Executive Summary

- Historically, Medicaid Managed Long Term Care (MMLTC) struggled but...
- Innovations in program operations and the promise of budget predictability have significantly increased interest
- Integration of Medicare and Medicaid for people who are duals also is fostering interest in MMLTC
- According to literature, states with established programs generally receive positive consumer feedback, but evidence of cost savings is mixed
- Notable concern at federal and state levels about the pace of and process for new program development and implementation
Agenda

- Defining Medicaid Managed Long-Term Care
- Processes States Use to Adopt MMLTC
- Medicare and Medicaid Integration Using Managed Care
- Medicaid Managed Long-Term Care State Activity
- Models of Medicaid Managed Long-Term Care
- Overall Assessment of MMLTC – In the Literature
- Typical State Considerations for MMLTC Development

DEFINING MEDICAID MANAGED LONG-TERM CARE
MMLTC Is a Delivery Model States Use in Lieu of Fee-for-Service

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

Plan Rate Setting is a State Decision Point but must be CMS Approved

- Developing plan base rates
- Updating plan base rates
- Plan rates may be risk adjusted
- Hypothetical risk assessment approach

<table>
<thead>
<tr>
<th>Risk Marker</th>
<th>Risk Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male Age 32</td>
<td>0.22</td>
</tr>
<tr>
<td>ADL/IADL Needs</td>
<td>1.32</td>
</tr>
<tr>
<td>Asthma/COPD</td>
<td>0.96</td>
</tr>
<tr>
<td>Low cost dermatology</td>
<td>0.30</td>
</tr>
<tr>
<td>Total</td>
<td>2.80</td>
</tr>
</tbody>
</table>

- Or, may be updated using historical data and trending
Risk Sharing may Occur at the Plan and the Provider Network Levels

- State and Plan Shared Risk
- Plan Risk Bands
- Provider Risk Sharing
  - More typical for Medicaid managed acute care
    - Global
    - Specific Services
  - In MMLTC, less common

Cost Savings and Improved Coordination Were Key Drivers, Now all About Budgets

- 1970s: Sharp rise in Medicaid-related nursing facility costs; sparked lawmaker concern
- 1981: Congress created Medicaid Home and Community Based Services (HCBS) waiver program
  - HCBS grew quickly, but did not slow growth of Medicaid nursing home expenditures
- 1990s: States adopted Medicaid managed acute care programs, leading a handful of states to create MMLTC programs
- 2000s: Same motivations with the assumption that managed acute care savings can be replicated on in LTC

Source: Saucier, Paul, Brian Bunwell, and Kerstin Gerst, The Past, Present and Future of Managed Long-Term Care, prepared for the HHS Office of the Assistant Secretary for Planning and Evaluation April 2005.
### TYPICAL STATE PROGRAM DESIGN CONSIDERATIONS

Several Actions are Necessary When MMLTC is Under Consideration

<table>
<thead>
<tr>
<th>Strategic Options</th>
<th>Required Decision Points/Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• LTC provider and consumer advocate perspectives</td>
<td>• Mandatory versus Voluntary</td>
</tr>
<tr>
<td>• Study State Medicaid Managed Care landscape</td>
<td>• Scope of Capitated Benefits</td>
</tr>
<tr>
<td>• Current plan marketplace</td>
<td>• Target Populations</td>
</tr>
<tr>
<td>• Penetration rates</td>
<td>• Geographic Coverage</td>
</tr>
<tr>
<td>• Enrollment of ABD populations</td>
<td>• Payment Methods</td>
</tr>
<tr>
<td>• SNP</td>
<td>• Enrollment Authority</td>
</tr>
<tr>
<td>• Same as above but also state contracts with SNPs</td>
<td>• Quality Oversight</td>
</tr>
<tr>
<td>• Duals Demo or Letter of Intent</td>
<td>• Contract development</td>
</tr>
<tr>
<td></td>
<td>• Operational resources</td>
</tr>
</tbody>
</table>
FEDERAL AUTHORITIES AND PROCESSES STATES USE TO ADOPT MMLTC

States Have Several Development Options with Differing Submission Requirements

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

- **MMLTC and Medicare-Medicaid Integration**
  - Initially Social Health Maintenance Organizations (S/HMO) and Section 222 Medicare Waivers
  - Replaced by Medicare Modernization Act authority for Medicare Advantage Special Needs Plans (SNP)
  - Affordable Care Act Medicare-Medicaid Innovation Models
States Must Follow Federal and State Public Notice Requirements

