

medicaid and the uninsured

April 2013

Medicaid Long-Term Services and Supports: Key Considerations for Successful Transitions from Fee-for-Service to Capitated Managed Care Programs

EXECUTIVE SUMMARY

Although relatively few Medicaid beneficiaries are currently enrolled in capitated managed long-term services and supports (LTSS) programs, significant expansion is anticipated as more than half of states are implementing or proposing new programs that would include a transition from fee-for-service (FFS) to capitated managed care in the LTSS delivery system. The most current data indicate that fewer than 390,000 people – less than 10 percent of Medicaid beneficiaries participating in Medicaid LTSS programs – are enrolled in capitated managed care.¹

The manner in which initial transitions from FFS to capitated managed care systems occur for Medicaid beneficiaries who use LTSS is a crucial matter for states and other stakeholders to consider. By definition, these Medicaid beneficiaries need assistance with activities of daily living. Thus poor transitions, particularly those that lead to gaps in services, can have dire consequences. The prospect of change to their state's Medicaid program can cause anxiety among beneficiaries who fear that longstanding relationships with providers who assist them in living independently may be at risk. Also, although many LTSS beneficiaries are able to advocate effectively for themselves, the high prevalence of cognitive impairment, low literacy, and limited English proficiency in the Medicaid LTSS population, as well as the need to accommodate beneficiaries such as those with hearing and/or visual impairments who need accessible forms of communication, elevates the importance of ensuring that all beneficiaries understand the effect of program changes.

This issue paper examines key policy and operational considerations related to the transition from FFS to risk-based capitated managed care for LTSS. Consistent themes regarding transitions are apparent from states' experience to date, from an examination of current and proposed practices and from discussions with a variety of stakeholders. Specific state examples are highlighted throughout the paper and state activities related to Medicaid managed LTSS are summarized in Table 1 and Appendix 1.

Key Considerations

Voluntary enrollment in capitated managed LTSS programs among beneficiaries with complex service and support needs facilitates proactive decision-making about care and support networks. State Medicaid LTSS programs have some flexibility in defining the enrollment process, and stakeholders maintain that a phased-in, voluntary enrollment process leads to more successful transitions for LTSS beneficiaries. Stakeholders say that with a voluntary

enrollment option, beneficiaries who make an affirmative choice to participate will likely be more familiar with and accepting of new programs. In programs with passive enrollment, however, beneficiaries may not have sufficient time to consult with providers; under this enrollment option, more accessible plan information and options counseling may ease transitions. When enrollment occurs in phases, states have time to correct problems or refine procedures before additional beneficiaries are enrolled. The use of beneficiary-specific data on current provider and service use will allow beneficiaries to be matched with the most appropriate plans and potentially minimize service disruption and plan switching.

Achieving successful, efficient transitions in Medicaid LTSS programs is aided by including community-based organizations familiar with the range of physical, environmental, cultural, linguistic, and social factors that support or impede a beneficiary’s ability to receive care in the setting of their choice and to live independently. Stakeholders emphasize the importance of involving community-based organizations familiar with these aspects of service delivery. In addition, multifaceted strategies are recommended to inform beneficiaries about program changes and to assist them in making transitions. Involving beneficiaries as program materials are developed and tested in the field can help ensure that materials are accessible and understandable to all beneficiaries, including those with disabilities and limited English proficiency. In-person, one-on-one counseling and telephone support are reported to be among the most effective strategies for informing and assisting beneficiaries as programs change.

Service continuity and provider network adequacy are of particular concern to beneficiaries preparing to transition into new payment and service delivery systems that may not be attuned to providing long-term services and supports. Assurances concerning service continuity are critically important in achieving successful transitions. A primary concern for beneficiaries is whether their current providers will be in new plan networks. The composition and capacity of networks are affected by whether plans are required to include certain types and numbers of providers and by the reimbursement rates they offer. Other policies can help ensure that current providers, treatments, medications, or other authorized services will be in place until plans and beneficiaries agree on a new service plan of care. These policies include contract requirements to pay current providers at existing rates during the transition period; transition periods that are sufficiently long; independent reviews of care plans that propose significant reductions in services or moves from the community to institutions; and the guarantee of continued availability of benefits pending the resolution of appeals.

Experts stress the importance of real-time monitoring program transitions so that successes are informative and issues and inefficiencies can be identified and addressed immediately. Despite a dearth of established LTSS quality measures, states can adapt performance measures and monitoring techniques used in other programs to evaluate transitions from FFS to capitated LTSS delivery systems. If performance measures are in place before programs are implemented, it is more likely that timely feedback to improve transitions will be available. To be most useful, data can be analyzed and measures reported by population, region, and plan. Techniques used to monitor program performance during transitions include direct observation and external oversight, including reports from beneficiaries. Specific examples are provided in

Table 2. Stakeholders note that in the absence of established best practices, studying the impact of transition policies and practices on beneficiaries can provide information for immediate program improvements and for the design of future programs.

Implications

Experience suggests that avoidable problems can occur if states rush to implement capitated managed care programs and do not make adequate early investments, particularly to support informed decision making on the part of beneficiaries and to monitor plan performance.

Sufficient time and resources can help ensure smooth transitions. The need for financial support for new program activities is a persistent theme manifested by some states' plans to make financial investments and other states' assertions that recommended activities cannot occur without an outside funding source. Experience indicates, for example, that adequate time and resources are needed to retrieve, transmit, and use data effectively. Adequate lead-time and initial investments to develop infrastructure, counsel beneficiaries, and adopt performance measures can ease transitions. Community-based organizations may also need extra support as they prepare to function in a managed care, rather than a FFS, environment.

The importance of providing person-centered services and supports is widely recognized; certain program features support this goal and extra effort focused on these activities may facilitate transitions. Program features that do promote a person-centered approach include the use of a voluntary enrollment process and the availability of one-on-one assistance to help beneficiaries understand their benefit options. Closer collaboration with current providers to encourage their participation in and support of new programs may help achieve greater service continuity. In states where Medicaid beneficiaries are affected by more than one initiative – for example when transitions to managed care for acute and LTSS occur sequentially or when a transition to managed care for all Medicaid beneficiaries, including dually eligible beneficiaries, is followed by an initiative to coordinate Medicare and Medicaid services for dually eligible beneficiaries – hands-on assistance to help coordinate services for beneficiaries can contribute to a person-centered, rather than a program-centered, transition. Similarly, even as initial transitions occur, planning for later transitions is recommended so that assistance will be available for beneficiaries if plan switching is required as provider networks change or as managed care organizations leave or enter the market. Extending strong beneficiary protections that have been developed for one initiative to all initiatives will help ensure that an optimal person-centered approach is achieved.

SUMMARY OF INSIGHTS FROM EXPERTS FOR SUCCESSFUL TRANSITIONS FROM FFS TO CAPITATED MANAGED CARE PROGRAMS

Enrollment

- Provide opportunities for voluntary program enrollment and plan choice.
- Provide sufficient time for beneficiaries to choose among plans.
- Utilize “intelligent assignment” for passive enrollment.
- Conduct enrollment in phases.

Information and Assistance

- Be sure program information is easily understood and accessible.
- Use multiple methods to communicate program information and assist beneficiaries.
- Involve a variety of community-based organizations that have existing relationships with beneficiaries.
- Support information dissemination and beneficiary counseling, including the opportunity for impartial in-person options counseling.

Promoting Service Continuity

- Include current providers in new plan networks.
- Specify how and when individual needs assessments will occur.
- Ensure that transition periods are long enough.
- Foster communication to ensure that beneficiaries understand proposed changes to service plans, their right to appeal, and how to access and navigate the appeals system.

Performance Measurement for Transitions

- Have strategies for transition performance measurement in place before programs are implemented.
- Adapt measures of transition effectiveness from similar programs.
- Use direct observation and external oversight to monitor program activity.
- Allot sufficient resources for evaluation and monitoring of transitions.

