Restructuring Maryland's Long-Term Care System:
Overview of Stakeholder Process and Discussion of Key Policy Issues

The Department of Health and Mental Hygiene (DHMH) is proposing to create a new Medicaid program, called CommunityChoice, to manage services for older adults and people with disabilities. The program would be mandatory for people who are eligible for both Medicaid and Medicare (the dual eligibles) and other individuals in need of long term care services. The CommunityChoice program would include all primary, acute, and long term care services, with the goal to integrate Medicare funding for dual eligibles.

Objectives

The objectives of the CommunityChoice program are to promote community-based long term care services, manage all health care costs, coordinate care, and establish accountability.

Promote community-based long term care services. Over the last few years, Medicaid has expanded home and community-based services. However, those services are still only available to a limited number of participants under very specific conditions and limitations. A new model of delivering services can create flexibility to offer any cost-effective community services to a greater percentage of Medicaid beneficiaries. Systemic financial incentives to provide alternatives to nursing home care will help support the State's *Olmstead* objectives and expand the array of services available to people who need long term care.

Manage all health care costs. The current system pays providers for providing specific services. There are no financial rewards for helping people stay healthy and independent. By changing the financing of services, we can create incentives to promote health, prevent unnecessary hospitalizations and nursing facility placements, and use the most cost effective means of care. Integrating Medicare and Medicaid services will help foster a continuum of care that offers the right service at the right time in the right place.

Coordinate care and establish accountability. By integrating the financing of health care services, community care organizations can help consumers and families navigate the maze of services, linking primary, acute, long term care, and social support services. Each organization will be accountable for delivering appropriate, high-quality services and will be required to develop a consumer-directed option for individuals willing and able to direct their own care.

Designing the Program

Designing a managed care program for long-term care recipients takes time and the involvement and collaboration of key stakeholders and State agencies. Decisions include: who will enroll in CommunityChoice; how will they do so; what services will be covered; how will community care organizations (CCOs) be paid; how will the quality of care be measured and monitored; how will we promote the delivery of more community-based services; and how do we structure the program to allow consumers more of a voice in how their care is delivered.

These are all important decisions that we need to consider before implementing a managed care program. Lessons can be drawn from our experience with HealthChoice, Maryland's managed care program for children, families, and individuals with disabilities who do not also qualify for

Medicare. Given the unique characteristics of this population and the goals of the program, however, considerable time and effort needs to be spent developing new tools and policies.

To begin discussions with stakeholders, DHMH has written short papers, outlining the issues and our initial thoughts on certain key topics. The papers are attached to this introduction. The titles and topics are as follows:

Paper	Key Questions Explored	Pages
Enrollment	• Who will enroll in the CommunityChoice program? • How will individuals enroll in CommunityChoice? • When CommunityChoice begins, how will we transition Medicaid recipients into CommunityChoice?	4-7
Benefits and Access to Services	• What services will be covered under the program? • How will DHMH ensure that there are enough providers? • How will the program integrate mental health services? • What rules will help ensure continuity of care for people entering the program?	8-12
Designing a Consumer Directed Program	• What populations will be covered under a consumer-directed program? • What services should be provided under a consumer-directed program? • What type of model is ideal for a consumer-directed program in Maryland? • What participant and CCO protections will be in place, and what level of State oversight is appropriate?	13-15
Quality Strategy	• How will participants be ensured access to high quality of care under CommunityChoice? • What are the components of the CommunityChoice quality strategy? • How will the quality strategy address consumer-directed care?	16-19
Financing and Payment System	• How will CCOs be compensated? • What methodology will the DHMH use to establish the payment rates? • What protections will exist for participants with high expenditures? • Will DHMH audit the CCOs' actual expenses?	20-25
Public Outreach	• How will Medicaid beneficiaries learn about their choices under the new program? • What parties will be involved in informing beneficiaries of their choices? • What rules will govern marketing efforts by CCOs?	26-27

DHMH is holding focused stakeholder meetings on the above papers between July 26 and 28. Some of the topics will be repeated during the three days to allow individuals with scheduling conflicts a chance to attend. The schedule and meeting locations are listed below.

Date	Time	Forum A (Room L-3)	Forum B (Room L-1)
Monday July 26, 2004	1:00	Introduction to Maryland's New Vision for Long-Term Care	Introduction to Maryland's New Vision for Long-Term Care
	1:30	*Break*	*Break*
	2:00	Enrollment	Benefits and Access to Services
Tuesday July 27, 2004	1:00	Enrollment	Designing a Consumer-Directed Program
	2:00	*Break*	*Break*
	2:30	Financing	Quality Strategy
Wednesday July 28, 2004	1:00	Quality Strategy	Designing a Consumer-Directed Program (**Location: Labs Auditorium**)
	2:00	*Break*	*Break*
	2:30	Public Outreach	

This will not be the only chance to provide comments. DHMH welcomes written comments and is planning on scheduling a second-round of stakeholder meetings in early to mid-September. Written comments should be directed to:

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Throughout the year, we anticipate holding regular stakeholder meetings to provide updates and to seek guidance from stakeholders as we refine the program's policies and procedures.

Thank you in advance for your willingness to participate in this exciting process. With your help, Maryland can transform its long-term care system. We look forward to your suggestions and support as we undertake this bold but necessary initiative.

ENROLLMENT

This paper explores the following questions:

Who will be in the CommunityChoice program?

How will people enroll in CommunityChoice?

When CommunityChoice begins, how will we transition Medicaid recipients into CommunityChoice?

Who will be in the CommunityChoice program?

The CommunityChoice will be a new Medicaid program to manage services for older adults and people with disabilities.

