in the pilot to support managed care operations. As described below, these considerations lead us to recommend a pilot in a small number of high-Medicaid counties.

4. Mandatory v. Voluntary enrollment: Voluntary enrollment can be a way to mitigate the impact of managed care during a pilot phase. States that have made managed long-term care voluntary for Medicaid beneficiaries generally see most of their LTC users stay in the fee-for-service system. However, voluntary enrollment also leads to intense pressure on plans to “cherry-pick” low-cost individuals. Long-term care costs are predictable and if plans can select favorable risks, managed long-term care will cost Medicaid more than fee-for-service. The issue of mandatory enrollment is also partly tied to the earlier question of whether to integrate with Medicare managed care for dual eligibles. The federal government has long ruled that Medicare managed care (Medicare Advantage) enrollment cannot be mandatory for dual eligibles.

5. What is Covered: Medicaid long-term care incorporates a mix of regular Medicaid benefits, such as nursing home care, personal care assistance, and medical day care and

special HCBS waiver benefits. Although we have flexibility in which of these benefits are covered by managed care, it is important not to leave major gaps through fee-for-service carve-outs in what managed care plans are at risk for. Because different long-term care services can substitute for each other, if managed care plans do not have to pay for a service they will be strongly incentivized to shift care into that service as a way to shift costs back to fee-for-service Medicaid.

Another question with regard to scope of managed care coverage is how much plans are at risk for residential or institutional placements—that is, nursing home and assisted living. Having plans fully responsible for institutional costs can be problematic, because many residents of nursing homes and assisted living begin their stay as private pay and then spend down to Medicaid eligibility. In this circumstance, there is often very little a plan can do to manage for a long-time resident of a facility. Plan finances could become dominated by whether or not they enroll these “spend-down” cases. However, if plans are not at-risk for any residential placements, they will have no incentive to avoid them, which undermines much of the potential benefit of managed long-term care. Most states that have implemented managed long-term care have given plans financial responsibility for only the first 2-6 months of nursing home care.

6. Insurance Regulation: The Department of Banking and Insurance currently regulates private long-term care insurers, but private insurers offer a much simpler long-term care benefit than Medicaid. The state will have to develop new regulatory standards for multiple areas in order to properly regulate Medicaid managed long-term care plans. These include:

- How provider groups could qualify for taking insurance risk as an organized delivery system;

- How the state will define an adequate network of providers: Network adequacy is a particularly important concern given the wide acceptance of Medicaid fee-for-service among long-term care providers and the importance of a local service provider for many users of long-term care.
- Utilization management: A strong system for the state to monitor whether plans are allowing for adequate levels of service is critical for a new program that focuses on a vulnerable population.
- Appeals and grievances: As with regular Medicaid managed care, the state has an important obligation to provide a transparent and consumer-friendly process for appealing plan decisions, beginning within the plan and then moving to a fair hearing process -- when necessary. The process should be open to providers as well as consumers. Given the high level of cognitive disability in Medicaid LTC, plans must establish procedures for appeals and grievances that include assistance for people with cognitive limitations and their surrogate decision-makers.

7. Types of plans: The type of managed care organizations has varied among MLTC states. In some states, managed long-term care has been dominated by long-term care agencies or community-based organizations who started their own plans. In other states, MLTC plans are administered by more traditional insurance companies. It is important to note that whether delivered by conventional insurance companies or by provider-based plans, managed long-term care is a labor-intensive business involving face-to-face care planning.

8. Capitation rates: States have varied widely in their approaches to rate-setting for managed long-term care monthly capitation rates, and some states have only minimally conducted risk adjustment of rates. Because long-term care costs are more predictable than

medical costs, there is a major risk of cherry-picking of low-cost enrollees in managed long-term care unless plans receive the appropriate rate for members with different risk profiles.

Furthermore, the state and its county partners have now developed a robust assessment and screening process that could be utilized in scoring new enrollees for risk adjustment purposes.

9. Provider rates: Managed care organizations often negotiate rates with medical providers on a contract by contract basis. Some states have structured their managed long-term care program with existing Medicaid fee-for-service rates as a floor for managed care rates. This places an emphasis on reducing costs by managing utilization rather than by reducing rates.