INTRODUCTION

Medicaid is the primary source of financing for long-term services and supports (LTSS) in the United States, paying for 41 percent of long-term care expenditures.² Long-term services and supports are essential to helping beneficiaries – such as those who need assistance related to mobility or cognitive functioning – live as independently as possible. Although the specific criteria vary from state to state, beneficiaries generally are eligible for LTSS if they need assistance with activities of daily living such as eating, bathing, or dressing or with instrumental activities of daily living such as meal preparation or medication management. Medicaid covers an array of medical and supportive services either in an institutional setting or in home and community-based settings. Community-based services generally include home health, personal care, medical equipment, assistive devices, rehabilitative therapy, adult day care, targeted case management, home modifications, transportation, and respite care for caregivers.³

The way that Medicaid finances LTSS is changing. Historically, reimbursement for these services has been available on a fee-for-service (FFS) basis. The Centers for Medicare & Medicaid Services (CMS) reports that more than half of states are expected to be operating Medicaid capitated managed LTSS programs by January 2014.⁴ As of March 2013, risk-based capitated Medicaid managed LTSS programs were operating or approved in 19 states, but the program features, such as the geographic area served, the range of services covered, and the groups of beneficiaries participating, differed considerably. Fewer than 390,000 people – less than 10 percent of Medicaid beneficiaries receiving Medicaid LTSS – were enrolled in capitated managed care as of 2012.⁵

Significant expansion in the delivery of Medicaid capitated managed LTSS is anticipated with more states establishing programs and covering new beneficiary groups. Projections indicate that by January 2014 more than 1.8 million people will be eligible for Medicaid managed LTSS.⁶ Table 1 shows the types of activities occurring in each of the 29 states that are expected to be operating Medicaid managed LTSS programs by January 2014.⁷ Three sets of activities are fueling this growth:

- Expansion of current Medicaid capitated managed LTSS programs established using Section 1115 Medicaid Demonstrations or Section 1915(b)/(c) waivers.⁸
- Implementation of new Section 1115 Medicaid Demonstrations or Section 1915(b)/(c) waivers for redesigned Medicaid programs that include capitated managed LTSS.⁸
- Implementation of the CMS-sponsored Financial Alignment Demonstrations to align the financing of the Medicare and Medicaid programs and integrate primary, acute, behavioral health, and LTSS for dually eligible beneficiaries.⁹

The proposed Financial Alignment Demonstrations include capitated and managed FFS financing arrangements. Only the capitated models are discussed in this paper. The CMS Financial Alignment Demonstrations will affect large numbers of beneficiaries who qualify for

and use LTSS. Nationally, approximately one-third of the 7.1 million beneficiaries dually eligible for full Medicare and Medicaid benefits use LTSS;¹⁰ CMS has indicated that up to two million dual eligible beneficiaries may be enrolled in a financial alignment demonstration. In addition, the financial and technical support that CMS has provided to states developing demonstration proposals along with requirements related to demonstration program design, transparency, and beneficiary involvement have brought new attention to the delivery of services, including LTSS, spurring discussion and activity across the country.¹¹

This issue paper focuses on the manner in which initial transitions from FFS to managed care systems occur for Medicaid beneficiaries who receive LTSS. The emphasis is on risk-based capitated systems operated by managed care organizations (MCOs), also called plans.¹² Appendix 1 provides more information about the examples that are cited in the paper.

By definition, Medicaid beneficiaries who receive LTSS need assistance with activities of daily living. Thus poorly managed delivery system transitions, particularly those that lead to gaps in services and disruptions of existing provider relationships, can have dire consequences for beneficiaries. The prospect of change in how services and supports are authorized and financed can understandably cause anxiety among beneficiaries who fear that longstanding relationships with providers who assist them in living independently may be at risk. Also, although many LTSS beneficiaries advocate effectively for themselves, the high prevalence of cognitive impairment, low literacy, and limited English proficiency in the Medicaid LTSS population elevates the importance of ensuring that all beneficiaries understand the effect of program and benefit changes. In addition, beneficiaries who receive LTSS include people with disabilities who may require alternative formats or other accommodations for communication to be accessible and effective.

The transition period also poses practical challenges for MCOs since most of them have much more experience with providing and coordinating medical services geared to treating or curing illness than with providing long-term services and supports to foster and support independent living.¹³ Tasks for MCOs associated with the transition include recruiting new types of providers and ensuring that all plan staff and participating providers understand and can be responsive to an LTSS model of care that is broader and includes more and different types of services than the medical model that may be more familiar to them. In preparing for a transition from a medical model of care to an LTSS model, plans currently have little experience to draw on, however.

**Table 1. State Activity Related to
Capitated Medicaid Managed Long-Term Services and Supports**

State	Capitated Managed LTSS Waiver Programs Implemented or Approved ¹	Waiver Proposals That Will Increase the Use of Capitated Managed LTSS ¹	Proposed Financial Alignment Demonstrations That Use Capitated Managed Care for Dual Eligible Beneficiaries ²
Arizona	√	-	√
California	√	√	√ ^b
Delaware	√	-	-
Florida	√ ^a	-	-
Hawaii	√	-	√ ^c
Idaho	-	-	√
Illinois	-	√	√ ^b
Kansas	√ ^a	-	-
Massachusetts	√	-	√ ^b
Michigan	√	-	√
Minnesota	√	-	√ ^c
Nevada	-	√	-
New Hampshire	√ ^a	-	-
New Jersey	√ ^a	-	-
New Mexico	√	-	√ ^c
New York	√	-	√
North Carolina	√	-	√ ^e
Ohio	-	-	√ ^b
Oklahoma	-	-	√
Oregon	-	-	√ ^c
Pennsylvania	√	-	-
Rhode Island	-	-	√
South Carolina	-	-	√
Tennessee	√	-	√ ^c
Texas	√	-	√
Vermont	-	-	√ ^d
Virginia	-	-	√
Washington	√	-	√ ^b
Wisconsin	√	-	√
TOTAL	19	3	22

Notes: ^a Waiver programs approved by the Centers for Medicare & Medicaid Services (CMS) following July publication cited below. ^b CMS has signed Memoranda of Understanding (MOUs) with these five states. The effective enrollment date is July 2013 for Massachusetts and Washington, September 2013 for Ohio, and October 2013 for California and Illinois. The Washington MOU is for a managed fee-for-service (FFS) demonstration. Washington's original proposal also included plans for a capitated demonstration. CMS continues to review proposals. ^c Activity following October publication cited below: New Mexico and Tennessee have withdrawn their proposals. Minnesota and Oregon have indicated that they will pursue other programmatic or administrative alignment. Hawaii's proposal is pending, though the state has indicated that it may not be able to meet the implementation deadline. ^d Vermont's proposed approach to capitated managed care differs from other states in that the state would function as the managed care organization. ^e North Carolina has a pending proposal for a managed FFS, not capitated model.

Sources: ¹ P. Saucier, J. Kasten, B. Burwell, and L. Gold, *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update*, July 2012, available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf. ² M. Musumeci, *State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS*, The Henry J. Kaiser Family Foundation's Commission on Medicaid and the Uninsured, October 2012, available at <http://www.kff.org/medicaid/8369.cfm>.

This issue paper compiles available information and insights related to the transition period. The key policy and operational considerations related to the transition from FFS to capitated managed care for LTSS are listed (Text Boxes) and discussed below. Examples from current and proposed programs are presented to illustrate points and present possibilities. The examples are meant to be illustrative. Although they describe activities in particular states, other states may be engaged in similar activities. The examples are not meant to comprise an exhaustive list of states that engage in particular activities.

A risk-based capitated managed care approach can potentially promote service coordination, increase the efficiency and effectiveness of the delivery system, and improve the predictability of costs over the long-term. Stakeholders generally agree that these outcomes are desirable, but also recognize that careful attention to program implementation and operations is needed in order to help ensure that new efforts succeed, particularly given the vulnerability of the population that relies on Medicaid LTSS.

<p style="text-align: center;">KEY CONSIDERATIONS: TRANSITIONS FROM FFS TO CAPITATED MANAGED CARE LTSS PROGRAMS</p> <p>Program and plan enrollment</p> <ul style="list-style-type: none">• Is enrollment mandatory or voluntary?• Do beneficiaries have sufficient time and information to choose among plans?• If passive plan enrollment is used, what factors are considered in assigning plans?• Is enrollment phased in? <p>Information and assistance</p> <ul style="list-style-type: none">• How are enrollees informed of changes in their coverage?• What assistance, including neutral options counseling, is available to them?• Are language, literacy, cognitive, and physical needs accommodated when information and counseling is offered?• Is adequate financial support available for information and counseling activities? <p>Service continuity</p> <ul style="list-style-type: none">• Are current providers included in new plan networks?• How and when do needs assessments occur?• What transition period policies promote continuity of care? <p>Program performance</p> <ul style="list-style-type: none">• What performance measures to evaluate transitions are used?• How are transition activities monitored?• Are sufficient resources available to support evaluation and oversight of transitions?
--

The information cited in this issue paper is based on reviews of literature and program materials as well as discussions with a variety of stakeholders: program and plan administrators, service providers, and beneficiary advocates. It is important to note that because experience with capitated Medicaid managed LTSS is limited and because capitated managed LTSS program design differs considerably among states, evidence that demonstrates which practices are best is weak. Most of the policies and practices described in this paper are not proven or best practices. As states move forward, however, it is instructive to point to relevant policies and practices that have been proposed or implemented and that are judged feasible and effective by people with experience in the field.

ENROLLMENT

Stakeholders' experience with the enrollment process can have a major impact on how well new programs are accepted and used by beneficiaries. As one observer explained, "With this population you can't just flip a switch."

Enrollment: Insights from Experts

- Provide opportunities for voluntary program enrollment and plan choice.
- Provide sufficient time for beneficiaries to choose among plans.
- Utilize "intelligent assignment" for passive enrollment.
- Conduct enrollment in phases.

Opportunities for voluntary enrollment

The first issue that drives the enrollment process is whether program participation is mandatory or voluntary. An important distinction among programs with voluntary enrollment is whether beneficiaries are passively enrolled and then given the opportunity to opt out of a program or whether they are asked to make a proactive decision to opt into a program. The voluntary opt-in approach is truly "person-centered" in that it allows beneficiaries to make a choice about whether FFS or managed care arrangements are best for them. Stakeholders say that in this model, MCOs have the greatest incentive to adopt policies and practices that will attract and retain enrollees. They also note that enrollees are most likely to be aware and accepting of program changes when they affirmatively choose to participate. Voluntary opt-out programs also have an element of choice, but stakeholders note that beneficiaries may not realize that there has been a change in coverage until they encounter a problem in accessing services or they may not understand that they cannot continue to see current providers if the providers are not in the plan's network. Beneficiaries have the least choice when mandatory program enrollment occurs, though they can switch plans at a later date.