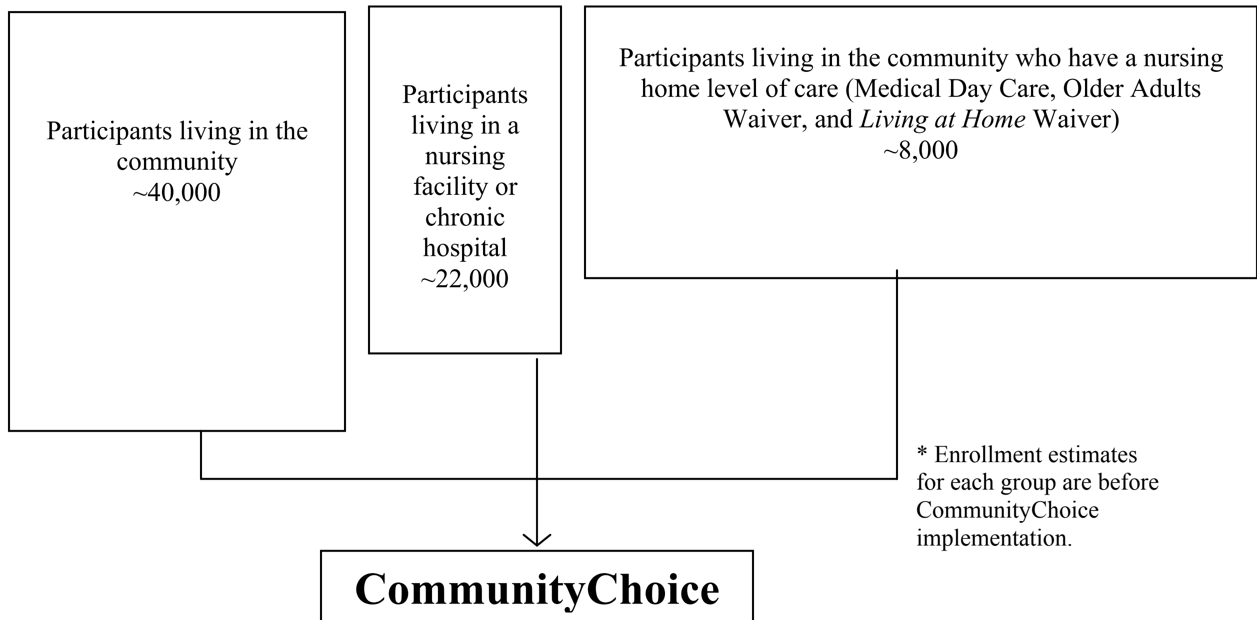
CommunityChoice will serve all Medicaid recipients who are:

- Age sixty-five and over, or
- Enrolled in Medicare, or
- Living in nursing facilities or chronic hospitals, or
- Qualified for a nursing facility or chronic hospital level of care (including people currently receiving community based long term care services such as Medical Day Care, Older Adults Waiver, *Living at Home* Waiver).

CommunityChoice will *not* enroll:

- Children under age twenty-one,
- Individuals enrolled in the Waiver for Individuals with Developmental Disabilities,
- PACE enrollees,
- People who are only eligible for Medicaid's cost sharing for Medicare services, (Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries),
- Individuals who are Medicaid eligible based on spend down.

Financial and medical eligibility rules will remain basically as they are today with some minor adjustments. This means that an older adult or person with disabilities who would quality for Medicaid today would more than likely also qualify for CommunityChoice. However, CommunityChoice enrollment may offer a broader range of services. Services will be discussed more in the Benefits discussion forum.



Will the Older Adults and *Living at Home* Waivers still be available?

The Older Adults and *Living at Home* Waivers provide community-based long term care service to many individuals who, without the waiver programs, would not be financially eligible to receive Medicaid benefits in the community. Under CommunityChoice we will continue to enroll individuals who meet the eligibility criteria for the existing waivers.

Additionally, we have applied to CMS to allow more liberal financial and medical eligibility standards for individuals applying for the Older Adults Waiver.

As with the Older Adults and *Living at Home* Waivers today due to budgetary constraints, we must continue to limit the number of participants that can be served (the "cap on the number of slots" will remain). Because demand for these services is greater than the available "slots," we will continue using a Waiver Services Registry so that individuals interested in waiver services may "save their place" until the State can accept new community applications.

Will CommunityChoice serve someone who becomes Medicaid eligible because they are living in a nursing home or chronic hospital?

Some Medicaid recipients only qualify for Medicaid services while living in a nursing facility or chronic hospital. This is because Medicaid's institutional financial qualifications allow a higher income than when someone lives in the community.

When an individual becomes Medicaid eligible while living in a nursing facility or chronic hospital, the participant must enroll in CommunityChoice and select a Community Care Organization (CCO). The CCO, working with the participant, will develop a plan of care that includes services that best fit the participant's individual needs. If the participant wants to move to the community, the CCO may use a broad range of community supports to help the participant transition from the nursing facility to the community when appropriate.

The waiver application to the federal government will request that individuals transitioning from a nursing facility or chronic hospital into the community maintain Medicaid eligibility and continue contributing to their cost of care. After returning to the community, the participant would remain in CommunityChoice as long as the participant continues to meet the program's eligibility criteria (including needing a nursing facility level of care). While in a nursing home and chronic hospital, many Medicaid recipients contribute to the cost of their care. CommunityChoice participants with incomes above a certain level may also be required to contribute to their care when receiving community-based long term care services.

How will participants enroll in CommunityChoice?

The Department of Health and Mental Hygiene (DHMH) is proposing to contract with an independent enrollment broker to administer enrollment in the program. The enrollment broker would have the responsibility of educating participants about their options and assisting them in selecting and enrolling in CCOs. When an individual is determined to be eligible for the program, the enrollment broker will send materials regarding each CCO available in the area so that he/she can choose a CCO. The information packet would include:

- The names and addresses of participating CCOs;
- A schedule of the benefits offered, including any benefits offered beyond the basic required package;
- A narrative description of the clinical expertise and experience of the CCO's network for special needs populations;
- Any forms necessary to select an CCO; and
- The toll-free telephone number of the enrollment unit (including a TTY number).

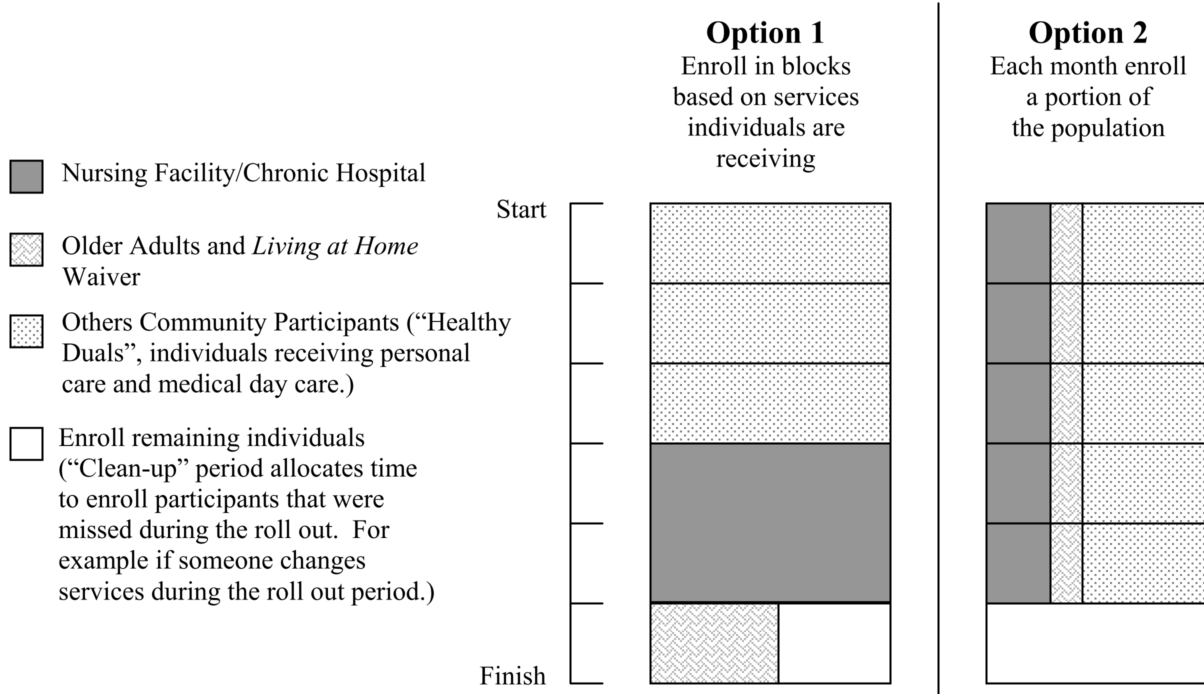
The enrollment broker will be available to assist with any aspect of the enrollment process. Individuals may enroll by mail, telephone, and through a face-to-face meeting, if necessary. Part of the enrollment process may include health risk assessments to identify services needed immediately by participants.

