

# **Creating a Balanced Long-Term Care System: Organizational and Administrative Options**

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January 11, 2006

# Creating a Balanced System

- Our major LTC policy goal should be to close the gap between what we know about LTC and what we do—between knowledge and practice
- We know that older people vastly prefer home- and community-based (HCB) care to nursing home care.
- We have learned how to provide HCB care in a reasonably cost-effective fashion over the last 25 years, largely through the aging network of area agencies on aging and non-profit service providers.
- We also know that the need for LTC services will double by 2025.

# Creating a Balanced System (cont'd)

- What we do, however, is not consistent with what we know.
- Most states spend 80% or more of our public LTC dollars on nursing home care. States have used Medicaid waivers to fund the slow expansion of HCB services, which the DD community has expanded much faster.
- We know that consumers and their families support these programs and that they can be efficiently used to reduce nursing home use.
- We must, however, ensure adequate nursing home funding for quality of care.

# Creating a Balanced System (cont'd)

- The projected growth in the need for LTC services over the next several years means that we need to accelerate our efforts to close “the gap.” We cannot wait until the average baby boomer is 75 years old.
- The two approaches that probably give states the best chance of rapidly expanding their HCB programs and closing “the gap” are:
  - *consolidating administrative responsibility for all LTC financing and service delivery at the state and local levels (Oregon and Washington).*
  - *or implementing managed care strategies designed to administer all services and funding sources under a capitated rate structure.*

# Creating a Balanced System (cont'd)

- Oregon and Washington have successfully balanced their LTC systems with a “single agency” approach, which has given them the administrative capacity to expand HCB programs rapidly and contain the nursing home costs since the 1980s.
- Several states have implemented some form of managed LTC (MLTC), but only one (Arizona) has a statewide MLTC system and only 3% of all publicly funded LTC consumers are in MLTC.
- This percentage may increase rapidly with the introduction of special needs programs (SNPs), which are part of the MMA and the growing interest of a few managed care organizations in LTC.

# Brief Overview of MLTC Programs

- 1. Arizona (ALTCS, 1984).* Statewide, HMOs and county organizations, cost-effective (Weissert, 1997) increased HMO participation since 2000, single capitation rate for all Medicaid services, mandatory participation (24,000).
- 2. Texas (Star Plus, 1998).* One urban county (Dallas), expansion proposed, capitated primary, acute and LTC services with multiple rate cells, *but* nursing home coverage limited to one month, no rigorous cost-effectiveness data, mandatory (11,000).

## Overview of MLTC (cont'd)

- 3. *Wisconsin (Family Care, 2000)*.** Five counties (urban and rural), capitated LTC *only*, with two rate cells, operated by AN county organizations (AAAs), more cost-effective than FFS Medicaid waiver HCB services programs (less expensive and better outcomes, including consumer satisfaction levels, controlling for consumer characteristics—APS, 2005), eliminated waiting lists in the five counties, based on two organizational components (Aging and Disabled Adult Resource Center and Care Management Organization in each county) and rigorous/flexible case management, mandatory (7,000+). The premier AN MLTC program.
- 4. *New York (1997)*.** Multiple counties (mainly urban) capitated LTC only, multiple rate cells, operated by a range of private, nonprofit organizations (AN based), including four PACE sites, relatively cost-effective (positive outcomes), voluntary (7,000+).

# Medicare/Medicaid Managed Care Programs

5. ***PACE (1983, OnLok)***. Forty urban programs in 17 states, capitated primarily, acute, LTC services (Medicare and Medicaid blended rate, 2.3% times average Medicare rate), several studies have documented cost-effectiveness, organized around medical day care, multidisciplinary teams and limited number of members (300-500), voluntary (9,000)
6. ***Wisconsin (Partnership Program, 1995)***. Six counties (urban and rural), capitated Medicare and Medicaid primary, acute and LTC services (nursing home coverage limited to six months), multiple rate categories, voluntary (1,700)

## Medicare/Medicaid Programs (cont'd)

7. ***Minnesota (Senior Health Options)***. Ten counties, statewide in 2005/06, capitated Medicare and Medicaid primary, acute and LTC (nursing home coverage limited to six months, multiple rate cells, operated by three non-profit managed care organizations, cost-effectiveness compared to FFS is not clear (the most comprehensive evaluation (Kane, 2005) shows little difference, but the state claims lower costs), voluntary (4,000+).
8. ***Massachusetts (Senior Care Options, 2004)***. Statewide, capitated Medicare and Medicaid primary, acute and LTC services, multiple rate cells, operated by for-profit and not-for-profit managed care organizations, which must contract with AN agencies (AAAs) and providers in the network of aging services.
  - ***Access Points (ASAP)*** to provide care coordination in cooperation with the managed care primary care teams that oversee care plans. This appears to be a rather complicated, overlapping organizational structure designed to accommodate multiple purposes.