Among the 17 state programs with operational capitated Medicaid managed LTSS programs in June 2012, nine had mandatory and eight had voluntary enrollment. Among the voluntary programs, one uses a passive enrollment process that informs beneficiaries that they will be enrolled unless they opt out; the others use an opt-in process.¹⁴ New program proposals feature both mandatory and voluntary enrollment, but all of the voluntary arrangements would use passive enrollment with an opt-out feature.¹⁵

*The **Massachusetts** Financial Alignment Demonstration will have an initial voluntary enrollment period. Beneficiaries will also have the opportunity to opt out of the Demonstration before passive enrollment takes place. During a 60-day period after notification about the new program, beneficiaries may decline, or if they decide to participate, they may choose a plan on their own. If they do not respond by the end of that period they will be passively enrolled in a plan. They may opt out of the Demonstration at any time.*

***Ohio's** Financial Alignment Demonstration will have an initial voluntary enrollment period followed by a passive enrollment period when the state will automatically assign beneficiaries to plans unless they opt out of the Demonstration. Beneficiaries will be able to opt out prior to the passive enrollment period, which will be conducted in phases by regions. Beneficiaries may change plans or opt out of the Demonstration at any time after they are enrolled.*

Provide sufficient time for plan selection

The amount of time that beneficiaries have to choose plans and the point at which passive plan enrollment occurs can affect how well the transition process works. States have taken different approaches. In **Delaware's** *Diamond State Health Plan-Plus* program, the state makes an initial plan choice and then informs beneficiaries of the choice and of the fact that they have 45 days to choose another MCO. In other instances, beneficiaries have an opportunity to choose a plan first; those who do not make a selection are assigned to a plan. The timeframe differs, however. For example, **Florida** specifies a 30-day period for beneficiary plan choice in its recently approved mandatory *Long-Term Care Managed Care* program and **New York** gives beneficiaries 60 days to select a plan before they are automatically assigned. Stakeholders note that it is important to allow adequate time for beneficiaries to obtain information that they can use to compare plans, to consult with providers or others they trust, and to receive options counseling. Federal law requires that beneficiaries also have 90 days after enrollment to switch plans.¹⁶

Consider “intelligent assignment”

The term “intelligent assignment” refers to a process used during passive enrollment to assign beneficiaries to the most appropriate MCOs. Information such as individuals’ service needs or current providers may be the basis for assignment. This is a logical approach, but experience suggests that there are a few key considerations related to feasibility: Is the necessary

information readily available? Is there capacity to retrieve and transmit data, or must those processes be developed? Has sufficient time been allotted to complete an appropriate assignment? Do states have the resources in place to use the information effectively to match beneficiaries with plans? How can beneficiaries who use multiple services or providers be matched to a single plan that may not include all of their existing providers?

It may be most appropriate in some cases to match beneficiaries with their primary care providers, but some beneficiaries may place a higher priority on the aide who provides daily assistance. Others may rely on a particular specialist who coordinates this care or they may have a mental health service provider who is central to their care. Stakeholders note that the question of how priorities for services or providers are determined is a particularly important one.

*The terms and conditions for **Delaware's** Diamond State Health Plan-Plus program provide that the state would pre-select MCOs for beneficiaries by taking into account the providers, including those for home and community-based services that beneficiaries had used historically.*

The Memoranda of Understanding (MOUs) for the **Illinois**, **Massachusetts** and **Ohio** Financial Alignment Demonstrations indicate that each state will work to develop an algorithm for the enrollment process that gives priority to provider or service continuity but do not provide details on how this will be achieved. **New York's** current transition of dually eligible beneficiaries to Medicaid managed LTSS uses a random auto-assignment process. The state's proposal for a Financial Alignment Demonstration indicates, however, that the use of an auto-assignment algorithm that takes into account provider networks and plans' capacity to adequately serve new enrollees is a long-term goal.

States may use other criteria in making plan assignments. **Michigan** indicates in its Financial Alignment Demonstration proposal that preference will be given to higher performing plans. Assignments based on plan performance will not occur immediately, however, but over the course of the Demonstrations.

Conduct enrollment in phases

When enrollment occurs in phases, states have time to correct problems or refine procedures before all beneficiaries are enrolled. In discussing prospective programs, several stakeholders cautioned that "the rush to implementation" could have negative consequences if beneficiaries and providers are confused or have difficult initial transitions. They suggested that a slower rollout could help ensure not only that program and plan staff are well prepared but also that the program is understood and accepted by beneficiaries and providers.

***Michigan's** Financial Alignment Demonstration proposal describes a phased implementation by geographic region and population group and notes that stakeholder comments, particularly those received from the developmental disability advocacy*

community, overwhelmingly supported this approach to allow early experience to inform and perhaps improve the overall process as it progresses.

Illinois' Financial Alignment Demonstration indicates that the state will phase in enrollment to ensure that MCOs have adequate time to process enrollment, complete assessments, and ensure a smooth transition. Six groups will be enrolled over six months with numerical limits on the number of enrollees per plan per month.

Another strategy is to enroll new Medicaid applicants in the managed care program first and then, after operations are well established, to help current beneficiaries make the transition from the existing FFS system.

INFORMATION AND ASSISTANCE

Efforts to minimize confusion as programs are introduced and begin operating are essential to program success. One stakeholder noted, "Insurance is complicated. Everyone has a hard time understanding how it works, but this population [Medicaid LTSS beneficiaries] often needs extra help." If beneficiaries have access to information that is easy to understand and to counseling when they have questions, they are likely to be more accepting of change and to participate in the transition by making proactive decisions about program participation and plan choice.

Information and Assistance: Insights from Experts

- Be sure program information is easily understood and accessible.
- Use multiple methods to communicate program information and assist beneficiaries.
- Involve a variety of community-based organizations that have existing relationships with beneficiaries.
- Support information dissemination and beneficiary counseling, including the opportunity for impartial in-person options counseling.

Be sure program information is easily understood

Experience indicates that beneficiaries may not understand letters or other plan materials that they receive. A survey of Medicaid beneficiaries newly enrolled in **Florida's 2006 Medicaid Reform** pilot project, which uses capitated managed care plans, found gaps in people's understanding of major components of the new program. The state sent a series of letters about program changes to Medicaid enrollees, including one informing them that if they did not select a health plan within 30 days a plan would be assigned to them. Even after they received the letters, about 30 percent of beneficiaries were not aware that they were enrolled in a new program. More than half of all beneficiaries and almost two-thirds of the adult

Supplemental Security Income population had trouble understanding plan information.¹⁷ Results from field tests conducted by CMS of letters to inform beneficiaries about the **Massachusetts** Financial Alignment Demonstration indicated that beneficiaries did not understand the information in the letters nor why they were receiving them. Although the results from the field test were disappointing, they provide useful information, and the state now has an opportunity to improve the letters before the program is launched.

Pre-testing materials with beneficiaries and involving beneficiaries in the development of materials have been suggested to help ensure that letters and other program materials will be easily understood and therefore more effective.

Illinois reports in its Financial Alignment Demonstration proposal that the state will ask its Client Education Advisory Subcommittee to review enrollment notices before they are sent to beneficiaries.

Accommodations for certain beneficiary populations

CMS guidance for the state Financial Alignment Demonstrations indicates that program materials must be accessible and understandable to beneficiaries, including those with disabilities and limited English proficiency.¹⁸ Stakeholders suggest that practical strategies to accomplish this include identifying beneficiaries when they first request materials or assistance in another language or format and ensuring that all subsequent communication is provided in that manner; including inserts in all mailings to alert beneficiaries to the availability of materials or assistance in another language or format; and, in areas where there are large numbers of people whose first language is not English, using language-specific telephone help-lines.

Information to compare plans

In addition to understanding how new programs operate, beneficiaries need information about the features of different MCOs so that they can make informed choices. If detailed information about plans is not available from an independent source, plan marketing materials may be the primary source of information, which may not easily allow for standardized comparisons among plans. Stakeholders report, for example, that in **New York City**, where the transition from FFS to managed care for LTSS is currently occurring, dually eligible beneficiaries can choose among approximately 20 MCOs. Yet they do not have access to a tool that allows for easy comparisons among plans. The Medicare Part D plan finder is often cited as a model tool that effectively explains the differences among plans and helps in determining which plans are best based on individuals' circumstances. Having easy access to information about whether particular providers are in MCO networks, either through searchable databases or through links to plan-specific network information, is a particularly important feature for beneficiaries who have established relationships with LTSS providers.

Provider involvement

One stakeholder noted that when doctors or other providers do not understand or are wary of new programs, their patients might be wary too. Informed providers may be more comfortable with program changes and better able to help beneficiaries understand the program and the potential changes in care.