- Federal rules for public notice and comment vary by authority
  - State Plan Option
  - Medicaid waiver
- New Section 1115 Waiver Transparency Rule
- State Administrative Code
  - Emergency Rulemaking Authority

States Are Integrating ACA and Other Options into MMLTC Programs

<table>
<thead>
<tr>
<th>ACA Option</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Money Follows the Person (MFP)</td>
<td>43 states and DC have MFP programs CMS Resource: <a href="http://info-nci.org/">http://info-nci.org/</a> State Interest*: Heavily leveraging to fund administrative infrastructure which may be used for a variety of HCBS expansion efforts</td>
</tr>
<tr>
<td>Aging and Disability Resource Centers (ADRC)</td>
<td>48 states have ADRCs Administration on Aging Resource: <a href="http://www.adrc-nea.org/">http://www.adrc-nea.org/</a></td>
</tr>
</tbody>
</table>
### THREE MODELS OF MEDICAID MANAGED LONG-TERM CARE

#### There Are Three Basic MMLTC Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Medicaid Services for Which Managed Care Contractor is at Risk</th>
<th>Medicare Services for Which Managed Care Contractor is at Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MODEL 1:</strong> Medicaid LTC Only</td>
<td>Home and Community Based Services (HCBS) Nursing Home Care</td>
<td>None</td>
</tr>
<tr>
<td><strong>MODEL 2:</strong> Medicaid-Only</td>
<td>HCBS Nursing Home Care Medicaid-Covered Primary Care Services Medicaid-Covered Acute Care Services Medicaid-Covered Pharmacy</td>
<td>None</td>
</tr>
<tr>
<td><strong>MODEL 3:</strong> Medicaid-Medicare Integration</td>
<td>HCBS Nursing Home Care Medicaid-Covered Primary Care Services Medicaid-Covered Acute Care Services Medicaid-Covered Pharmacy</td>
<td>Medicare Acute Care benefits Medicare Prescription Drug Benefit</td>
</tr>
</tbody>
</table>

Dual eligibles may also be enrolled in Medicare managed care and receive Medicaid LTC services in either FFS Medicaid, or in MMLTC Models 1 or 2.
MEDICAID MANAGED LONG-TERM CARE STATE ACTIVITY

By 2014, Approximately 23 States Likely will be Operating MMLTC Programs

Source: Cheek, M., et. al., On the Verge: The Transformation of Long-Term Services and Supports. AARP Public Policy Institute (February 2012); Personal Interviews with AHCA/NCAL State Executives
INTEGRATING
MEDICARE AND
MEDICAID

SNPs are MA-PD Plans but With Special Requirements

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

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

<table>
<thead>
<tr>
<th>Current Delivery System</th>
<th>Integrated SNP Delivery System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare and Medicaid administered by different units of government</td>
<td>Plans contract with CMS for Medicare Advantage services; state contracts for Medicaid MCO services</td>
</tr>
<tr>
<td>No vehicle for beneficiary health care information exchange</td>
<td>Care coordination provides assistance with service access, tracking, utilization management</td>
</tr>
<tr>
<td>Medicare and Medicaid cover some of same services but with different service definitions and limits</td>
<td>SNP gets capitated payments for duals from both Medicare and Medicaid</td>
</tr>
<tr>
<td>Medicaid covers key services Medicare does not</td>
<td></td>
</tr>
</tbody>
</table>

SNP Marketplace has a Mixed Outlook

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

- Affordable Care Act Changes
  - Pending changes in MA-PD Reimbursement
**Duals are a Significant area of Focus because of Costs and Acuity**

Source: Kaiser Family Foundation, The Role of Medicare for People Dually Eligible for Medicare and Medicaid (January 2011)

**New CMS Divisions**

- **AHCA Staff and Members Actively Been Working with These Offices**
  - Center for Medicare and Medicaid Innovation
    - Health Care Innovation Challenge funding
    - Innovation advisors program
  - Medicare-Medicaid Coordination Office
    - State Demonstrations to Integrate Care for Dual Eligible Individuals
    - Medicare Data for Dual Eligibles for States
    - Initiative to Align the Medicare and Medicaid Programs
    - Financial Models to Support State Efforts to Integrate Care for Medicare-Medicaid Enrollees
    - Reducing Preventable Hospitalizations Among Nursing Facility Residents
    - Integrated Care Resource Center Available to All States
In Terms of ACA Options, States are Most Heavily Focused on Duals

