



Expanding Publicly Financed Managed Long-Term Care Programs to Provide Greater Access to Home and Community-Based Care

Many states are actively designing and financing managed long-term care (LTC) programs. Capitated payment systems are a central feature of many of these programs, which in some cases integrate acute and LTC. In 1998, twenty states had at least one publicly-funded program with capitated LTC services, while five other states had plans to begin programs over the subsequent 12 months. Nevertheless, the number of individuals enrolled in these programs was still fairly small. In almost half of the states with programs that capitated at least some LTC, total enrollment was less than 500 people.¹ This policy brief draws on current research and expert opinion to highlight key issues and to identify strategies that state policymakers can use to expand publicly financed managed LTC programs for older people.

Key Issues for State Policymakers

Most states are still in the early stages of planning and implementing managed LTC. As policymakers decide whether to initiate or expand these efforts, several key questions emerge:

- What policy goals are of primary importance? To what extent do they focus on changes in finance and administration versus changes in care management or provision? Are they consistent

with efforts to expand home and community-based care options?

- Whom should managed LTC programs serve? Should enrollment be voluntary or mandatory?
- What services should be included in a managed LTC program? How will the role of current LTC providers change under managed LTC and what impact will this have on support for these programs?
- How should managed LTC programs be financed? Is capitated payment desirable and feasible?
- What policies should be adopted to ensure high quality care while allowing program managers the flexibility to match clients with a cost-effective set of services?

Local characteristics (such as service infrastructure, fiscal climate, provider influence and consumer activism) will shape and constrain state policymakers' choices in each of these areas.

Determine Goals

Two broad goals motivate efforts to initiate or expand managed LTC programs. Policymakers want to:

1. **Improve the quality of publicly funded LTC services.** Managed LTC programs are expected to better coordinate services typically administered by numerous entities in a fragmented delivery system. Managed LTC also could improve consumers' quality of life by introducing greater flexibility and choice into the delivery of services and by increasing access to a wide range of home and community-based services (HCBS).
2. **Increase fiscal predictability and constrain public expenditures on LTC.** Improvements in the coordination of care could increase the efficiency of service delivery and allow policymakers to maintain service levels at lower total cost. Capitated payment greatly increases fiscal predictability and gives risk-bearing organizations a strong incentive for efficiency. Capitated payment also gives the states a mechanism for constraining per capita expenditures.

To date, policymakers have tended to focus on program financing goals rather than on care process and client outcome goals.

Research Findings

The extant research primarily concerns qualitative aspects of program design and implementation. Research findings from existing initiatives – including the Arizona Long-Term Care System (ALTCS), On-Lok and Program for All-Inclusive Care for the Elderly (PACE) replications, and Social Health Maintenance Organizations (S/HMOs) – are somewhat mixed about the extent to which desired outcomes have been achieved.

- Arizona successfully de-emphasized institutional care through its managed LTC program. Data from an evaluation of ALTCS indicate that 41 percent of ALTCS members received HCBS in 1998 compared to only 7 percent in 1989.² The

emphasis on HCBS over institutional services in ALTCS appears to be cost-effective and the savings do not appear to be declining as the program matures.^{3,4} Compared with traditional Medicaid, costs were 16 percent less per year and had a lower rate of growth. Still, the same evaluation found that outcomes for individuals receiving nursing home care could have been improved.⁵

- Capitation under the PACE program appears to reduce acute care and nursing home utilization, but it is not clear that integrated financing of acute and LTC generates additional savings.⁶

- An early evaluation of S/HMOs suggested that they reduce the use of hospital services, although this finding was not statistically significant.⁷ A more recent comparison of S/HMO and TEFRA HMO⁸ enrollees from the same health plan found no evidence of overall savings associated with S/HMO membership and no evidence of successful substitution of S/HMO-specific services.⁹

- A review of the experience of the first four S/HMOs concluded that not enough effort was made to change the behavior of physicians participating in S/HMOs. The LTC benefit was not well integrated with the acute care benefit and care coordination did not happen to the extent hoped.¹⁰

Although capitation is an important component of most managed LTC efforts, giving a single organization the responsibility for managing a pool of dollars will not automatically lead to improved care coordination for individual clients. To improve coordination at the client level, state policymakers need to emphasize not only administrative and financial incentives of managed LTC programs, but also how care will be improved for the frail older people who enroll in these programs.

Managed LTC programs take a long time to design and implement and require a significant commitment of resources from states and providers. Savings most likely will not be realized soon after implementing a managed LTC program. States and organizations need to be flexible and keep a long-term perspective.