DHMH is proposing to give Medicaid beneficiaries more time to select a CCO than under the HealthChoice. (Under HealthChoice, beneficiaries have 21 days.) If the beneficiary does not pick a CCO, DHMH will choose one on the beneficiary's behalf.

On an individual level, the enrollment broker will provide the most effective means of personal and direct outreach, including face-to-face enrollment when necessary. In addition, the enrollment broker will take a proactive role to provide education and outreach activities at the community level. For example, since some Medicaid beneficiaries cannot or do not read written materials or may not attend an informational session, the enrollment broker will conduct outreach to social service and community organizations who interact with beneficiaries. In addition to outreach conducted by the enrollment broker, individual CCOs will conduct DHMH-approved outreach with their participants.

How will the State transition its current Medicaid recipients into CommunityChoice?

Approximately 70,000 current Medicaid recipients will be enrolled in CommunityChoice. We are considering a number of rollout options. Participants could be enrolled into CommunityChoice by random selection or based on services the individuals are currently using. Diagrammed below are two possible options.



Next steps:

- Develop a new Aged, Blind, and Disabled eligibility process.
- Identify a rollout plan taking into account:
    - Continuity of services
    - Administrative ease
    - Fiscal implications

BENEFITS AND ACCESS TO SERVICES

This paper explores the following questions:

What services will be covered under the program?
How will DHMH ensure that there are enough providers?
How will the program integrate mental health services?
What rules will help ensure continuity of care for people entering the program?

Introduction
Under a managed long term care system, a community care organization would receive a capitation rate in exchange for meeting the health and long term care needs of Medicaid beneficiaries. To a large extent, CCOs will have the flexibility to provide whatever services meet a participant's needs, even if those services are not currently offered under the fee-for-service Medicaid program. However, DHMH is proposing to require that certain services be included in each CCO's benefits package. These required services are listed below.

Primary care and acute care services
Physician services
Hospital services
Laboratory services
Prescription drugs
Disposable medical supplies
Durable medical equipment
Oxygen
Transportation
Home health
Hospice

Specialty mental health services
Inpatient psychiatric services
Medicaid-covered community mental health programs
Mental health prescription drugs

Long term care services
Nursing facility services
Chronic hospital services
Personal care
Medical day care

Augmented community support services (for people at nursing home level of care)
Case management/care coordination
Assisted living
Attendant care
Environmental assessments
Environmental accessibility adaptations
Assistive devices/technology
Behavioral consultation services
Respite care services
Personal emergency response systems
Consumer and family training
Dietician/nutritionist services
Senior Center Plus
Transition services
Home delivered meals

Augmented community support services are currently only available through the Waiver for Older Adults or the *Living at Home* waiver. These services will be an integral part of the new program, and DHMH is proposing to require that they be part of the benefits package available for participants who meet nursing home level of care and can be cost-effectively served in the community, not just those people who come from one of the two waivers. As is the case now, many benefits will have limitations. However, CCOs will have the flexibility to provide additional services to help participants stay in their own homes.

Under CommunityChoice, participants in certain income categories will still be responsible for contributing to the cost of their own care. For example, many nursing facility and assisted living residents currently contribute to their cost of care. In assisted living, participants are responsible for covering the room and board expenses, and additional income goes to offset costs. For people at higher income levels who may transition from nursing facilities to their own homes under CommunityChoice, DHMH may require a contribution to the costs of care after considering the costs of maintaining a home in the community.

For CommunityChoice participants who are also eligible for Medicare, many of the primary and acute care services listed above – including prescription drugs – will be covered by Medicare and subject to Medicare rules. To the extent that DHMH and CCOs can integrate the funding from Medicare and Medicaid, different coverage rules between the programs should become transparent to participants. Medicaid will cover any cost sharing requirements when Medicare is the primary payer of services.

Network adequacy standards

Before an organization can qualify to become a CCO, it must demonstrate that it can contract with a sufficient number of various types of providers. The providers who contract with the CCO are known as a network. DHMH will establish provider network standards to ensure that CCOs maintain a sufficient supply of providers to meet the needs and desires of participants, including timely access to the full complement of home and community-based service providers.

Selective contracting

In general, each CCO will be responsible for developing its own network of providers. The ability of a CCO to selectively contract with certain providers allows the CCO to exclude poor-quality providers and drive improvements in quality of care. However, networks must be broad enough to allow participants the opportunity to choose providers for certain services. There will be cases where DHMH will need to set rules regarding provider networks.

Special cases: nursing homes, personal care aides

Nursing homes. Nursing facility services are unique in two ways. First, the choice of nursing facilities is often driven by social factors, such as proximity to family or religious affiliation. Second, many individuals become Medicaid-eligible for the first time in their lives after residing in a nursing facility for an extended period of time. The nature of the relationship between CCOs and nursing facilities will need to recognize these two factors.

Proposal:

- When nursing facility placement is necessary, participants will have free choice of Medicaid-participating nursing facilities
- Nursing facility residents who become newly eligible for Medicaid may choose among any CCOs operating in the jurisdiction
- DHMH will regulate reimbursement rates for nursing facility services based on the fee-for-service methodology, but permit CCOs and nursing facilities to mutually agree to different payment rates
- CCOs may offer incentives for participants to choose certain nursing facilities as a means of encouraging the choice of high-quality, efficient nursing facilities
- CCOs may not involuntarily remove a resident from a nursing facility if that resident continues to qualify for services

Personal care aides. Personal care aides perform some of the most essential and intimate services for people with long term care needs. Today, Medicaid beneficiaries can receive personal care services through the state plan personal care program, the Waiver for Older Adults, or the *Living at Home* waiver. In each program, participants have the option to choose any provider that meets certain minimum qualifications. In the state plan program, providers cannot be family members of the beneficiary. Although some services are delivered through an agency, the vast majority of personal care aides are independent workers. (Features to support consumer direction of personal care services are discussed in a separate paper.)