# Overview of MLTC (cont'd)

- 9. Florida (Frail Elder Option, 1987).** Two urban counties, capitation for all Medicaid services with three rate cells, one year nursing home coverage, cost-effective compared to other Medicaid HCB services programs due to relatively low capitation rate (limited nursing home coverage responsibility, voluntary (6,000+).
- 10. Florida (Diversion Program, 1998).** Several urban and contiguous counties, statewide in 2004/5, single capitation rate for all Medicaid services, permanent nursing home coverage responsibility, less cost-effective than Frail Elder Option and other Medicaid HCB services programs operated by aging network (AN) agencies, due to higher capitation rate to cover unlimited nursing home care and similarity of consumer characteristics.

# Overview of MLTC (cont'd)

- AN agencies can participate in diversion programs (2004 legislation) but managed care regulatory requirements (capital reserves, etc.) are barriers and there has been little participation.
- Two evaluations of Florida's Medicaid HCB services programs (2004 and 2005) indicate that the AN managed programs (Aged and Disabled Adult waiver, the Assisted Living waiver, and the Channeling program) serve essentially the same kinds of consumers (health and impairment profiles, caregiver availability, etc.)
- They generate similar or better outcomes (hospital and nursing home use) as the MLTC programs, but cost significantly less than Diversion programs and a little more than the Frail Elder Program.

# Overview of MLTC (cont'd)

- The relative cost-effectiveness of MLTC programs is largely a function of the capitation rate, which should be informed by accurate consumer, service, cost, and outcome data and rigorous analysis (Medicaid administrative and analytical capacities).
- The following tables show comparisons among new entrants to the HCB services programs and nursing homes.

# HCBS Waiver Comparisons

## 1999-2000 New Entrants

	Aged & Disabled Adult N=2,848	Assisted Living for the Elderly N=1,103	Channeling N=781	Nursing Home Diversion N=361	Frail Elder Project N=921	All Programs N=6,014
	Percent					
Race (White)	58	73	52	49	46	57
Gender (Female)	76	76	79	76	79	77
Caregiver available	47	12	63	61	48	44
Needing help with medications	58	91	75	70	77	70
Dementia diagnosis	34	59	42	29	38	37
Diabetes	33	20	26	37	26	29
Meets Nursing Home Diversion Criteria	37	54	36	56	43	41
	Mean					
ADLs needing some/total help (0-6)	2.8	3.3	4.1	3.9	3.7	3.3
IADLs needing some/total help (0-8)	6.3	7.4	7.0	6.7	6.8	6.7
Total Chronic Conditions	3.2	2.9	3.3	3.5	3.2	3.2
Months in Program	18.5	18.0	23.6	20.6	18.5	20.0

# Waivers v. Nursing Home New Entrants 1999-2000

	All Waivers	NHD	NH
Total Medicaid Claims	34814	55820	73382
Nursing Home Days	63	35	487
ADLs Requiring Some Assistance	2.26	2.63	2.54
ADLs Requiring Total Assistance	1.03	1.22	1.30
Chronic Health Conditions	3.17	3.52	3.43
Assistance with Bathing	86.88	86.98	94.97
Assistance with Dressing	74.02	72.85	80.39
Assistance with Eating	37.60	42.66	47.93
Assistance with Toileting	48.95	53.74	59.73
Assistance with Transferring	39.95	62.60	50.04
Assistance with Walking	41.52	66.48	40.49
Assistance with Medications	70.14	70.64	79.19
Available Caregiver	43.88	62.60	34.94
Incontinence	49.92	56.39	58.45
Dementia	37.19	29.17	44.21

# Waivers v. Nursing Home New Entrants 2000-2001

	All Waivers	NHD	NH
Total Medicaid Claims	38122	62497	72382
Nursing Home Days	39	21	487
ADLs Requiring Some Assistance	2.33	2.58	2.65
ADLs Requiring Total Assistance	0.83	0.98	1.06
Chronic Health Conditions	3.12	3.54	3.28
Assistance with Bathing	86.37	89.25	93.50
Assistance with Dressing	72.60	77.42	81.57
Assistance with Eating	32.64	35.48	44.84
Assistance with Toileting	46.75	50.54	64.88
Assistance with Transferring	38.98	50.54	46.31
Assistance with Walking	39.28	52.69	47.18
Assistance with Medications	68.48	67.74	93.77
Available Caregiver	41.35	62.37	31.97
Incontinence	46.23	52.22	57.71
Dementia	35.31	35.16	43.56