*A lesson learned from the transition from FFS to managed care for the Community-Based Adult Services (CBAS) program in **California** is that significant time and effort are needed to prepare providers so that they understand the new system and can give beneficiaries accurate information about how to achieve service continuity. When the program was introduced, the number of people opting out and therefore slated to lose services was much higher than anticipated. The state responded by extending the time frame for program implementation and holding conference calls to educate providers in an effort to dispel inaccurate perceptions about the program.*

Use multiple methods to communicate with and assist beneficiaries

The most common method that has been used and proposed to advise beneficiaries of program changes is to mail letters to their homes, but experience suggests that this may not be a sufficient communication strategy. As a practical matter, contact information for Medicaid beneficiaries is often out-of-date.¹⁹ Stakeholders report that beneficiaries often do not understand the information or simply discard letters. In commenting on the Financial Alignment Demonstrations, the Medicare Payment Advisory Commission suggested a multi-channel education strategy that includes the use of letters, phone calls, notices in community publications, and outreach through community-based organizations.²⁰ California's experience reinforces the potential success of this outreach and education strategy.

*Written materials were the primary type of communication beneficiaries received about the Seniors and People with Disabilities (SPD) transition in **California**, but were judged to be the least effective. Respondents felt that another strategy, holding community meetings, was not effective because of the impersonal nature of the meetings and because many in the target population have mobility limitations. Stakeholders reported that "high-touch" and personalized outreach and communication, including in-person, one-on-one counseling and telephone support, were the most effective strategies for informing and assisting beneficiaries.²¹*

Enrollment brokers

States commonly use or propose the use of enrollment brokers. The nature and extent of activities performed by brokers varies. They may be private contractors that simply handle the logistics of enrollment. Some respond to phone inquiries about the program. Less commonly, they provide more personal, one-on-one or face-to-face assistance. In some instances, states or private firms subcontract with community-based organizations to assist beneficiaries.

Stakeholders point out that if states anticipate that brokers will be involved in information and counseling activities, states' expectations, contract requirements, and reimbursement rates can affect enrollment brokers' performance. They stress that to be most effective, the brokers must have a thorough understanding of each plan's features. In addition they must be familiar with LTSS as well as other Medicaid services that beneficiaries need. The ability to communicate effectively in languages other than English and in a way that is accessible to people with disabilities and to understand cultural norms or preferences were also cited as important factors affecting the ability of enrollment brokers to help beneficiaries. Experience indicates that perceptions about enrollment brokers may differ. In **California's SPD transition** program, plans rated enrollment broker services as effective or very effective, but among other stakeholders, including providers, community-based organizations and advocates, more than half (60%) rated the services as not very or not at all effective.²²

Timeframe

The amount of time allotted to educate beneficiaries in advance of enrollment can also have an impact on program success. Health plans and other stakeholders in **California** report that the short timeline for communication was a major challenge affecting the effectiveness of outreach and education activities for beneficiaries when the *SPD* transition occurred. Plan staff were trained to provide information and support to beneficiaries, but stakeholders say that this did not occur early enough in the transition period before beneficiaries were enrolled and needed to access care.²³

Involve a variety of community-based organizations

Stakeholders generally agree that trusted community-based organizations that have expertise and established relationships with people who use Medicaid LTSS are well-positioned to help beneficiaries understand and use new programs. For example, Aging and Disability Resource Centers (ADRCs) operate in every state and are charged with providing information, counseling, referrals, and application assistance for individuals who have questions related to LTSS. Beneficiaries also rely on organizations that work with particular disability groups and are familiar with all of the physical, environmental, and social factors in ensuring that people are able live independently. Community-based organizations can play a particularly important role for beneficiaries with limited English proficiency or cultural norms, preferences, and practices that may differ from the majority of beneficiaries. Among the established organizations on which states plan to rely are health insurance counseling programs, health consumer centers, Centers for Independent Living, ADRCs, recovery learning communities, deaf and hard of hearing independent living services programs, county agencies, the ARC, and Easter Seals. These non-profit organizations, many of which rely on government funding, generally have lean budgets and may not have the capacity to take on new roles or serve the number of beneficiaries seeking assistance without additional financial support.

Support information dissemination and impartial beneficiary options counseling

An important distinction is whether states assume that community-based organizations will simply take on the functions of disseminating information and counseling beneficiaries about new Medicaid managed LTSS options, or whether financial support will be available to support these activities. Although **California** proposes to involve community-based organizations to help beneficiaries understand their health care coverage and select a plan under its pending Financial Alignment Demonstration, the state makes that activity contingent upon available private or public funds other than money from the state's general fund. The proposal also notes that health plans have suggested a contracting relationship with community-based organizations to assist with outreach and help beneficiaries early in the enrollment process. **Washington's** capitated Financial Alignment Demonstration proposal asks CMS to provide funding for an independent enrollment/options counseling function to ensure that beneficiaries have an unbiased source of information.

In August 2012, CMS announced a funding opportunity to support options counseling performed by State Health Insurance and Assistance Programs and ADRCs in states that have signed an MOU with CMS for a Financial Alignment Demonstration. As a condition of the funding, the State Unit on Aging, Department of Insurance, Disability agencies, and Medicaid agency must all be involved.²⁴ Demonstration implementation funding is also available to states that received a design contract and have a signed MOU.²⁵ Stakeholders call the financial support and requirements for collaboration among agencies welcome developments, but note that similar and more immediate support would be helpful in states that have or are proposing to redesign their Medicaid program to increase the use of managed LTSS. Also, support for more varied groups to provide outreach and options counseling could help increase opportunities for beneficiaries to receive effective assistance.

One caveat is that if community-based organizations provide services other than enrollment options counseling, and particularly if they contract with some, but not all, MCOs, they are not completely disinterested parties. Observers in some states point to the risk of informal marketing if options counselors are also providers who are associated only with particular MCOs.

PROMOTING SERVICE CONTINUITY

Beneficiaries and those who work with them stress that information and assurances regarding service continuity as program transitions occur are essential if programs are to succeed. One stakeholder explained, "Lots of people who rely on aides or case managers equate program changes with loss of control. They worry that relationships that are critically important to them will be disrupted." Confusion and concern about continuity of care has been reported among stakeholders during program transitions.²⁶ Beneficiaries with particularly complex needs, such as individuals with mental illness, developmental disabilities, or multiple chronic conditions or who are experiencing homelessness may require special attention to achieve service continuity.

Promoting Service Continuity: Insights from Experts

- Include current providers in new plan networks.
- Specify how and when individual needs assessments will occur.
- Ensure that transition periods are long enough.
- Foster communication to ensure that beneficiaries understand proposed changes to service plans, their right to appeal, and how to access and navigate the appeals system.

Include current providers

Including current providers in new networks, at least for some period of time, is one way to ease transitions and build strong programs. When the **Texas STAR+PLUS** program was established, the state mandated a three-year transition period during which MCOs were required to contract with any willing provider that had been providing LTSS in the Medicaid FFS system. **Washington** notes in its capitated Financial Alignment Demonstration proposal that health plans will gain experience with the developmental disability and home and community-based LTSS systems because they will be required to contract with qualified providers in these systems.

Short of requiring that MCOs contract with providers, some states require that plans affirmatively reach out to providers about joining networks.

*In their Financial Alignment Demonstration proposals, **Illinois, Rhode Island, and Tennessee** all note that plans will be provided with data to identify providers that dually eligible beneficiaries are currently using so that the plans can recruit those providers who are not already in their networks.*

Provider payment rates

Payment rates affect providers' willingness to participate in new managed care programs. There is some precedent for state involvement in setting provider reimbursement rates as well as regulating MCOs' contracts with other providers. When the **Tennessee CHOICES** program was established, MCOs were required to offer contracts for the first three years to all nursing facilities that were certified at the time. In addition, the state set reimbursement rates for LTSS provided in nursing facilities and in the community. With the shift to mandatory enrollment in the *Managed Long Term Care* program in **New York City**, plans were required to contract with home attendant vendors who already have contracts with the city and to pay those vendors established rates for a certain period of time.

Community-based organizations as providers

Given their experience in working with people who have a range of disabilities and LTSS needs, community-based organizations are viewed by many stakeholders as essential to efforts to form adequate provider networks with sufficient expertise in caring for vulnerable populations. The move to managed care presents opportunities for community-based organizations to perform and be reimbursed not only for counseling beneficiaries, but also for coordinating care or providing other direct services. A few states have defined roles for aging services networks. **Florida's Medicaid Reform** proposal requires that MCOs offer initial network contracts to aging network service providers; the proposal indicates that MCOs may negotiate contracts with other organizations such as those that assist with community-based services for younger beneficiaries, but this is not a requirement. The MOU for the Financial Alignment Demonstration in **Ohio** specifies that MCOs must contract with Area Agencies on Aging for home and community-based waiver service coordination for beneficiaries over the age of 60. It does not require that the MCOs contract with similar organizations to coordinate services for younger beneficiaries, however.

*Managed Care Organizations in the **Massachusetts** Senior Care Option program must establish contracts for service coordination with Aging Services Access Points and the MOU for the new Demonstration includes a requirement that MCOs contract with community-based organizations to provide Independent Living-LTSS coordinators on the care teams.*

In general, the role of community-based organizations – particularly organizations that are not part of the aging network – is not well defined and the practical aspects of including them in new programs are not addressed. Many community-based organizations face challenges related to making the transition from a FFS system in which they had one contract with a state Medicaid program that authorized care to a managed care system that requires them to negotiate contracts with multiple plans. Additionally, they are limited in the amount of upfront investment they can make and in the amount of time they have to negotiate with plans, develop billing and other administrative systems, and hire and train staff. In **New York**, when the state shifted from FFS reimbursement to managed care for personal care services, plans reported that the contracting experience was time and resource-intensive and even more so for providers who did not have prior contracting experience.²⁷ Stakeholders suggest that it would be useful for health plans and community-based organizations to conduct cross-training so that both can understand the new system, what the plans can offer, what beneficiaries need, and how services can be delivered most effectively.