DHMH will want to preserve a beneficiary's ability to choose a provider to perform personal care services. However, minimal credentialing standards are necessary to ensure that personal care providers are competent to provide quality services and do not have a history that may place the beneficiary in danger.

Proposal:

- DHMH will establish minimum qualifications for personal care providers (e.g., criminal background standards, etc.)
- CCOs may establish additional credentialing requirements for personal care providers, subject to DHMH approval
- CCOs must allow participants to choose any qualified personal care provider and allow the participant to change providers at any time
- CCOs cannot restrict choice to a certain network of providers
- CCOs will have the option to enroll a participant's family member (except the participant's spouse) as a personal care provider
- CCOs and/or DHMH will intervene in cases of neglect or abuse

Specialty Mental Health Services

DHMH proposes making mental health services an integral part of the CommunityChoice capitated long term care program. Participants would access primary and specialty mental health services through their CCOs.

Advantages of Increased Coordination of Mental and Physical Health. A primary goal of CommunityChoice is to overcome existing fragmentation of the current system. Coordination of mental and physical health is essential to promoting quality care for the CommunityChoice population. Mental health needs are prevalent and growing among the older adult population. One in five older persons suffer from a diagnosable psychiatric illness, and the number of persons aged 65 and older with a psychiatric disorder will more than double over the coming decades.[1]

Increased Detection of Mental Health Needs. Older adults suffering from mental illnesses often do not seek care from mental health professionals due to stigma they believe to be associated with receiving mental health care. They sometimes seek care from their primary care providers. However, primary care providers may not have the expertise needed to identify and treat mental health needs. It can be particularly difficult for primary care providers to diagnose mental health needs among older adults since their symptoms may not meet the full diagnostic criteria for depression or anxiety. The interplay among depression and behavioral symptoms with dementia and other cognitive conditions contributes to the challenges of identifying mental health needs among older adults. For example, detection of mental health disorders can be hindered by the fact that physical illnesses can imitate psychological problems.

Integration of physical and mental health care under CommunityChoice has the potential to address these challenges, for example by creating incentives for primary care providers to better screen for mental health needs in their patients, or by installing mental health professionals in primary care offices. Allowing participants to address mental health issues through their primary care providers may help to reduce stigma of seeking mental health care.

Better Management of Physical and Mental Comorbidities. Research shows that mental health management provided in a primary care setting is associated with better mental health outcomes than usual primary care.[2] Integration of physical and mental health care is important for individuals with diagnosed mental health conditions who have age-related onset of significant physical health conditions, such as heart disease or diabetes. Moreover, physical and mental health comorbidities can exacerbate one another.

> [Psychiatric] disorders can substantially impair functioning and can result in unnecessary hospitalizations and nursing home placement, poorer health outcomes, and increased rates of mortality. For example, older persons who suffer from depression have worse outcomes after medical events such as hip fractures, heart attacks, or cancer, and individuals who are age 75 and older have the highest suicide rate of any age group.[3]

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[1] Stephen J. Bartels, MD, MS. http://www.nami.org/. Forward to "Mental Health, Mental Illness, Healthy Aging: A New Hampshire Guidebook for Older Adults and Caregivers."

[2] Wells KB, Sherbourne C, et al. Impact of disseminating quality improvement programs for depression in managed primary care: a randomized controlled trial. JAMA 2000; 28;283(2): 212-20.

[3] Bartels, Foreward to "Mental Health, Mental Illness, Healthy Aging: A New Hampshire Guidebook for Older Adults and Caregivers."

Integrating and coordinating mental and physical health needs can be challenging regardless of the financing model. A capitated system that holds a single CCO accountable for the delivery of high quality physical and mental health care has the potential to reduce fragmentation and increase opportunities for coordination. CCOs will have the infrastructure to implement management or oversight tools, such as disease management programs, which promote high quality care and coordination.

Reduced Cost Shifting. CommunityChoice establishes the participant's CCO as the clear payer for both physical and mental health services. This reduces the potential for cost shifting among providers and agencies. For example, a participant who suffers from dementia, medical problems, and a psychiatric illness could access either medical day care or a psychiatric rehabilitation program (PRP). Under a model of separate mental and physical health payers, the CCO would have an incentive to deny medical day care and shift costs to the PRP program. Including mental health services under the capitated CommunityChoice model removes this incentive. Reduced cost shifting can also increase system efficiency by reducing the administrative burden associated with resolving cost shifting disputes.

Continuity of Care and Transition Plan

Some of the Medicaid beneficiaries who will enroll with a CCO are continuously receiving services from long term care providers such as personal care aides, medical day care centers, assisted living centers, nursing facilities, or mental health providers. For many of these individuals, any disruption in services could lead to negative outcomes. Therefore, it will be important to ensure that Medicaid beneficiaries transition smoothly into the new program.

One proposal would be that during the transition period, CCOs must reimburse for any services received by the participant before a plan of care can be developed and implemented. Reimbursement rates paid by the CCO to providers during this period would be based on existing Medicaid fee-for-service rates.

DESIGNING A CONSUMER-DIRECTED PROGRAM

This paper explores the following questions:

What model of consumer direction would be most feasible in Maryland?
What populations will be covered under a consumer-directed program?
What services should be provided under a consumer-directed program?
What participant/Community Care Organization (CCO) protections will be in place, and what level of State oversight is appropriate?

Introduction

A consumer-directed program enables individuals to make their own decisions regarding their long term care needs. A consumer-directed program is not one unique model of service delivery; rather, there is a continuum of approaches. The different approaches vary by the level of decision-making, control, and autonomy allowed.

The Department of Health and Mental Hygiene (DHMH) aims to design a consumer-directed model as a unique feature of the CommunityChoice managed long term care program. A number of states, including Arkansas, New Jersey, and Florida, have implemented consumer-directed programs (Cash and Counseling) in recent years. However, Maryland will be one of the first states to implement a consumer-directed option under a capitated system. DHMH believes that a consumer-directed program will provide older adults and individuals with disabilities with greater independence and autonomy in obtaining services, increase participant satisfaction, and improve access to services. DHMH will require participating CCOs to offer consumer-directed services as an option for certain participants.

Selecting a Consumer-Directed Model

DHMH envisions a consumer-directed program that allows consumers to manage their own services and hire, train, supervise, and pay their own paraprofessionals. Maryland already has established these concepts under its *Living at Home* Waiver. DHMH plans on building on these concepts and expanding this option to a broader population, not just home-and community-based waiver participants.