Planning activities and decisions to date

As noted above, the 2009 budget directed the Department of Health and Senior Services to develop a plan for the implementation of Medicaid managed long-term care in New Jersey. Almost from the point the NJDHSS received this directive, we began a series of public discussions with major Medicaid provider, insurer and consumer groups regarding the possibility of managed long-term care. With support from the Robert Wood Johnson Foundation, the Center for Health Care Strategies, a major Medicaid managed care consulting firm and think-tank located in New Jersey, has been working with the Departments of Health and Senior Services and Human Services on an intensive consultation program regarding both regular Medicaid managed care and managed long-term care. The long-term care program has focused on lessons learned from other states with managed long-term care and related programs, including Minnesota, Wisconsin, New Mexico and Washington State.

Based on these efforts as well as our analysis on where change is most needed in long-term care delivery, we would make the following recommendations for managed long-term care in New Jersey:

- Start with a pilot program: Managed care has promise for long-term care, but it also is a relatively new model nationally. Our recommendation is to proceed with managed long-term care on a pilot basis and to include a rigorous third-party evaluation of the program before making a decision regarding managed care's utility in New Jersey more broadly.
- Focus initially on the elderly and physically disabled: As demonstrated above, frail elderly and people with physical disabilities still receive most of their long-term care in nursing homes, although significant progress has been made. Indeed, New Jersey is slightly below the national average in the balance of institutional vs. community-based care for these populations. Given the potential power of managed care to drive rebalancing efforts, it makes sense to pilot managed care with these populations.
- Make enrollment mandatory or mandatory with an opt-out provision: Although voluntary enrollment may seem less risky, in a number of ways it is more risky from a policy perspective. Voluntary enrollment also leads to intense pressure on plans to "cherry-pick" low-cost individuals. Long-term care costs are predictable and if plans can select favorable risks managed long-term care will cost Medicaid more than fee-for-service. Moreover, the purpose of the pilot program will be to evaluate the effectiveness of managed long-term care organizations as a new delivery system for long-term care, an evaluation that will be difficult in a voluntary program.
- Risk-adjust capitation rates: States have varied considerably in the degree to which they vary capitation rates based on the individual risk profile of the individual consumer.

We recommend engaging an actuarial firm to develop an effective risk-adjustment system for setting MLTC rates. Such a system will minimize pressures to cherry-pick low-cost enrollees. One attractive option is to utilize New Jersey's existing screening and assessment infrastructure to conduct risk measurement at the onset of managed long-term care enrollment and on an ongoing basis. New Jersey is now implementing a uniform screening and assessment tool as part of its ADRC effort, and this tool could be used by county staff to support risk measurement and rate-setting. In this model county staff would conduct an assessment and assign a risk score for each new member of a managed long-term care plan, which would then be a factor in the plan's reimbursement. The county assessment would also serve as a guide to quality monitoring activities.

- Separate managed long-term care from Medicare managed care: Managed care plans may be better able to coordinate care if they cover the entire Medicare and Medicaid package with one plan for dually eligible people, and PACE programs have achieved strong results integrating these two funding streams. However, there is at least one significant downside to tying Medicaid managed care to Medicare managed care. It is not possible to cover an entire population with Medicare managed care because it is against federal law to mandate enrollment in Medicare managed care, which is a voluntary program. It is also notable that the Obama Administration has made clear that it intends to make significant changes in Medicare managed care, possibly in the next two years.

- Pilot MLTC in two or more counties with high Medicaid enrollment: Both other states that have tried managed long-term care and managed care organizations have indicated that if plan enrollments are too small it is difficult to have critical mass to support the intensive

care management and insurance functions involved. Therefore, even in a pilot it is important to have enough Medicaid enrollment to support managed care operations.

- Put plans at-risk for all long-term care services: If managed care plans do not have to pay for a service they will be strongly incentivized to shift care into that service as a way to shift costs back to fee-for-service Medicaid. We recommend that comprehensive long-term care capitation to managed long-term care plans include the following services :

- i. All Medicaid para-professional home care services including those covered by the Global Options 1915(c) waiver and the regular Medicaid personal care assistance benefit,
- ii. Adult Day Health services,
- iii. Assisted Living,
- iv. Adult Family Care,
- v. Nursing Home.