Assessments

When Medicaid LTSS are provided on a FFS basis, the state or an organization working with the state usually conducts an initial assessment to determine whether individuals meet “level of care” criteria developed by the state and therefore qualify to receive LTSS. In addition, LTSS cannot be furnished in the community until a written plan of care has been developed by an

authorized organization, indicating the specific services to be provided. Information from the initial assessment may be used in developing the plan of care, as may additional information gathered during subsequent assessments and in consultation with beneficiaries.

When transitions from a FFS to a capitated managed care system occur for beneficiaries who already have plans of care and are receiving services, MCOs generally conduct a new separate assessment to determine the types and amounts of services that enrolled beneficiaries will receive.

Objectivity

Ideally, parties that do not have a financial interest in the care that beneficiaries receive will perform assessments. Stakeholders note that while it may be efficient for plans to conduct assessments, they also have an interest in controlling costs and perhaps in limiting services. Community-based organizations may be logical choices to conduct assessments because they are familiar with the strengths and needs of the beneficiaries, but they may have an incentive to recommend higher levels of services if they are also service providers.

A particular concern associated with transitions is whether plans will have adequate services and networks in place to continue providing community-based LTSS on which beneficiaries already rely. Another concern expressed by stakeholders is that when MCOs are not financially responsible for the full continuum of services, for example when they have only partial or no risk for institutionally-based LTSS, they may have a financial incentive to serve fewer people in the community. One way to address the potential bias is to require reviews of assessments and care plans that recommend changes in the types or amounts of services provided.

*The CMS terms and conditions associated with **Delaware's** DSHP-Plus program specify that the state is required to review and approve all service reductions proposed by plans as part of an initial assessment during the implementation of the program. Subsequently, the state is required to review and approve a sample of proposed reductions prior to changes.*

Type of needs assessment

Stakeholders stress that beneficiary needs assessments for LTSS must account for social as well as medical needs and include, for example, questions about desire and ability to live in the community and to self-direct services. Interest in moving away from a purely medical model of assessment extends to considerations about who conducts assessments. Those who emphasize the need for a more expansive assessment of beneficiaries' strengths and needs generally recommend a team approach to assessment, with experienced medical and social service personnel included. This is the approach used currently in the **Massachusetts Senior Care Options** program.

Experts recommend the development and use of uniform assessment tools to help ensure that assessments cover all relevant topics, that they are conducted in an objective manner, and that

all applicants, regardless of where they live or what health plan they join, are assessed in the same manner. CMS is engaged in efforts to develop a uniform independent assessment for home and community-based service initiatives.²⁸ **Washington** and **Wisconsin** have developed and used evidence-based standard assessment tools for beneficiaries receiving LTSS. A uniform assessment system is planned for in **New York**, but early in the transition to Medicaid managed LTSS for dually eligible beneficiaries, the tools were not yet available. Plans are charged with conducting needs assessments, and each has its own method for translating assessment results into care plans.

Information about prior service use

Providing plans with information about an individual's past service use is a practice that has been proposed to ease transitions.

*The terms and conditions for **New Jersey's** new waiver program, which expands existing managed care programs to include LTSS, specifies that the state must provide MCOs with claims data as well as past and current plans of care and information about current providers.*

In **California**, plans for the *SPD* transition called for the transfer of beneficiary-specific provider and health data to health plans, but stakeholders report that the state underestimated the lead time required to accomplish this.²⁹ Given adequate time and resources, however, the practice could be very useful in promoting continuity of care.

Transition periods

Policies that allow beneficiaries to continue to see current providers for a certain period of time, even if the providers are not part of new networks, are used to help ensure continuity of care during transitions. The length of the transition period varies among programs, however. An argument for longer transitions periods is that beneficiaries – particularly those who have been mandatorily enrolled in programs or passively enrolled with an opt-out provision – may not be aware that their coverage has changed and that, consequently, they may not be able to continue to see certain providers. Stakeholders maintain that the transition period should be long enough to allow time for beneficiaries to see current providers and make plans for changes in care. For beneficiaries who have long-established relationships with their provider(s) and may be anxious about making a change, longer transition periods provide an opportunity for current providers to counsel and support beneficiaries in establishing new provider relationships. In addition, it may take some time for current providers to join or be credentialed for new plans. Thus, the likelihood that beneficiaries' current providers can continue to provide services is greater with longer transition periods.

When the **Tennessee CHOICES** program was implemented, beneficiaries could receive the same services from existing providers for one month regardless of whether they were in-network providers. The **Illinois** MOU specifies a six-month period when enrollees may maintain a current

course of treatment with out-of-network providers. **California's** Financial Alignment Demonstration proposal gives beneficiaries access to out-of-network providers for up to 12 months if there is an ongoing relationship with a provider.

Ohio developed transition policies for its Financial Alignment Demonstration that are specific to different services and types of consumers and range from three to twelve months. For example, plans must maintain physician services at current levels and with current providers during the 90-day transition for individuals identified for high risk care management and for 365 days for all others unless enrollees request a change, providers choose to discontinue providing services, or performance issues are identified.

In addition to establishing time frames, some states specify that that needs assessments or care plans must be completed before provider changes occur. The Medicare Payment Advisory Commission recommends that when Financial Alignment Demonstrations that use a capitated managed care approach are implemented, beneficiaries should have access to current providers and prescriptions until new assessments and care plans are completed.³⁰ The Medicaid managed LTSS programs in **Delaware** and **New Jersey** require that current care plans be followed until new assessments are completed.

Stakeholders note that simply conducting new needs assessments may not be sufficient to warrant a provider change. Having a care plan in place is recommended, as is having agreement on the approved services between the plan and the beneficiary.

Service guarantees

Stakeholders note that to maintain continuity, prior authorizations for services and equipment must also carry over to new plans for certain periods. The **Illinois** Financial Alignment Demonstration proposal states that all prior approvals for drugs, therapies, or other services at the time of enrollment will be honored for 90 days post-enrollment and will not be terminated without advance notice and transition to other services if needed.

Washington's Financial Alignment Demonstration proposal for the state's capitated program specifies that during a 90-day "retention period," MCOs cannot make changes in providers, treatments, medications, or terminate or reduce services. The intentions are to prevent the interruption of services while new assessments are occurring and keep beneficiaries informed about proposed changes.

Some states recognize that, in certain cases, the continued provision of services by an out-of-network provider may be advantageous to beneficiaries and to the state Medicaid program and therefore MCOs have the option to negotiate single-case-out-of-network agreements. This policy is featured in the **Massachusetts** Financial Alignment Demonstration.

Another important consideration is whether beneficiaries will continue to receive services while awaiting the outcome of an appeal related to changes in services or treatment that occur when

beneficiaries transition from FFS to managed care and initial service plans are developed. Established Medicaid rules require that if a beneficiary or provider files a timely appeal involving the termination, suspension, or reduction of a previously authorized course of treatment and requests that services continue, MCOs must provide the benefits for the period originally authorized while the appeal is pending.³¹ Clarity about the applicability of these requirements during the transition period could be helpful to MCOs and beneficiaries.

Communication

Policies to engage beneficiaries during the process of transitioning from FFS to managed care are important, but such policies have received less attention. For example, beneficiaries who are in transition and those who counsel them must be aware of whether there are state policies that allow beneficiaries to continue to see their current providers or policies pertaining to whether new plans must honor prior authorizations for a certain period, should the beneficiaries decide to change providers. In either case, the details of the policies must be clearly stated and readily available. At a minimum, beneficiaries should receive understandable notices explaining the details of policies that may affect their choices. Similarly, as specified in the **Massachusetts** MOU, when services from out-of-network providers are authorized, beneficiaries should be advised specifically that they have received care that would not otherwise be covered at an in-network level.

PERFORMANCE MEASUREMENT OF TRANSITIONS

A potential advantage of using a managed care approach is that plan performance can be measured and, based on outcomes, program improvement can occur. As one person noted, “Programs with fewer problems at the start are more likely to succeed.” Performance measurement with regard to LTSS, and particularly community-based LTSS, has lagged behind measurement of the delivery of medical services. A point stressed by many stakeholders is that LTSS outcome measures must differ from more established medical care outcome measures. For example, established clinical outcome measures that gauge improvement in health status may not always be relevant for beneficiaries who use LTSS if they have conditions that are not expected to improve. Measures related to maintaining independence, having an optimal living situation, and having the option to self-direct services if desired are very important, however.

National efforts to develop and test LTSS quality measures are underway. Stakeholders note that this is a much-needed and positive development, and have offered guidance related to identifying and selecting measures.³² Stakeholders also note that even as measures related to the plan experience for program enrollees are being developed, programs are being implemented and operated. They suggest that a more immediate assessment of program implementation activities such as those related to transitions from FFS to managed care can provide important feedback as some states begin to operate programs and others make plans for new programs. Current programs and proposals provide examples of performance

measurement and monitoring activities related to transitions from FFS to managed care programs.