Within the consumer-directed vision, there are several ways that a consumer can direct care. While there is no single model for a consumer-directed program, an individual’s responsibilities *could* include some or all of the following: hiring his/her personal care assistant; training and supervising an assistant; determining a plan of care; managing a budget and handling payroll responsibilities; or reviewing performance of a personal assistant. A Cash and Counseling program is one type of consumer-directed program. The Cash and Counseling model enables individuals needing personal care or other home-and community-based services to direct their own care with a cash allowance.

Defining the Eligibility Criteria

Eligibility criteria will need to be established to specify which populations would be eligible for participation in the consumer-directed program. For example, any individual needing personal care may be eligible for the program, or alternatively, certain population groups may be phased-in over time (e.g. participants in the home-and community-based service waivers followed by other individuals needing personal care services). DHMH may limit the number of people who can enroll in the consumer-direction option initially until program success can be evaluated to determine the feasibility of future expansion.

There are currently approximately 5,400 individuals receiving personal care services in Maryland's Medicaid long term care system (including individuals in the *Living At Home* and Older Adults Waivers). There are 390 participants in the *Living At Home* Waiver, all of whom receive personal care services. Approximately one-third have chosen to participate in the consumer-directed care option. There are 2,800 participants in the Older Adults Waiver, of which 1,456 receive personal care services (most of the remaining individuals receive personal care through Assisted Living providers). Any enrollment limits will take into account that future utilization of personal care services may be higher than current utilization because CCOs will likely expand personal care as they provide more care in less costly home-and community-based settings.

Defining the Services

Personal care is the most common consumer-directed service, although other community care services like housing assistance, transportation, environmental modifications, and food services are sometimes cited as options for consumer-directed services. Decisions about which services are consumer-directed need to take into account cost-effectiveness and feasibility, including legal liability and safety issues.

Consumer direction for personal care services, for example, has shown to be cost-effective in previous studies. In the Cash and Counseling demonstration in Arkansas, it was found that while personal care expenditures rose initially, higher quality of care received through consumer direction has led to improved health outcomes, reducing the costs of nursing home care and other Medicaid services over the long-term[4].

Defining the Parameters

Individuals eligible for the consumer-directed program will be given the choice of whether or not to participate in the consumer-directed program. However, assessing individuals' ability to fully manage their care will be challenging. An process will be developed to screen eligible individuals for enrollment, taking into account their cognitive function and preferences for care. In the instance where a consumer is not able to direct his/her own plan of care, DHMH may allow a representative chosen by the consumer to assume these responsibilities.

[4] Dale, Stacy, et al. "The Effects of Cash and Counseling on Personal Care Services and Medicaid Costs in Arkansas." *Health Affairs*, November 19, 2003.

Participants will have the right to make informed choices about their care. DHMH and the CCOs need to ensure that enrollees are given accurate and sufficient information in order to make informed choices. Participants will also have responsibilities that they must be willing to assume. Policies and procedures related to participants' rights and responsibilities will need to be carefully balanced with CCO quality oversight standards and CCO protections. For example, if participants choose to hire their own personal assistants, DHMH would need to determine how much CCOs are held accountable for provider credentialing and quality.

The ability of a consumer to manage his/her own care and finances will vary from person to person. The CCOs' consumer-directed programs should be flexible enough to meet the different needs of individuals participating in the program. DHMH will need to determine the optimal level of supports that should be made available to participants within the consumer-directed program, e.g., whether consumers should be given direct access to cash allowances, or whether fiscal intermediaries or counselors should be made available to help manage budgets/payroll and plans of care.

Quality Assurance

One of the unique features of the CommunityChoice quality assurance program will be measuring the quality of care for participants who choose consumer-directed benefits. All quality assurance activities specific to consumer direction will be integrated into the overall CommunityChoice quality strategy.

Under the consumer-directed model, DHMH will need to balance the freedom of participants to manage their care plans with sufficient consumer protections. Assessment of consumer experiences and satisfaction with the delivery system will be essential. Ensuring safety in the community will also be vital. Methods need to be in place to detect and immediately address incidents of neglect, misuse of funds by the consumer or their proxy, and mistreatment. Whatever feedback or reporting mechanism that is established must be able to immediately address critical safety issues and concerns.

Next Steps - Building the Consumer-Directed Program

Communication and education issues warrant additional care when introducing the consumer-directed program to potential participants. In order to ensure adequate participant protections, DHMH may initially limit enrollment and services. Once DHMH and its partners are comfortable that the consumer and CCO protections are working appropriately, we will explore expanding the program to reach more individuals or to include additional services.

In the next couple of months, several important decisions about the model of consumer-direction (e.g. Cash and Counseling or a model similar to consumer direction in the current *Living At Home* Waiver), the populations that will be eligible for participation in the program, and the services that will be included will need to be made. In making those decisions, issues related to cost, feasibility, and phase-in will need to be considered. DHMH will need to pay special attention to the risks associated with implementing too broad a consumer-directed program too quickly. Many additional consumer direction policy issues will need to be discussed over the next year.

QUALITY STRATEGY

This paper explores the following questions:

How will participants be ensured access to high quality of care under CommunityChoice?
What are the components of the CommunityChoice quality strategy?
How will the quality strategy address consumer-directed care?

The Department of Health and Mental Hygiene (DHMH) will implement an aggressive CommunityChoice quality strategy to:

- Protect consumer access to services;
- Hold providers accountable for outcomes; and
- Promote cost-effective delivery of services.

The quality strategy must balance the State's and community care organizations (CCOs') responsibility to provide extra protections for services delivered in an individual's home with the desire for individuals to be independent and to freely control their service delivery. Development and implementation of the quality strategy will require consumer input in order to identify meaningful measures of CCO performance.

DHMH will work with its partners and contractors to design and implement an overall quality assurance program that is outcome-focused. Independent reviewers will ensure that the results of quality assessments are fair and objective.

DHMH's HealthChoice Quality Management Expertise

DHMH has a comprehensive approach for evaluating managed care organization (MCO) performance in HealthChoice, Maryland's statewide mandatory managed care program which serves most nonelderly, noninstitutionalized Medicaid beneficiaries. This approach involves numerous quality activities. HealthChoice was implemented in 1997 and provides health coverage to approximately 470,000 Marylanders. In January 2002, DHMH completed an extensive evaluation of HealthChoice. The evaluation found that HealthChoice had been successful in improving access while controlling costs, and had served as a platform for major program expansion.

The HealthChoice quality strategy provides a starting point for CommunityChoice quality. Many aspects of the CommunityChoice quality strategy will be similar to HealthChoice strategies. However, the CommunityChoice quality strategy will be tailored to (1) the different needs of older adults and people with disabilities, (2) the emphasis on services provided in the home, and (3) the focus on consumer direction.