Managed care plans also have the flexibility to offer additional value-added benefits including home modifications, tele-monitoring, and other services. In each case, payment to plans and regulation of plans must focus on ensuring adequate levels of service, with a particular emphasis on adequate levels of home care services.

We recommend that the following services be carved out of managed long-term care, at least in the pilot phase:

- i. Consumer-directed para-professional home care services, whether through the Personal Preference Program or through the Global Options Waiver. Consumer-direction means that consumers receive a monthly cash allowance and work with a consultant to develop a plan regarding the services they need

and the individuals and/or agencies they can hire to provide those services.

This structure is an alternative to managed care in New Jersey's long-term care strategy.

- ii. Nursing home spend-down cases and long-term nursing home stays: As noted above, giving plans no risk for nursing stays gives them a perverse incentive to admit high cost members to nursing homes. However, giving plans total risk for nursing home costs can lead to a risk of forcing plans to cut back on necessary nursing home care. Moreover there is little to be gained from plan enrollment of long-term nursing home residents after they spend-down to Medicaid eligibility; the state should avoid having plans compete to avoid such enrollments. We recommend leaving in fee-for-service both long-term nursing home stays and spend-down cases who have been long-term nursing home residents.

- Pass through some or all Medicaid fee-for-service rates: The purpose of managed long-term care is to change utilization patterns, not to reduce Medicaid rates. Long-term care providers are sometimes heavily dependent on Medicaid and particularly sensitive to Medicaid rate changes. In this pilot program, we recommend protecting some or all existing Medicaid rates for long-term care, encouraging plans to focus their cost reduction efforts on avoidance of high-cost services in general and nursing home care in particular. (As detailed above, we recommend that New Jersey engage an actuarial firm to develop an effective risk-adjustment system for setting the monthly rates that MLTC plans receive.)

- Administer a three year pilot: This will allow for two years of program operation before an evaluation in year three.

- Pay for a third-party evaluation: Managed long-term care has not had a strong history of rigorous evaluation. If New Jersey is going to make an informed decision regarding managed long-term care, evaluating the pilot is vital to future expansion across populations and across the state. This evaluation should be selected via RFP to include a robust methodology for quality assurance performance, as well as an examination of cost-effectiveness.

Timeline

Develop/Finalize Program Design: As an important preparatory step the New Jersey Department of Health and Senior Services will establish an interdepartmental committee comprised of representatives from the Departments of Health and Senior Services, Human Services and Banking and Insurance to develop and finalize the program design. Through a Robert Wood Johnson Foundation grant, the Center for Health Care Strategies, Inc. will provide technical assistance to the committee by researching other states' managed long-term care programs, soliciting stakeholder input regarding key program design issues, and determining federal/state authority options. It is anticipated that the planning phase will require between eight and 12 months to complete the program design and to develop and release a Request for Information to determine interest/ideas of potential contractors.

Implementation Planning Process: The committee will work with actuaries to get a high-level idea of rate structures, draft managed long-term care insurance regulations, and determine whether there is a state or federal public notice requirement. The timeframe to complete this phase will require between three to six months.

Medicaid Waiver(s) Approval: Following the two phases, we will initiate three time-consuming administrative processes involved in establishing a pilot managed long-term care program in New Jersey:

1. Applying to the federal Centers for Medicare and Medicaid Services (CMS) for approval of a Medicaid waiver.
2. Developing an approved contract format and rate structure with CMS.
3. Establishing a new regulatory framework for a new type of managed care organization

Identify/Address Infrastructure Needs: The Interdepartmental Committee must identify and resolve necessary changes to the State's Medicaid Management Information System (MMIS). To modify the system will require extensive programming, so we anticipate this activity to will take between 12-18 months to complete. This activity will be initiated as part of the program design phase.

We anticipate these processes taking until SFY 2011 – at which point a pilot program could begin enrollment.