Massachusetts Programs Are Fully Integrated SNPs for Dual Eligibles

* Managed Fee-for-Service (MFFS)
OVERALL ASSESSMENT OF MMLTC – IN THE LITERATURE

MMLTC Program Evaluations Have Not Generated Conclusive Cost Savings

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

MMLTC Consumer Satisfaction Is Generally High

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


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

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

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

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### APPENDIX A: OVERVIEW OF ACTIVE STATES

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

<table>
<thead>
<tr>
<th>Program for All-Inclusive Care for the Elderly (PACE), 1983</th>
<th>Nursing facility (NF)-eligible individuals over age 55 who are eligible Medicare and Medicaid</th>
<th>All Medicaid and Medicare covered services</th>
<th>PACE State Plan Option (SPO) Voluntary program</th>
</tr>
</thead>
<tbody>
<tr>
<td>FL Frail Elder Option program, 1987</td>
<td>Medicaid beneficiaries eligible for NF care</td>
<td>All Medicaid covered services</td>
<td>1915 (a) SPO and 1915 (c) Waiver Voluntary program</td>
</tr>
<tr>
<td>AZ Long-Term Care System (ALTCS), 1989</td>
<td>Medicaid beneficiaries eligible for NF care</td>
<td>All Medicaid covered services</td>
<td>1115 Waiver Mandatory program</td>
</tr>
<tr>
<td>WI Partnership Program, 1995</td>
<td>Dual eligibles eligible for NF care</td>
<td>Began providing both Medicaid and Medicare covered services in 1999</td>
<td>222 and 1115 Waivers – Now SNP Voluntary program</td>
</tr>
<tr>
<td>MN Senior Care, 1997</td>
<td>Aged dual eligibles</td>
<td>All Medicaid and Medicare covered services</td>
<td>1915 (a) SPO &amp; 1915 (c) Waiver and SNP Mandatory program</td>
</tr>
</tbody>
</table>

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

| NY Managed LTC, 1997 | Medicaid beneficiaries eligible for NF care | Medicaid covered HCBS services, only: NF not included | 1915 (a) SPO & 1915 (c) Waiver Voluntary program |
| TX STAR+, 1998 | Medicaid beneficiaries NOT residing in NFs, but at high risk of institutionalization | All Medicaid covered services | 1915 (b) (c) Waiver Mandatory program |
| FL Diversion, 1996 | Aged eligible for NF care | All Medicaid covered services | 1915 (a) SPO & 1915 (c) Waiver Voluntary program |
| WI Specialty Services and Supports, 1998 | Persons with developmental disabilities | Medicaid financed behavioral health, developmental disability, and substance abuse services | 1915 (b) (c) Waiver Mandatory program |
| WI Family Care, 2000 | Medicaid beneficiaries with any LTC needs | Medicaid covered long-term care services only | 1915 (b) (c) Waiver Mandatory program |
| MA Senior Care Options (SCO), 2004 | Aged dual eligibles | All Medicaid and Medicare covered services | SNP and MassHealth Section 1115 Voluntary program |
| North Carolina, Piedmont Care, 2004 | Persons with developmental disabilities | Medicaid financed behavioral health, developmental disability, and substance abuse services | 1915 (b) (c) Waiver Mandatory program |
## Several States Recently Have Adopted MMLTC

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

### APPENDIX B: OVERVIEW OF MMLTC AUTHORITIES

23
Options for States to Use to Create MMLTC Programs (1)

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

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

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

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

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

4. Section 1915(b) and HCBS 1915(c) Combination Waiver
   - Permits states to provide LTC and HCBS in a managed care environment
   - Must demonstrate cost effectiveness and cost neutrality but does not have to be statewide
     - States apply for two separate waivers, which may be burdensome to renew

5. Section 222 Waiver and Medicare Advantage Special Needs Plans
   - Permits states to coordinate Medicare funding for the provision of services not typically covered under Medicare, such as LTC
   - Some states combined 222 waivers with other waivers or state plan options to provide MMLTC to dual eligibles
   - Phased out as of 2006 with establishment of Special Needs Plans (SNPs)
   - May see a return to Medicare waivers with new duals initiatives

Source: Centers for Medicare and Medicaid Services Waiver Website, available at http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp
Options for States to Use to Create MMLTC Programs (3)

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

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


Tennessee

CHOICES – Long-Term Care Integration Through Managed Care Organizations
CHOICES

- CHOICES is the Long Term Care Program of TennCare

- TennCare replaced the existing fee-for-service Medicaid delivery system with a managed care program in January 1994. (All non-LTC services delivered by the member’s Managed Care Organization)