Performance Measurement for Transitions from FFS to Capitated Managed Care Programs: Insights from Experts

- Have strategies for performance measurement in place before programs are implemented.
- Adapt measures for transition effectiveness from similar programs.
- Use direct observation and external oversight to monitor program activity.
- Allot sufficient resources for evaluation and monitoring of transitions.

Have measurement strategies in place

Having strategies for performance measures in place before programs are implemented will help ensure that timely feedback can be used to improve transitions. If new programs are implemented in phases, experience with transitions from FFS to managed care for a particular population or area of the state can inform later transitions efforts.

Adapt performance measures to assess transitions

Table 2 lists several questions related to transition performance in three areas – program and plan enrollment, information and assistance, and service continuity – and describes measures that have been used or proposed to assess these questions. The measures were obtained from a review of selected literature, state program materials, and proposals for new initiatives from states. In general, the measures that are being used or proposed to gauge performance during transitions from FFS to managed care are process measures related to enrollment dynamics and plan operations. Other measures examine beneficiary experience. A variety of information sources include state and plan administrative data as well as beneficiary and provider surveys, interviews, and focus groups. Most of the measures have not been validated, but given that program implementation is occurring, the use of performance measures (such as those featured in Table 2) can not only help improve program operations during transitions, but can also contribute to efforts to develop and validate measures.

Regardless of the measures, stakeholders stress that to be most useful, data can be analyzed and measures reported by population, region, and plan. Ideally, for example, it should be possible to examine data for people with disabilities and for subgroups with particular types of disabilities.

Michigan’s Financial Alignment Demonstration proposal notes that plans will be required to report performance and quality metrics for unique populations, for example, persons with serious mental illness and for certain geographic regions such as those where network development or workforce recruitment challenges are anticipated.

Stakeholders note that results will be most useful if they are publicly available in a timely manner and in a format that is easily understood.

Ohio's Financial Alignment Demonstration proposal indicates that the state would post data collected from plans, reported by plan and region, on its Medicaid website.

Table 2. Transitions from Fee-for-Service to Capitated Managed Care Programs – Performance Measures

Enrollment Dynamics	
Question of interest	Measures
To what extent do people enroll voluntarily in managed long-term services and supports (MLTSS) programs?	% of beneficiaries eligible for the program who enroll [1,2]
To what extent are beneficiaries who can opt out staying in MLTSS programs?	% of eligible beneficiaries initially enrolled in an integrated care program who stay enrolled for more than three months [3]
To what extent are beneficiaries choosing plans?	% of beneficiaries who choose a plan on their own [4]
To what extent are people who choose switching plans?	% of individuals who chose initially, then change to a different plan within 90 days [5]
To what extent are people who were passively enrolled switching plans?	% of individuals passively enrolled who changed plans within 90 days [5]
What are the reasons for changing plans?	Sample questions from beneficiary survey: [6]
	I changed my health plan because: <ul style="list-style-type: none"> • The county or state put me in a health plan that I did not choose. • I wanted everyone in my household in the same health plan. • I moved and the health plan was no longer available. • I voluntarily enrolled in Minnesota Senior Health Options to get my Medicare services, including Part D drugs. • I did not like my health plan. (Please tell us why below)
	I did not like my health plan because: <ul style="list-style-type: none"> • I could not get the service I wanted. • The information I was given before I signed up for the plan was not correct. • The doctor I wanted was not in my health plan. • The dentist I wanted was not in my health plan. • Another provider I wanted was not in my health plan. • When I called my health plan with a question or needed help, they did not help me.
	I did not like my health plan's providers for personal care, home health care, assisted living, transportation, or other services that help me to stay in my home and the community because: <ul style="list-style-type: none"> • The providers on my health plan's list would not take new clients. • The providers I wanted would not take my health plan. • I could not get as many of these services as I needed.
Information and Assistance	
Question of interest	Measures
Are call centers operating effectively during the transition period?	% of callers who are on hold for less than a specified number of minutes [7]
How responsive are call centers?	% of calls answered within 20 seconds or less [8]
Availability of foreign language interpreter or TTY/TDD from call centers	% of time that requests for foreign language interpreter or TTY/TDD are fulfilled [7]
	% of members who need an interpreter and always wait fewer than 15 minutes for the interpreter [8]
	% of members who are screened for their preferred language [8]
Are plans providing useful information for enrollees?	Sample questions from beneficiary survey: [9]
	Does the health plan explain all of their services to you clearly? (Always, Usually, Sometimes, Never)
	If you called the plan with questions or for help, <ul style="list-style-type: none"> • Were you able to speak with a person quickly? (Always, Usually, Sometimes, Never) • Were your questions answered quickly? (Always, Usually, Sometimes, Never) • Were you able to understand the answers? (Always, Usually, Sometimes, Never) • Were you treated with politeness and respect? (Always, Usually, Sometimes, Never)
	Sample questions from beneficiary survey: [8]
	Over the last ___ months, <ul style="list-style-type: none"> • How often did your health plan's customer service give you the information or help you needed? • How often did your health plan's customer service treat you with courtesy and respect? • How often were the forms for your health plan easy to fill out?

Table 2. Transitions from Fee-for-Service to Capitated Managed Care Programs – Performance Measures, continued

Service Continuity	
Question of interest	Measures
Are assessments conducted in a timely manner?	% of enrollees with an initial assessment within 90 days of enrollment [1]
Are plans of care developed/implemented in a timely manner?	% of beneficiaries with health action plans within 60 days of beneficiaries being assigned to a care coordination organization [3]
Are care goals discussed with beneficiaries?	% of beneficiaries with documented discussion of care goals [2]
Are beneficiaries aware of an option for self-directed care?	% of assessed enrollees with signed forms regarding the self-directed care option [10]
Are beneficiaries involved in decisions about care?	% of members whose records confirm they were asked about their care preferences [used by several state Medicaid MLTSS programs] [11]
	Sample question from a beneficiary survey: [9]
	<ul style="list-style-type: none"> Are you involved in making decisions about your plan of care? (Always, Usually, Sometimes, Never, Don't Know or Not Sure)
	Sample question from a beneficiary survey: [6]
Do plans have adequate services and networks in place to continue providing community-based services?	# moved from the community to institutions following initial assessments [10]
Do beneficiaries continue to receive the same services?	% of beneficiaries who have lost any services they had received before [12]
Do beneficiaries continue to use community-based services?	% of LTSS enrollees served in the community at the time of transition and still served in the community three months later [13]
Are beneficiaries satisfied after the transition?	Sample question from a beneficiary survey: [14]
	<ul style="list-style-type: none"> Do the people who help you treat you the way you want them to? (Y,N) Do you like where you live? (Y,N)
	Sample question from a beneficiary survey: [15]
	<ul style="list-style-type: none"> My life is stable. (Y,N)

Sources:

- [1] Massachusetts Senior Care Options program
- [2] Massachusetts Financial Alignment Demonstration proposal
- [3] Washington State Financial Alignment Demonstration proposal
- [4] California SPD transition program
- [5] Michigan Financial Alignment Demonstration proposal
- [6] Minnesota’s *Survey of Your Reasons for Changing Health Plans*, April 2010
- [7] Medicare Part D Prescription Drug program
- [8] *Consumer Assessment of Healthcare Providers and Systems* survey question as used by the Massachusetts Senior Care Options program
- [9] New York State Department of Health’s *Managed Long-Term Care Member Satisfaction Survey*
- [10] Variation of measure currently used in the Medicaid home and community based services programs
- [11] See Lipson et al., *Keeping Watch: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports*, AARP Public Policy Institute, 2012.
- [12] Measure suggested by California stakeholders, See A. Lind, *Quality Measurement in Integrated Care for Medicare-Medicaid Enrollees*, Center for Health Care Strategies, 2013.
- [13] Illinois Financial Alignment Demonstration proposal
- [14] See The Hilltop Institute, *Medicaid Long-Term Services and Supports in Maryland: Money Follows the Person Metrics, a Chart Book, prepared for Maryland Department of Health and Mental Hygiene*, January 2011.
- [15] Wisconsin’s *Personal Experience Outcomes Integrated Interview and Evaluation System* survey

Transition monitoring activities

Direct observation is one technique that can be used to gauge program performance during transitions. For example, in monitoring managed care plans, states have relied on “secret shoppers” who pose as beneficiaries to obtain information about network adequacy or other aspects of plan operations. This type of observation can help state and plan administrators better understand how beneficiaries are treated in the transition process and whether their questions are answered adequately when they request assistance with enrollment or plan use. Other states send program staff to observe activities such as the needs assessment or care planning process.

Stakeholders note that the requirement for state officials to review and approve certain changes proposed by MCOs, such as plans for changes or reductions in services during the transition period or recommendations to move beneficiaries from community to institutional settings, is another important monitoring strategy.

The use of ombuds programs is often cited as an important component of managed LTSS performance monitoring efforts. In addition to helping beneficiaries resolve issues, ombuds program staff can identify systemic issues. Several states already have long-term care ombuds programs. Stakeholders note that if ombuds programs are to be effective during the transition period, they must be created with adequate funding and their responsibilities established before beneficiaries are enrolled in new programs.