Determine Program Scale

Although PACE and S/HMO demonstrations are being replicated in increasing numbers and almost half of all states capitate at least some LTC services, the total number of individuals enrolled in these programs is still small. In addition to limiting the overall potential for savings and improvements in care, low enrollment in capitated programs presents problems in establishing a stable financial base. Economies of scale are needed to make programs more viable and appealing to providers. Some states, such as Texas and Arizona, have obtained federal waivers to make enrollment in managed LTC mandatory for Medicaid beneficiaries. Mandatory enrollment ensures managed LTC programs of a larger risk pool and reduces some of the inefficiencies associated with optional enrollment and disenrollment.

- In Arizona, where approximately 25,000 individuals are enrolled in ALTCS, tight control by the state over program eligibility and enrollment has been identified as an important reason why ALTCS is cost-effective.¹¹

- A review of S/HMOs found that the financial incentives for efficiency within the system were weakened by the fact that people could disenroll at any time.¹²

However, most states are expanding managed LTC more cautiously through voluntary programs

(see Table on page 4). Not only do voluntary programs ensure freedom of choice (something required for all Medicare benefits), these smaller “boutique” programs allow state policymakers to gain experience and expand managed LTC programs incrementally.

Program features clearly affect enrollment in voluntary programs.

- Requirements that participants in the original PACE program attend adult day health care 4 to 5 times per week and give up their freedom of choice of providers inhibited program enrollment according to the PACE evaluation.¹³

- In contrast, enrollment in the largest plan operating under New York State’s capitated Medicaid Long-Term Care program has surpassed enrollment expectations with faster enrollment and lower disenrollment than anticipated. Individuals who enrolled cited the flexibility of benefits (especially access to transportation) as one reason why they enrolled. Enrollees do not have to give up their primary care provider or attend adult day health care to participate.¹⁴

Marketing strategies also impact enrollment in voluntary programs.

- Although none of the first PACE sites met their original enrollment targets, in-person marketing was found to be a very important part of enrollment efforts.¹⁵

- The initial marketing strategy of the largest plan in New York State’s capitated Medicaid Long-Term Care program was to refer individuals already being served by the provider to its managed LTC program while building an external community-based client referral system. During the first year of operation, almost 90 percent of enrollees were from internal referrals.

TABLE: SELECTED MANAGED LONG-TERM CARE PROGRAMS

State	Program	Target Population	Capitated	Capitated Benefits	Voluntary or Mandatory	Approach to Medicare Benefits	Statewide?	Status	Enrollment
AZ	Arizona Long-Term Care System	nursing facility eligible elderly, physically or developmentally disabled	yes	Medicaid acute, long-term care, and mental health services	mandatory for Medicaid	usually coordinated on a FFS basis	yes	operating since 1989	approximately 25,000 enrollees
ME	MaineNet	elderly and adult disabled who are either SSI or dually eligible	no	none. Medicare and Medicaid services are coordinated on a FFS basis by a primary care case manager	voluntary	Medicare and Medicaid benefits are primary care case managed	no	state revised scope and goals of the program in 1989	not yet implemented
MA	Senior Care Options	elderly Medicaid, including dually eligibles	yes	Medicare and Medicaid services (including HCBS waiver services), which will be paid through separate capitation payments	voluntary	capitated through Senior Care Organizations (SCOs)	yes	the state and HCFA signed a Memorandum of Understanding in April 2000, affirming the commitment of HCFA and the state to the initiative with the goal of implementation in Jan 2001	not yet implemented
MN	Minnesota Senior Health Options (MSHO)	elderly dually eligible	yes	Medicare and Medicaid services including prescription drugs, HCBS waiver services, and 180 days of nursing facility care	voluntary	capitated through Medicare waiver	no	operating since 1997	estimated to reach approximately 4,000
NY	Medicaid Long-Term Care Capitation Program	elderly and adult disabled, including dually eligible	yes	all Medicaid long-term care services, including nursing home care, and prescription drugs, dentistry, podiatry and optometry	voluntary	Medicare benefits are not included in capitation. However, some physicians may be paid a monthly case management fee	no, but the state is expanding	program initiated with help of grant from the Commonwealth Fund; state is seeking to expand managed long-term care to 25,000 additional persons through 1997 legislation	enrollment thus far is limited, with the exception of one plan, which has enrolled approx. 2000
TX	Texas Star+Plus	elderly and adult disabled, who are either SSI or dually eligible	yes	primary and acute care (covered by Medicare for dual eligibles), in addition to a range of long-term care services (not including prescription drugs)	mandatory for Medicaid	provided on FFS basis or capitated through Medicare HMO or Medicare Choices MCO	no	program began enrolling individuals in November 1997	55,000 as of 2/00
PACE	Program for all-Inclusive Care for the Elderly	dually eligible individuals 55+ years and nursing facility eligible	yes	Medicare and Medicaid services, in addition to prescription drugs and HCBS waiver-like services (e.g., social services, extended personal care, and transportation)	voluntary	capitated through Medicare waiver	N/A	at On-Lok since 1983; replication sites since 1990	PACE operates in 25 sites nationwide; enrollment at the largest PACE site is under 1000
S/HMO	Social HMO	elderly Medicare, including dually eligible	yes	full range of Medicare HMO benefits (including prescription drugs), in addition to home and community-based care and a limited amount of nursing home care	voluntary	capitated through Medicare HMO	N/A	implemented in four locations in 1995; second generation S/HMOs mandated by Congress in 1990	59,000 (as of 1997)

State managed care experience and the level of commitment to managed LTC are key factors to consider when determining program scale. Strategies for achieving a minimum level of enrollment for financial viability should be included in the design of all voluntary programs.