The HealthChoice quality strategy looks at:

- **Access to Care.** The ability of patients to get needed services in a timely manner.
- **Quality of Care.** The ability of services to achieve desired health outcomes.
- **Administration.** The structure of the care delivery system that enables delivery of services.

Comprehensive CommunityChoice Quality Strategy
Contractors will assist DHMH and its partners with designing a comprehensive quality strategy. This includes defining measures of quality as well as establishing performance targets. We will also seek consumer input to identify outcomes that are meaningful to participants.

The quality strategy needs to be flexible to meet the evolving needs of the program. It must also include mechanisms for informing participants of quality review findings so they can make informed decisions about their care. Quality review findings may be shared with participants via enrollment broker mailings, postings on the DHMH website, or other methods.

Because some CCOs may also participate as HealthChoice MCOs or Medicare Advantage/ Medicare+Choice plans, quality requirements will be coordinated to promote efficiency and reduce administrative duplication.

The following are key areas for the development of quality activities.

- **Outcomes and Standard of Care Indicators**

  To develop outcome measures (e.g., reduced rates of hospitalization; rates of decubitis ulcers and falls in institutional settings) and standard of care indicators (e.g., comprehensive diabetes care), we will need to assess what measures are already collected in Maryland and nationally. In addition, it will be necessary to develop new measures for areas that are specific to CommunityChoice goals (e.g., percent of people meeting nursing facility level of care who are served in different community-based settings). The challenge will be to identify measures and available data to assess non-medical services provided in the community (e.g., successful maintenance of functional status over time), and to implement quality assurance for consumer directed services.

- **Care Plan and Care Coordination Standards**

  Assessment of the timeliness of care plan development and care coordination activities by care coordinators will be important to ensuring the quality of consumer directed care. DHMH will need standards for timeliness of the initial assessment of care plans (when required) and subsequent reassessment. There may be different standards for reassessment based on the social and clinical needs of different populations.

  Reviews of the content of care plans will provide key information on access, quality, and consumer involvement in care planning. Such reviews will allow for monitoring of services even with the flexible and individualized nature of home and community based services. Care plans will address coordination of (1) physical and mental health and (2) Medicare and Medicaid systems.

- **Consumer Satisfaction Surveys**

  Consumer experiences with the delivery system and consumer satisfaction are essential components of assessing CCOs. It will be necessary to go beyond

traditional mail and phone survey methods to get sufficient response rates and representative samples, particularly for older adults or people with disabilities. Survey questions will need to be sensitive enough to gain accurate assessments, and methods of administration must ensure that responses are unbiased. Early in the survey development, DHMH may hold focus groups with participants to get input on survey design.

- **Provider Satisfaction Surveys**

  DHMH will administer surveys to providers to learn about their experiences and satisfaction with the delivery system.

- **Provider Network Standards**

  Provider network standards will ensure that CCO provider capacity is sufficient for timely access to providers, including home and community based service providers.

- **Systems Performance Reviews**

  Required systems performance reviews will be conducted to ensure that CCOs have the infrastructure necessary to deliver high quality care to their enrollees. CCO systems reviews will be similar to HealthChoice system reviews, with some new areas such as home and community based service provider credentialing and access standards.

- **Complaint, Grievance, and Appeal Procedures**

  Consistent with federal requirements and as in HealthChoice, there will be an infrastructure of complaint, grievance, and appeal procedures for the protection of consumer rights. Enrollees not satisfied with complaint or appeal resolution by the CCO may file an appeal or grievance with DHMH. Enrollees not satisfied with the determination of the DHMH may pursue additional appeal rights.

- **Call Centers**

  DHMH maintains a participant call center, the HealthChoice Enrollee Action Line, to help HealthChoice members who are having trouble getting care and to track complaints and grievances. DHMH will have also have a participant call center for CommunityChoice to serve these functions. In addition, DHMH will have a CommunityChoice provider hotline.

- **Review of CCO Applications**

  Under a capitated program, DHMH needs to assure that only those organizations that can provide high quality care and are financially stable can qualify as CCOs. Reviews will be comprehensive and will look at: organization and operations; network access and capacity; financial solvency; quality assurance systems; and management information and data reporting systems.

Quality of Consumer-Directed Care

Quality activities specific to consumer direction will be integrated into an overall CommunityChoice quality strategy. Under the consumer-directed model, DHMH will need to balance the freedom of participants to manage their care plans with sufficient consumer protections. Assessment of consumer experiences and satisfaction with the delivery system will be essential. To ensure safety in the community, processes need to be in place to detect and immediately address issues of neglect and mistreatment.

Next Steps

DHMH and its partners will outline a quality strategy in compliance with federal requirements for submission with the CommunityChoice waiver application. Details of the quality strategy will be further developed with subsequent stakeholder input.

FINANCING AND PAYMENT SYSTEMS

This paper explores the following questions:

- *How will Community Care Organizations (CCOs) be compensated?*
- *What methodology will the Department of Health and Mental Hygiene (DHMH) use to establish the payment rates?*
- *What protections will exist for participants with high expenditures?*
- *Will DHMH audit the CCOs' actual expenses?*

Introduction

In an effort to restrain the current expenditure growth and improve services, Maryland seeks to contract with CCOs and pay them a capitated rate for managing the care and providing services to seniors and individuals with disabilities.   To do so, Maryland needs approval from the federal government to operate a managed care program under waiver authority. Under a federal waiver program, states must demonstrate that high quality care can be delivered to recipients in a managed care setting at a cost at or below that of traditional fee-for-service. Maryland believes greater flexibility will exist under a capitated program to provide long-term care in less costly home and community-based settings, while controlling long-term care expenditures.

Setting capitation rates, however, is complex. While Maryland's capitation payments need to be more cost-effective than its fee-for-service expenditures, they cannot be so low that they create problems regarding access or provider reimbursement. The most challenging problem facing Maryland is how to translate its fee-for-service reimbursement structure to a prepaid monthly capitation rate. The long-term care population's cost varies significantly depending on both the level of need and site of care, *i.e*., institution or community. Maryland's rate-setting methodology must capture these cost variations using current fee-for-service data and tools.

Risk Adjustment

A risk adjustment methodology brings payments closer to participants' expected expenditures. Effective risk adjustment of the capitated, long-term care program will allay concerns among payers that adverse selection of participants, *e.g.,* participants who are too frail or sick to be cared for in the community, will not lead to underpayments or financial insolvency. In addition, effective risk adjustment will encourage plans to treat participants in the most appropriate setting based on their needs.

Variations in functionality will help estimate the likelihood of whether or not the individuals can be cared for in the community or in the nursing home. Functionality means an individual's ability to perform basic activities of daily living, *e.g.,* eating and meal preparation. CCOs that opt to provide services to individuals in the nursing home when those same individuals could be served in the community should incur a financial loss. CCOs that prevent individuals from entering the nursing home or are transitioned from the institutional setting into the community, however, should make a reasonable profit. Maryland seeks a payment structure that facilitates movement towards home and community-based services, when appropriate.