*The legislature in **Wisconsin** created and funded an ombuds-program for non-elderly beneficiaries participating in LTSS programs; Disability Rights Wisconsin, the state’s protection and advocacy agency for people with disabilities, plays that role. Similar advocacy services are available for beneficiaries age 60 and older from the state’s Long Term Care Ombudsman program.*

***Ohio** specifies that the state’s existing Long-term Care Ombudsman program will play an expanded role as the Financial Alignment Demonstration is implemented. CMS will provide training and technical assistance related to the Demonstration, which places an emphasis on home and community-based services. The **Illinois** MOU indicates that the state intends to support an independent ombuds program in its Financial Alignment Demonstration.*

*The availability of extra resources to support the Ombudsman’s expanded role is not guaranteed, however. **Massachusetts** has sought implementation grant funding for an ombuds program in its Financial Alignment Demonstration.*

Advisory groups convened by the state or by plans to solicit input from beneficiaries or organizations that work with them can also play an important role in monitoring program operations during transitions, but stakeholders do not view these groups as particularly effective unless there is a mechanism to use feedback to improve program operations in a

timely manner. Timeliness is critical during transitions, and therefore, those familiar with the process recommend frequent meetings and the flexibility to quickly implement changes.

Beneficiary feedback can also be gathered by tracking the number of calls by topic that enrollment brokers or other assisting organizations receive. During the transition period, for example, questions regarding provider availability or changes in service plans can be tracked. Similarly, states can track and respond to grievances and appeals on particular topics.

Focus groups are another means of gathering impressions from beneficiaries.

*The **Massachusetts** Senior Care Options program requires that MCOs conduct surveys or convene focus group interviews with particular groups of enrollees: non-English speaking enrollees, people with physical disabilities, enrollees from a minority ethnic group, and family members or significant care givers.*

Independent beneficiary and family monitoring teams provide feedback in some instances. A beneficiary-led evaluation team model has been used in **Pennsylvania** and other states to conduct surveys or interviews with beneficiaries about the mental health services they receive.³³ A similar model could be used to assess transitions.

Using results from monitoring activities to improve transitions

Stakeholders stress that monitoring activities are useful but are of limited value if appropriate follow-up does not occur. Suggestions for program improvement based on monitoring results include the development of targeted training programs and changes in contract specifications as well as broader policy changes.

Support transition evaluation and monitoring activities

Even if states develop robust plans for measuring and monitoring program performance, inadequate resources may limit them.

*Recognizing the need for investment, **Illinois** indicates in its Financial Alignment Demonstration proposal that the state is hiring additional staff and buying new analytical tools to increase capacity to collect, track, and analyze program data.*

New York included an ombuds role in its Financial Alignment Demonstration proposal but made the staff position contingent on funding from CMS. **Washington** proposes to conduct beneficiary surveys at several points in the Financial Alignment Demonstration but notes that additional resources will be needed to accomplish this.

CONCLUSION

As states transition from FFS to a capitated managed care model for the coordination, delivery, and financing of Medicaid LTSS, there are several key policy and operational factors that stakeholders advise should be addressed to increase efficiency and minimize the disruption of much-needed medical and supportive services. To date, insights from states with operating capitated Medicaid managed LTSS programs as well as analyses of effective strategies for transitioning from FFS to risk-based capitated managed care are limited. An examination of current and proposed programs as well as conversations with a variety of experts suggest that the achievement of program goals depends in large part on practical details related to program design, policy, and operations.

Careful planning, early and ongoing participation by beneficiaries, sufficient time for implementation, and adequate financial support for transition activities increase the likelihood that a transition from FFS to capitated managed care will be successful and well received by beneficiaries and providers alike. Thus, attention to program and plan enrollment, information and assistance, service continuity, and performance measurement is critical in planning and implementing Medicaid managed LTSS programs for beneficiaries who rely on daily assistance from trusted providers. Since many of the transition strategies are untested and therefore cannot be considered best practices, experts recommend that states not rush to implement capitated Medicaid managed LTSS programs but instead move forward in a thoughtful, deliberate way. Stakeholders also recommend that states put in place as many beneficiary safeguards as possible to help assure smooth person-centered transitions. Further analysis of the process of transitioning from FFS to capitated managed care for Medicaid LTSS would be helpful given the number of beneficiaries who will be affected by the expected widespread expansion of Medicaid managed LTSS care programs in the near future.

This issue paper was prepared by Laura Summer, Senior Research Scholar, Georgetown University Health Policy Institute, Washington, DC for the Kaiser Family Foundation's Commission on Medicaid and the Uninsured. Special thanks to MaryBeth Musumeci and Erica Reaves of the Kaiser Commission on Medicaid and the Uninsured for their comments and review of this paper.

Appendix 1 State Managed Care Initiatives Cited in the Report

California: The *Bridge to Reform* Medicaid waiver expanded mandatory managed care for seniors and people with disabilities covered by Medi-Cal, the state's Medicaid program. The *SPD transition* program began in June 2011 and was phased in over a one-year period.

<http://www.dhcs.ca.gov/provgovpart/pages/waiverrenewal.aspx>

California: In October 2012, the Medicaid *Community-Based Adult Services (CBAS)* program, a managed care program, replaced the Medi-Cal Adult Day Health program, which provided similar services on a FFS basis. <http://www.dhcs.ca.gov/services/medi-cal/pages/adhc/adhc.aspx>

California: In March 2013, the state signed an MOU with CMS for a Financial Alignment Demonstration that will use a capitated payment model to provide all Medicare and Medicaid services to dually eligible beneficiaries. Enrollment in the demonstration will begin in October 2013 (*see link below).

Delaware: An amendment to the state's § 1115 waiver to create The *Diamond State Health Plan Plus*, providing Medicaid LTSS on a managed care basis, was approved in March 2012.

<http://www.dhss.delaware.gov/dmma/dshpplus.html>

Florida: The Florida *Long-Term Care Managed Care* program is one component of the state's *Medicaid Managed Care* proposal, which was submitted to CMS in 2011. It was approved in February 2013. http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml

Illinois: CMS and Illinois signed an MOU in February 2013 for a Financial Alignment Demonstration that will use a capitated payment model to provide all Medicare and Medicaid services to dually eligible beneficiaries ages 21 and over in five regions of the state. The anticipated date for enrollment is October 2013 (*see link below).

Massachusetts: *Senior Care Options* is a voluntary program that provides comprehensive services on a capitated basis for dually eligible beneficiaries ages 65 and over.

<http://www.mass.gov/eohhs/provider/insurance/masshealth/senior-care-options/senior-care-options-overview.html>

Massachusetts: CMS and Massachusetts signed an MOU in August 2012 for a Financial Alignment Demonstration that will provide comprehensive services on a capitated basis for dually eligible beneficiaries ages 21 to 64. Enrollment in the demonstration will begin in July 2013 (*see link below).

Michigan: The state has proposed a Financial Alignment Demonstration that will use a capitated payment model to all dually eligible beneficiaries (*see link below).

Minnesota: The *Minnesota Senior Health Options (MSHO)* program is a voluntary program that provides comprehensive services (with the exception of institutional LTSS that exceeds 180 days) on a capitated basis for dually eligible beneficiaries ages 65 and over

(http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionS electionMethod=LatestReleased&dDocName=id_006271). The state submitted a proposal for a

Financial Alignment Demonstration but has since indicated that it will pursue other administrative or programmatic alignment initiatives.

Appendix 1, continued
State Managed Care Initiatives Cited in the Report

New Jersey: The *New Jersey Comprehensive* Medicaid waiver, which expands existing managed care programs to include managed LTSS, was approved by CMS in October 2012.

<http://www.state.nj.us/humanservices/dmahs/home/waiver.html>

New York: In August 2011, the state included personal care services in managed care contracts. Previously, these services had been provided on a FFS basis.

New York: In August 2012, CMS approved a request to amend New York's Medicaid § 1115 Demonstration, entitled *Partnership Plan*, to establish a managed long-term care program, which expands mandatory Medicaid managed care enrollment to dually eligible beneficiaries.

http://www.health.ny.gov/health_care/managed_care/appextension/

New York: The state's proposal for a Financial Alignment Demonstration includes a component – the *Fully-Integrated Duals Advantage* Program, or FIDA – that will provide capitated managed care in eight counties for all services to full duals age 21 and over who require 120 or more days of LTSS, are not receiving state mental health facility services, and do not have a developmental disability. Two other components (not cited in this report) are also proposed for the Demonstration: a capitated program to provide services to dually eligible beneficiaries who have intellectual or developmental disabilities and a statewide managed FFS program that would integrate care through health homes for duals with two or more chronic conditions, HIV/AIDS and/or one mental health diagnosis, who are not receiving developmental disability or state mental health facility services, and who do not require 120 or more days of LTSS (*see link below).

Ohio: In December 2012, the state signed an MOU with CMS for a Financial Alignment Demonstration that will use a capitated payment model to provide all Medicare and Medicaid services to dually eligible beneficiaries. Enrollment in the demonstration will begin in September 2013 (*see link below).

Rhode Island: The state's proposal for a Financial Alignment Demonstration relies on a capitated payment model to provide services to certain dually eligible beneficiaries (*see link below).