Determine Financing and Service Delivery Arrangements

In designing managed LTC programs, state policy-makers are faced with several important decisions related to financing and service delivery. These decisions include:

- Who will assume financial risk in a capitated LTC system (e.g., a public or private entity? a for-profit or not-for-profit? an HMO, nursing home, home health agency, or other provider?)
- Which benefits will be included in the capitated payment?
- What financial incentives will managed care organizations (MCOs) be given and how will risk be managed while new MCOs build their financial base for these programs?

Coordinate or Integrate Financing?

Whether to capitate only LTC services or both acute and LTC services is a major decision with implications for program financing and design. The latter approach, in theory, offers the greatest potential for better coordination of the full range of services employed to meet elders' acute and LTC needs. However, states have encountered significant obstacles when attempting to integrate Medicare and Medicaid financing.

- It is difficult to obtain federal approval in the form of waivers to combine Medicare and Medicaid funds in a single, state-administered system.

- LTC and consumer advocates are afraid that acute care services will be given a higher priority in a fully integrated system, especially when programs face fiscal constraints. They also fear that LTC will be over-medicalized and that consumer direction and participation in the care-planning process will be diminished.

Rather than fully integrating acute and LTC, states have developed alternative models including managed LTC programs that capitate all Medicaid services, capitate only LTC services, or coordinate services without capitation or financial risk.

- ALTCS contractors are put at financial risk for all Medicaid acute care services in addition to LTC services. Although Medicare services are not capitated, ALTCS contractors do have at least some financial incentive to manage the full range of services and not to shift costs to acute care providers.
- Acute care services currently are not capitated under New York State's capitated Medicaid Long-Term Care program (except for PACE sites). Enrollees' primary care physicians, however, order medical services and collaborate in the development of the initial care plan. In addition, some physicians may be paid a monthly case management fee.¹⁶
- After much consideration of capitated LTC, the state of Maine decided instead to proceed with a primary care case management model that is mandatory for Medicaid beneficiaries and does not capitate any benefits. The state changed its strategy in part because of a shortage of MCOs interested in participating in a capitated LTC program.

Managed care models that capitate all acute and LTC services are not always feasible. In addition to full capitation of acute and LTC, states

should consider capitation arrangements that are more limited in scope as well as managed care models designed to improve care coordination without capitating LTC services.

Rely on Existing MCOs or Develop New Managed LTC Entities?

It is difficult to find organizations that have experience with managed care, elderly and disabled individuals, and LTC.

- Many LTC policy experts argue that Medicare risk-based HMOs have little experience or interest in caring for disabled individuals; in any case, these organizations are scaling back their participation in the Medicare program because of financial losses.

- LTC providers, on the other hand, may not be willing or able to take on the financial risk of a managed LTC program. A substantial amount of financial risk can be associated with capitated payment for people with chronic disabilities, especially when new rate setting methodologies are developed and little data are available for organizations to project their likely costs.

The supply side of managed LTC initiatives needs to be nurtured by states. Not only must states work to identify and develop organizations that can meet the diverse needs of disabled individuals in a capitated environment, but states must be reliable business partners. MCOs are looking for rate stability and contracting standards that remain stable over time.

Potential for Savings

Savings from managed care programs are expected to flow, at least in part, from the substitution of lower cost services for higher cost services. The

promise of cost containment within managed LTC relies on the belief that these programs can substitute potentially less expensive HCBS for institutional care.

- Arizona gives contractors an incentive to substitute HCBS for institutional LTC by basing the capitation rate for the ALTCS on HCBS utilization targets. As noted above, a recent study indicates that 41 percent of ALTCS members received HCBS in 1998 compared to only 7 percent in 1989.¹⁷

Expanding HCBS benefits alone does not ensure cost savings. Success is most likely when expanded benefits are coupled with strong financial incentives and care management practices that lead to the substitution of appropriate lower cost for higher cost services.

Political Barriers to Managed LTC

Politics plays a large role in the development of managed LTC programs. State policymakers face opposition from multiple stakeholders in their attempts to expand managed LTC. These include:

- Opposition from traditional HCBS providers who no longer would be assured of participating in publicly funded programs or might have to respond to different payment incentives.