Maryland's level of care tool is one of the tools DHMH may consider using to measure functionality. The level of care tool determines whether an individual is nursing home eligible. Today, not all Medicaid recipients who would be eligible for this program receive a level of care evaluation. The level of care tool is used only to determine whether an individual should be cared for in an institutional setting or whether that person qualifies for medical day care or one of Maryland's home and community-based waiver programs. It is a yes or no decision. In order to be used in the rate-setting process, the level of care tool needs to determine differences in functionality. Within the rate-setting methodology, a standard would also need to be established to decide which populations need a level of care assessment. Linking the level of care tool to expenditures may not be possible for the first couple of years. The two data elements are not currently linked, and it may prove too difficult to link retroactively. Initially, DHMH may need to rely more on diagnoses to distinguish differences in functionality.

DHMH needs to be careful that expenditures do not explode as a result of using the level of care tool to determine payment rates. Many participants who might be nursing home eligible today do not seek out a level of care determination, since the community services offered today are limited. Once CCOs improve the community services available, there is the potential that individuals who are in the community will "come out of the woodwork" and start asking for services that currently are being provided by family and friends at no cost to the State. Similar to the fee-for-service program, protections will need to be established, such as service limitations. Protections also need to exist to prevent CCOs from unnecessarily seeking level of care determinations simply to get a higher payment rate.

In addition to functionality, Maryland needs to explore additional ways to categorize the eligibility groups into risk categories, such as age, sex, or geographic area.

Integration with Medicare

Because a large number of the enrollees will be dual eligibles, coordination between the Medicare and Medicaid programs will be important to managing expenditures and improving health outcomes. The federal government prohibits the mandatory enrollment of Medicaid beneficiaries in managed care organizations (MCOs) for Medicare-covered services. Maryland seeks to explore opportunities to better integrate and coordinate the two plans. In the absence of the federal government allowing us to integrate the two plans, Maryland plans to encourage recipients to enroll in a Medicare Advantage plan by mandating that CCOs are also licensed as a Medicare Advantage plan. The tremendous cost savings available from integrating Medicare and Medicaid benefits under one plan may prompt CCOs on their own to offer incentives to participants who select their plan to provide both Medicaid and Medicare services.

The rate setting methodology will need to remove any incentives for cost shifting and duplication of services. The more Medicare and Medicaid are integrated, the more effective a CCO can be at improving health status, saving money, and reducing the dependence on nursing homes. A key area for coordination will be pharmacy services. When Medicare takes over pharmacy benefits for dual eligibles in 2006, the CCOs will lose a significant tool for coordinating and managing enrollees' care. Prescription drugs have taken an increasing role in the delivery of health care.

Through rate setting, Maryland will encourage plans to gain access to pharmacy data and incorporate it into their care coordination process.

Key Steps In Establishing Capitation Rates

Maryland needs to develop a rate-setting methodology and set capitation rates for the program. This is not something DHMH can develop on its own. It will need the assistance of the University of Maryland at Baltimore County (UMBC) as well as an outside actuarial firm. UMBC has been instrumental in assisting DHMH with developing the capitation rates each year for HealthChoice, Maryland's managed care program for children, families, and individuals with disabilities who are not also covered under Medicare. Similar to our experience with HealthChoice, we anticipate that the rate methodology will need considerable refinement once there is actual experience with the program. Many of the key steps outlined below, therefore, will need to be repeated each year.

Defining the Goals

The first task will be to clearly define our goals for the rate-setting methodology. One of our primary goals will be to develop a payment methodology that is actuarially sound and promotes home and community-based services and care.

Researching Other States' Programs

A number of states, such as Wisconsin, Arizona, Texas, and Minnesota, already have managed long-term care programs. Maryland needs to assess and evaluate existing rate-setting methodologies to identify lessons learned and any transferable elements to Maryland's stated goals. Two key areas of interest are how other states have promoted a community-based model under capitation rates and have risk-adjusted rates to appropriately reimburse CCOs based on level of need.

Establishing the Financial Baseline

Once the population to be served under this program is defined, DHMH needs to begin estimating expenditures and determining how to segment the population into different risk categories. Expenditures will go beyond the typical costs of hospitalizations and physician services and include personal care and more community supportive care.

Maryland anticipates that at least two separate risk categorizations will be needed: one for dual eligibles and a second for Medicaid-only recipients. Maryland's existing data will provide the foundation for these analyses. As a point-of-comparison regarding how complicated and how much work this will entail, there are 84 different risk-adjustment levels for the HealthChoice population.

The risk categories and expenditures should differentiate participants who are required to pay towards the cost of their care. When nursing home residents' resources are too high to qualify for Medicaid, they may become eligible by using their excess resources to contribute to the cost

of their care. Maryland wants these same individuals to maintain their eligibility if they are transitioned into the community. To do so, however, DHMH must obtain special permission from the federal government. A condition of approval will be that Maryland requires that participants' excess resources be applied towards their community housing expenses and care. These cost sharing arrangements should be reflected in the rates.

As stated earlier, the risk categories may take into consideration functionality, which should directly tie to how care should be delivered, *e.g.*, in a nursing home or in the community. Individuals who are too fragile to leave a nursing home should receive a higher capitation rate. Maryland knows, however, that nursing home eligibility is too narrow a category and that, as a result, it is necessary to identify different levels of need. An assessment of the functionality tools currently available must be conducted to determine what improvements are required and how to accurately incorporate functionality into the rate-setting calculations. A combination of functionality tools and diagnoses may need to be used to segment the population. Until we have properly linked our functionality tools with expenditures, diagnosis codes may need to be the primary tool used to segment the population. Similar to HealthChoice, the population most likely will be further segmented based on age, sex, and geographic location.

Ensuring these risk categories and baseline expenditures are correct is crucial to a successful program. Without them, CCOs will decide either to not participate or to exit the program quickly due to financial losses.

Trending Forward

The baseline expenditures need to be adjusted for anticipated cost changes in order to accurately reflect costs for the year in which services will be provided. In HealthChoice, the expenditure trends consider the growth in Medicaid expenditures in previous years as well as what is happening in the surrounding states and overall health care industry. These trends are not usually calculated at an aggregate level but rather on a service and eligibility group level.

The trends also need to consider program changes or whether there are any beneficiary cost sharing changes. For instance, in the fee-for-service program, beneficiaries are charged a fee for their prescription drugs. We need to make sure the baseline appropriately accounts for this cost sharing, since it may or may not be already accounted for in the fee-for-service data. An actuarial firm will need to calculate these trends and apply them to the baseline expenditures.