Tennessee: *CHOICES*, which was established in 2010, is the program for LTSS operated by TennCare, the state's Medicaid program. The state also submitted, but has since withdrawn a proposal for a capitated Financial Alignment Demonstration (*see link below).

http://www.tn.gov/tenncare/long_choices.shtml

Texas: *STAR+PLUS* is a managed long-term care program for Medicaid beneficiaries piloted in one county in 1998 and expanded to include 10 multi-county service areas. Texas has also submitted a proposal for a capitated Financial Alignment Demonstration (*see link below).

<http://www.hhsc.state.tx.us/starplus/Map.pdf>

Washington: The *Medicaid Integration Partnership* integrates all services using a managed care model. The state has also been at the forefront of providing community-based LTSS.

<http://hrsa.dshs.wa.gov/mip/index.html>

Appendix 1, continued
State Managed Care Initiatives Cited in the Report

Washington: CMS and Washington signed an MOU in October 2012 for the managed FFS model for the use of Health Home Coordinators for dually eligible beneficiaries. A capitated model of care delivery in certain counties has also been proposed; the proposal is still pending.

Enrollment in the managed FFS demonstration will begin in July 2013 (*see link below).

Wisconsin: The *Family Care and Family Care Partnership* programs are integrated health and long-term care programs for the Medicaid's frail elderly and people with disabilities. The Partnership program covers Medicare services as well. <http://www.dhs.wisconsin.gov/ltcare/> and <http://www.dhs.wisconsin.gov/wipartnership/>

Wisconsin: *IRIS – Include, Respect, I Self-Direct* – is Wisconsin's self-directed supports program for older people and adults with disabilities (<http://www.wisconsin-iris.com>). The state also has submitted a proposal for a capitated Financial Alignment Demonstration (*see link below).

*Link for Financial Alignment Demonstration proposals and MOUs:

<http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html>

Endnotes

¹ P. Saucier, J. Kasten, B. Burwell, L. Gold, *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update*, Centers for Medicare and Medicaid Services, July 2012, available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf.

² E. Reaves and K. Young, *Medicaid's Role in Meeting the Long-Term Care Needs of America's Seniors*, Kaiser Commission on Medicaid and the Uninsured (January 2013), available at <http://www.kff.org/medicaid/8403.cfm>.

³ In some states, the number of beneficiaries who can be served in the community is limited.

⁴ Saucier et al., July 2012.

⁵ *Ibid.*

⁶ *Ibid.*

⁷ This total represents the number of states that had completed planning documents and submitted formal proposals or waiver applications to CMS as of June 2012, as reported in Saucier et al., July 2012.

⁸ Under Section 1115 of the Social Security Act, states can apply to CMS for waivers of certain Medicaid requirements and permission to use federal Medicaid funds in ways that are not otherwise allowable under federal rules. This authority is for experimental, pilot or demonstration projects that are likely to assist in promoting the objectives of the Medicaid program. For more information, see Kaiser Commission on Medicaid and the Uninsured, *An Overview of Recent Section 1115 Medicaid Demonstration Waiver Activity* (May 2012), available at <http://www.kff.org/medicaid/8318.cfm>. States may also establish Medicaid capitated managed LTSS programs using a combination of Section 1915(b) enrollment authority with Section 1915(c) home and community-based service waiver authority.

⁹ Pursuant to new authority under Section 1115A of the Social Security Act, CMS is offering states the opportunity to test two models to better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health and LTSS for dually eligible enrollees. A total of 26 states submitted demonstration proposals in spring 2012. As of March 2013, CMS had signed Memoranda of Understanding with five states: California, Illinois, Massachusetts, Ohio, and Washington. Two states (New Mexico and Tennessee) have withdrawn their proposals. Two others (Minnesota and Oregon) have indicated that they will pursue other programmatic or administrative alignment. The other proposals remain pending (Washington's managed fee-for-service model was approved, and its capitated proposal is still pending). For more information, see Kaiser Commission on Medicaid and the Uninsured, *Explaining the State Integrated Care and Financial Alignment Demonstrations for Dual Eligible Beneficiaries* (October 2012), available at <http://www.kff.org/medicaid/8368.cfm>.

¹⁰ CMS, *Medicare-Medicaid Enrollee State Profile, The National Summary* (2012), available at http://www.integratedcareresourcecenter.com/PDFs/National_Summary_Final.pdf.

¹¹ In spring 2011, CMS awarded design contracts of up to \$1 million to 15 states to develop service delivery and payment models to integrate care for dual eligible beneficiaries. States that received a design contract and finalize an MOU with CMS to implement a financial alignment demonstration are eligible to apply for grant funding of \$1 million to \$15 million for implementation activities over two years.

¹² In Medicaid, the term "managed care" may refer to different types of arrangements: 1) fully risk-based capitated systems in which MCOs contract with states to provide a comprehensive package of benefits. The state pays a per-member-per-month premium to the plan; 2) primary care case management programs, which pay certain primary care providers a monthly case management fee for a group of patients assigned to them; and 3) non-comprehensive prepaid health plans that are at risk for providing specific types of services. For more information, see K. Gifford, V. Smith, D. Snipes, J. Paradise, *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*, Kaiser

Commission on Medicaid and the Uninsured (September 2011), available at <http://www.kff.org/medicaid/8220.cfm>.

¹³ J. Connolly and J. Paradise, *People with Disabilities and Medicaid Managed Care:*

Key Issues to Consider (February 2012), available at <http://www.kff.org/medicaid/8278.cfm>.

¹⁴ The 17 programs are located in 16 states. Minnesota, which operates two programs, has one voluntary and one mandatory program.

¹⁵ Saucier et al., July 2012.

¹⁶ Federal Medicaid rules stipulate that if states mandate enrollment into managed care programs, enrollees must have one opportunity to change plans within the first 90 days of enrollment as well as an annual opportunity to change plans and they may disenroll for cause at any time. 42 CFR § 438.56(c).

¹⁷ T. Coughlin, S. Long, T. Triplett, S. Artiga, B. Lyons, R. Duncan, and A. Hall, *Florida's Medicaid Reform: Informed Consumer Choice?* *Health Affairs* 27, no.6 (2008).

¹⁸ CMS, *Guidance for Organizations Interested in Offering Capitated Financial Alignment Demonstration Plans*, Letter to Organizations in Interested States, January 25, 2012.

¹⁹ B. Wunsch and K. Linkins, *A First Look: Mandatory Enrollment of Medi-Cal's Seniors and People with Disabilities into Managed Care*, California HealthCare Foundation, August 2012.

²⁰ Medicare Payment Advisory Commission, Letter to the Centers for Medicare and Medicaid Services regarding CMS demonstrations with states on integrated care programs for dual-eligible beneficiaries, July 11, 2012.

²¹ B. Wunsch and K. Linkins, August 2012.

²² *Ibid.*

²³ *Ibid.*

²⁴ CMS, *Funding Opportunity Under the Affordable Care Act to Support SHIP and ADRC Options Counseling for Medicare-Medicaid Individuals in States with Approved Financial Alignment Models*, Office of Public Affairs, August 23, 2012.

²⁵ See <https://www.grantsolutions.gov/gs/preaward/previewPublicAnnouncement.do?id=16200>

²⁶ B. Wunsch and K. Linkins, August 2012.

²⁷ S. Samis, A. Detty, M. Birnbaum, *Implementing Long-Term Care Reform in New York's Medicaid Program*, United Hospital Fund, February 2012.

²⁸ See, e.g., 77 Fed. Reg. 28362, 26371 (May 3, 2012); 77 Fed. Reg. 26828, 26855 (May 7, 2012).

²⁹ B. Wunsch and K. Linkins, August 2012.

³⁰ Medicare Payment Advisory Commission, July 11, 2012.

³¹ For more information, see Kaiser Commission on Medicaid and the Uninsured, *A Guide to the Medicaid Appeals Process* (March 2012), available at <http://www.kff.org/medicaid/8287.cfm>.

³² See Disability National Committee for Quality Assurance, *Integrated Care for People with Medicare and Medicaid*, White Paper, March 2013, available at <http://thescanfoundation.org/national-committee-quality-assurance-integrated-care-people-medicare-and-medicaid-%E2%80%93-roadmap-quality>.

Rights Education and Defense Fund and National Senior Citizens Law Center, *Identifying and Selecting Long-Term Services and Supports Outcome Measures* (January 2013), available at <http://dredf.org/2013-documents/Guide-LTSS-Outcome-Measures.pdf>; A. Lind, *Quality Measurement in Integrated Care for Medicare-Medicaid Enrollees*, Center for Health Care Strategies (January 2013), available at http://www.chcs.org/usr_doc/Quality_Measurement_in_Integrated_Care.pdf.

³³ S. Plachta-Elliott and J. Delman, *Consumer-Led Evaluation Teams: A Peer-Led Approach to Assessing Consumer Experiences with Mental Health Services*, National Empowerment Center (June 2009), available at <http://www.power2u.org/downloads/CET-ReportByCQI.pdf>.

1330 G STREET NW, WASHINGTON, DC 20005
PHONE: (202) 347-5270, FAX: (202) 347-5274
WEBSITE: WWW.KFF.ORG/KCMU

This publication (#8433) is available on the Kaiser Family Foundation's website at www.kff.org.



The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.