# HCBS Waiver Cost Comparisons

## 1999-2000 New Entrants

	<i>Coeff.</i>		<i>Coeff.</i>
<u>Constant</u>	1685.6000	<u>Pre-Waiver Experience</u>	
Died	-251.5360	PMPM Medicaid Total Claims	0.1953
Age	-9.1661	<u>Waiver Experience</u>	
Gender=Female	3.5791	PMPM Inpatient days	68.0945
Race=White	-15.3949	PMPM Outpatient claims	1.7554
Available caregiver	41.5254	PMPM Nursing home days	88.4947
Living in the Community	79.1064	<u>Region of the State</u>	
Meets NHD Frailty Criteria	80.8591	Ref.= Region 11 (Dade/Monroe)	
N of Chronic Health Conditions	0.8887	Region 1 (Western Panhandle)	-342.2300
<u>Chronic Health Problem</u>		Region 2 (Eastern Panhandle)	-416.4420
Dementia	30.1346	Region 3 (North Central)	-296.9750
<u>Waiver Program Enrollment</u>		Region 4 (Northeast)	-396.8410
Aged & Disabled Adult	-54.8412	Region 5 (Central Gulfcoast)	-292.9170
Assisted Living for the Elderly	229.1980	Region 6 (Tampa Bay area)	-266.4860
Channeling	87.9725	Region 7 (Orlando area)	-234.8580
Nursing Home Diversion	944.3810	Region 8 (Southwest)	-375.1890
Frail Elder Project	-130.0170	Region 9 (West Palm Beach area)	-230.4640
<u>Pre-Waiver Experience</u>		Region 10 (Broward County)	-208.7430
PMPM Medicaid Total Claims	0.1953		

# Enrollee Characteristics

- Although the programs are similar in terms of many of these variables, there are some notable differences. Enrollees in Assisted Living for the Elderly are more likely to be white compared to those in the three managed care programs. They are the least likely to have a caregiver available (12%) while two-fifths of those in Channeling and Nursing Home Diversion have a caregiver. They are the most likely to need help with medications (91%) and have a dementia diagnosis (59%).
- Aged and Disabled Adult enrollees are the least likely to need medication help and Nursing Home Diversion enrollees are the least likely to have dementia. They are also the most likely to have diabetes.
- Enrollees in Nursing Home Diversion and Frail Elder Project are the most likely to be hospitalized and have the highest PMPM inpatient days, holding all other factors constant, while enrollment in Aged and Disabled Adult, Assisted Living for the Elderly, and Channeling was associated with reduced inpatient days.
- In addition, each day of PMPM inpatient experience in the six-month period pre-enrollment was associated with 0.17 inpatient days PMPM after enrollment.

# Nursing Home Care

- In the model to explain PMPM nursing home days ( $R^2=0.40$ ; Table 5), Medicaid nursing home bed occupancy rates was associated with decreased nursing home use; being assessed in a nursing home or hospital increased the likelihood of nursing home use.
- Enrollment in Nursing Home Diversion or Frail Elder Project also increased the likelihood of experiencing nursing home care. Nursing home admission, however, is low across all HCB services programs.
- Higher inpatient or outpatient utilization was also associated with a greater likelihood of nursing home stay.

# Total Medicaid Claims

- The coefficients for enrollment in the five Medicaid HCBS programs describe the average difference in PMPM total Medicaid claims after controlling for all other variables ( $R^2=0.61$ ; Table 6).
- Among the five Medicaid HCBS programs, the savings or additional costs for each program range from a savings of \$130 (Frail Elder Project) to an additional cost of \$944 (Nursing Home Diversion) relative to the other four programs.
- The second highest relative cost is Assisted Living for the Elderly (\$229 a month), followed by Channeling (\$88 a month). The Aged and Disabled Adult program generates a small savings (\$55 a month).
- Partly in response to the findings reported here which were confirmed by a separate actuarial analysis conducted for the Department of Elder Affairs, the monthly capitation rate for Nursing Home Diversion was reduced from \$2,342 to a variable rate based on region of the state in January 2004. The rates range from \$1,699 in the Florida panhandle to \$2,231 for Miami and Monroe counties in south Florida. The average rate is \$1,881.

# Summary Observations

- Perhaps the most fundamental message conveyed by this overview is that the traditional aging network organizations who administer the HCB services Medicaid waiver have the demonstrated capacity to provide an array of community-based long-term care services efficiently.
- This does not mean, however, that aging network organizations can assume that the future of community-based long-term care will be a replication of the past.
- In many states, they are likely to be challenged by for-profit managed care organizations, which are increasingly prepared to administer long-term care through integrated plans.

# Summary Observations (cont'd)

- In response to this emerging challenge, aging network providers should seriously consider the development of their own not-for-profit managed long-term care programs designed to achieve greater efficiencies in the use of resources and improve the fit between consumer preferences and services provided.
- The aging network has demonstrated its value to elders and the larger community for over 30 years, but the future of the aging network in many communities may depend on its capacity to compete with for-profit managed care organizations in the administration of LTC programs, including nursing homes.

# Summary Observations (cont'd)

- One method of strengthening the aging network and maximizing its demonstrated capacity to administer LTC programs efficiently would be to create aging network-based managed long-term care systems that could include risk for nursing home care within the capitation rate as is currently done in the Wisconsin Family Care Program (Alecxi, Neill, Zeruld et al., 2002; APS, 2005).
- This initiative could begin with Area Agencies on Aging and aging network providers who are best prepared in terms of fiscal and administrative capacities, but could be gradually expanded based on the lessons learned from initial evaluations of these capitated rate programs.
- At a minimum, policymakers, taxpayers, and long-term care consumers are likely to benefit from a diversity of strategies to provide long-term care more efficiently over the next several years, including managed long-term care systems and the current fee-for-service approach where managed care strategies are not feasible (e.g., some rural areas)