- Opposition from the nursing home industry, especially when admission to nursing homes is controlled by a different entity (e.g., an MCO).

- Opposition from counties and other local organizations (e.g., Area Agencies on Aging) who are responsible for overseeing or delivering some LTC services.

- Opposition from consumers who are afraid that managed care will result in less choice of qualified providers who are familiar with disability and LTC and less opportunity for consumer input into care.

States must be flexible and prepared to address the concerns of multiple stakeholders when planning and implementing managed LTC programs. A strategy for obtaining the input of key parties should be developed as well as a strategy for communicating the rationale and benefits of a managed LTC program.

Develop Quality Management Strategy

There are two important components of a quality management strategy. First, information systems are needed to provide the state with timely information about areas such as assessment, eligibility, case management, service utilization, expenditures, and other data that help to determine if client process and outcome goals are achieved. Data reporting requirements can be difficult to meet for many MCOs, especially since multiple providers typically are involved in caring for individual clients. Developing adequate information systems not only is expensive but also can require a culture change in provider-based MCOs that must collect and analyze data from multiple providers.

- In the ALTCS, contractors generally have performed well, except for the timely reporting of data. Administrative costs of the program have been high.¹⁸

Second, the quality management strategy should include policies that help enrollees of managed LTC programs advocate for themselves. In particular, there should be a grievance and appeals process and other program features to help ensure enrollee and family input into care.

State policymakers will need to devote considerable resources to developing a quality management strategy and overseeing its implementation. Significant lead time is necessary to ensure that the necessary information technology infrastructure is in place when managed LTC programs become operational.

Endnotes

¹Murtaugh CM, MS Sparer, PH Feldman, et al. 1999. *State Strategies for Allocating Resources to Home and Community-Based Care* (New York: Center for Home Care Policy and Research, Visiting Nurse Service of New York).

²Sparer, MS. 1999. *Health Policy for Low-Income People in Arizona* (Washington, D.C.: Urban Institute).

³McCall N, J Korb, CW Wrightson, et al. 1997. *The Arizona Long-Term Care System: Six Years Integrating Acute and LTC in a Capitated Medicaid Program* (San Francisco: Laguna Research Associates).

⁴Weissert WG, T Lesnick, M Musliner and KA Foley. 1997. Cost Savings from Home and Community-Based Services: Arizona's Capitated Medicaid Long-Term Care Program. *Journal of Health Politics, Policy and Law* 22(6): 1329-1357.

⁵McCall, op cit.

⁶Wiener JM and J Skaggs. 1995. *Current Approaches to Integrating Acute and Long-Term Care Financing and Services* (Washington, D.C.: AARP Public Policy Institute).

⁷Capitman JA. 1986. Community-Based Long-Term Care Models, Target Groups, and Impacts on Service Use. *Gerontologist* 26(4): 389-397.

⁸TEFRA HMOs were established by the Tax Equity and Fiscal Responsibility Act of 1982. TEFRA spells out the conditions under which HMOs can participate in the Medicare program. S/HMOs differ from TEFRA HMOs (the typical Medicare HMO) in that they cover a limited amount of LTC as well as case management services that are not part of the standard Medicare benefit package.

⁹Dowd B, S Hillson, T VonSternberg and LR Fischer. 1999. S/HMO Versus TEFRA HMO Enrollees: Analysis of Expenditures. *Health Care Financing Review* 20(4): 7-23.

¹⁰ Kane RL, RA Kane, M Finch, et al. 1997. S/HMOs, the Second Generation: Building on the Experience of the First Social Health Maintenance Organization Demonstrations. *Journal of the American Geriatrics Society* 45(1): 101-107.

¹¹ McCall, op cit.

¹² Kane RL, op cit.

¹³Branch LG, RF Coulam and YA Zimmerman. 1995. The PACE Evaluation: Initial Findings. *Gerontologist* 35(3):349-59.

¹⁴Long SK, K Liu, S Wallin and DG Stevenson. 1999. *Integrating Care for the Elderly: A Case Study of a Medicaid Long-Term Care Capitation Program in New York* (Washington, D.C.: Urban Institute).

¹⁵Branch, op cit.

¹⁶Long, op cit.

¹⁷Sparer, op cit.

¹⁸McCall, op cit.

THIS POLICY BRIEF WAS PREPARED BY
David G. Stevenson, Christopher M. Murtaugh, Penny H. Feldman, and Mia Oberlink.



THE HOME CARE RESEARCH
INITIATIVE:
A PROGRAM OF THE
ROBERT WOOD JOHNSON
FOUNDATION

www.vnsny.org/hcri

 Visiting Nurse Service Of New York™

107 EAST 70TH STREET NEW YORK, NEW YORK 10021
PH. 212.794-6300 FAX 212.794-6610