CHOICES

- The Long-Term Care Community Choices Act of 2008 was passed unanimously by the General Assembly

- Fundamentally restructures the Medicaid long-term care system for the elderly and adults with physical disabilities in Tennessee
Legislation passed in 2008 puts long term care services under Managed Care delivery system

Goals
- Rebalance Long-Term Care Funding
- Increase Home and Community-based Services (HCBS)
- Improve Care Coordination Through Managed Care Organizations (MCOs)

Phased in implementation - 2010

CHOICES – Industry Efforts

Bill pushed by strong democratic governor through democratic legislature

Industry had no option but support and worked to mitigate negative impact

Several key compromises were negotiated
**CHOICES – Industry Efforts**

- The State Sets Medicaid Rates in accordance with SPA (not in legislation, but an agreement with the administration)
- Avoids individual negotiations for Medicaid rates with MCOs
- Avoids an arbitrary Medicaid rate cut or freeze by MCOs

**CHOICES – Industry Efforts**

- MCOs Must Contract With Any Willing Medicaid Provider For The First Three Years
- MCOs cannot choose among providers to contract
- Does not apply to facilities that previously opted out of the Medicaid program that come back in
- Does not apply to facilities decertified after CHOICES implementation; however, MCOs have been contracting with them when re-certified
CHOICES – Industry Efforts

- **Diversification Grants to Providers ($5 million)**
  - Funds to assist nursing homes expanding into HCBS
  - Only half the funding was distributed due to budget issues
  - Facilities that diversified are not reporting significant referrals to their HCBS

CHOICES – Industry Efforts

- **Assisted Living Limitations**
  - Language was included in the bill to ensure that MCOs could not transfer patients that would normally receive nursing home care to assisted care living facilities (ACLFs)
  - Patients cannot be admitted to an ACLF that require
    - 24-hour continuous care
    - Treatment for a stage III or IV decubitus ulcer
    - Physical or chemical restraints
CHOICES – Industry Efforts

- Prompt Payment Guidelines Were Included To Ensure Timely Reimbursement By MCOs (Not part of legislation, but part of MCO contract)
  - 90% of clean claims paid within 14-days
  - 99.5% of clean claims paid within 21-days

- Act Called For The Development of a New Acuity-Based Reimbursement System
  - Has not been pushed due to lack of funding
  - Ongoing discussions
Nursing Home Transition Program Established To Facilitate Movement Of Medicaid Patients From Facilities To HCBS

Some patients have transitioned home, but most facilities report that the numbers have not been significant. According to the facilities, those that have transferred home were for the most part appropriate placements.

Global Long-Term Care Budget

Nursing homes no longer have a separate line item in the budget. Opens up nursing home funding to be used to support HCBS.
CHOICES – Key Components

Single Point of Entry

Area Agencies on Aging and Disability were given the responsibility to serve as an informational resource for potential Medicaid patients. Has not significantly occurred as patients and families continue to seek help from nursing homes.

CHOICES – Key Components

Medicaid Eligibility Criteria

CHOICES Act gave TennCare the responsibility of developing Level of Care and continuous stay criteria for nursing home admission. Recent SPA calls for revision of LOC criteria.
CHOICES
What Have We Learned

- **State, not MCOs, Set Medicaid Rates**
  - Needs to be formalized in statute as players change over time

- **MCOs Must Contract With Any Willing Medicaid Provider**
  - Needs to be formalized in statute and not limited to a time period

CHOICES
What Have We Learned

- **Prompt Payment Guidelines**
  - Prompt payment guidelines have not been effective
  - Elements of a “Clean Claim” should be clearly defined to ensure that properly filed billings are paid
  - MCOs may deny claims for unsubstantiated reasons leading to increased Account Receivables
  - Clearly defined and all inclusive denial codes
CHOICES
What Have We Learned

- Single Billing System For Claims Submissions To All MCOs
  - Tennessee’s use of three different billing systems has resulted in confusion among providers and increased denials
  - Uniform billing format should be established for all MCOs

- Global Budget
  - Nursing homes should retain a line item in the budget
  - Failure to do so opens the opportunity to move funding to HCBS
CHOICES
What Have We Learned

- Quality Assurance and Improvement Strategies
- No real oversight of services for HCBS from MCOs or Survey Agency

Tennessee

CHOICES - Long Term Care Integration Through Managed Care Organizations