Program changes need to include changes in the fee-for-service reimbursement rates as well as whether new services are required. Ideally the rates would encourage and provide the flexibility to provide long-term care in less costly community settings without having to add additional services to the mandatory benefits.

Lastly, any savings from managed care need to be reflected in the baseline as well as the trends. Maryland needs to determine how much to discount the fee-for-service costs based on its managed care assumptions.

Estimating Profit and Administrative Costs

The capitation rates should provide a reasonable amount for the CCOs' administrative expenses as well as for them to obtain a small profit. Both of these levels should be based on what is required for an efficiently operating CCO. Given the health care needs of this population and DHMH's goal of mandating that CCOs offer consumer-directed care, more administrative money may need to be spent on coordinating care. For instance, under a consumer-directed program, enrollees may need guidance with their decisions or help paying providers. Administrative costs of paying bills are usually a fixed expense that cannot simply be shifted over to cover the operational costs of a consumer-directed program. These unique program differences need to be accounted for when establishing the administrative allowance in the rates.

Of course, Maryland needs to be cognizant that the rate-setting methodology does not allow for CCOs to achieve excessive profits. Any profit and administrative costs built into the rates still cannot exceed the overall cost of caring for this population in the fee-for-service program.

Auditing CCOs' Expenses

Once the managed care program becomes operational, Maryland plans on auditing and monitoring the CCOs' actual expenses. Standardized reports will need to be developed and submitted regularly, *e.g.*, quarterly. These reports should provide enough detail to assist with future rate setting calculations as well as to provide DHMH with timely data regarding what is driving certain expenditure trends by service type, eligibility group, or geographical area.

In HealthChoice, the Maryland Insurance Administration audits MCOs every five years. DHMH began doing audits when it became apparent that the fee-for-service data could no longer be used to set rates. Through the audits, Maryland not only establishes capitation rates, but it has also become a better purchaser of health care.

While Maryland probably will use its existing data for several years to establish the CCOs' capitation rates, it still believes there are significant benefits to conducting the audits. Since the administrative cost allocation will not be based on fee-for-service data, the audits will allow Maryland to make future adjustments. It also will assist in identifying areas that need more regulation or oversight.

Mandating Stop-Loss Insurance

DHMH will require that CCOs purchase stop-loss insurance. Stop-loss insurance protects plans from unusually large expenditures from any one participant. Once the CCO has paid out a certain dollar amount, the insurance pays the remaining covered expenses of the participant. This reduces CCOs' risk and ensures that high-cost participants will receive needed services.

DHMH allows plans under HealthChoice to either purchase stop-loss insurance through DHMH or through a private company. Once they decide to purchase insurance through a private company, however, they must continue to do so in future years. All but one plan purchase their stop-loss insurance from a private insurer. The small size and high cost of the population under

CommunityChoice may make it harder for CCOs to purchase insurance in the private market. DHMH will need to consider these factors when deciding whether to offer stop-loss insurance.

Establishing Future Rates

Many of the same steps outlined above also will need to occur in order to establish rates for the next service year. The baseline needs to be analyzed to determine whether new or different risk categories need to be added. New trend analyses also need to be completed, and a new calculation for administrative and profit levels needs to be performed. After eight years of operating HealthChoice, we still make changes to improve the risk-adjustment of the population and work with UMBC and an outside actuarial firm. Likewise, we will need the assistance of outside contractors to set rates for the CCOs in future years, working closely with program staff to coordinate data and manage program knowledge.

Next Steps

In our waiver application to the federal government, we are not required to have the actual capitation rates calculated. Before approving the waiver, however, the federal government, specifically the Office of Management and Budget, needs to evaluate the rates and determine whether the program is cost effective. In order to meet the start date of January 2006, therefore, DHMH needs to begin actively working on developing the methodology. As we further refine the methodology over the upcoming months, updates will be provided to interested stakeholders.

PUBLIC OUTREACH

This paper explores the following questions:

How will Medicaid beneficiaries learn about their choices under the new program?
What parties will be involved in informing beneficiaries of their choices?
What rules will govern marketing efforts by community care organizations (CCOs)?

Introduction

Under the new long term care system, Medicaid beneficiaries will have the opportunity to choose among multiple CCOs to meet their health and long term care needs. It is important that beneficiaries understand their options and have the information necessary to make an informed decision.

Enrollment broker

The Department of Health and Mental Hygiene (DHMH) is proposing to contract with an independent enrollment broker to administer enrollment in the program. The enrollment broker would have the responsibility of educating participants about their options and assisting them in selecting and enrolling in CCOs. When an individual is determined to be eligible for the program, the enrollment broker will send materials regarding each CCO available in the area so that he/she can choose a CCO. The information packet would include:

- the names and addresses of participating CCOs;
- a schedule of the benefits offered, including any benefits offered beyond the basic required package;
- a narrative description of the clinical expertise and experience of the CCO's network for special needs populations;
- any forms necessary to select an CCO;
- and the toll-free telephone number of the enrollment unit (including a TTY number).

The enrollment broker will be available to assist with any aspect of the enrollment process. Individuals may enroll by mail, telephone, and through a face-to-face meeting, if necessary. Part of the enrollment process may include conducting health risk assessments to identify services needed immediately by participants.

DHMH is proposing to give Medicaid beneficiaries more time to select a CCO than under the HealthChoice. (Under HealthChoice, beneficiaries have 21 days.) If the beneficiary does not pick a CCO, DHMH will choose one on the beneficiary's behalf.

On an individual level, the enrollment broker will provide the most effective means of personal and direct outreach, including face-to-face enrollment when necessary. In addition, the enrollment broker will take a proactive role to provide education and outreach activities at the community level. For example, since some Medicaid beneficiaries cannot or do not read written materials or may not attend an informational session, the enrollment broker will conduct outreach to social service and community organizations who interact with beneficiaries. In

addition to outreach conducted by the enrollment broker, individual CCOs will conduct DHMH-approved outreach with their participants.

DHMH's public outreach activities will focus on educating Medicaid participants on their rights and choices under the new long term care system and developing materials to answer frequently asked questions (e.g., can I switch plans? can I choose my nursing home? can I choose to leave my nursing home? how do I complain about not receiving the right services?) All outreach efforts should leverage the existing network of aging and disability resources. Special expertise from consumer organizations may be necessary to effectively communicate with hard-to-reach populations such as nursing facility residents.

Marketing
DHMH is proposing that CCOs not be permitted to engage in unsolicited individually targeted marketing to people who are not participants, and will not be permitted to offer material or financial awards to induce enrollment. All CCO marketing efforts would be subject to prior approval from DHMH. However, to the extent permissible under federal regulations, DHMH will permit CCOs to market their Medicare health plan to their current Medicaid participants.

Upon enrollment, the CCO would be responsible for contacting the new participant and providing information on available services and providers, how to obtain services, and how to appeal any denials of services.