FORUM

THE AGING NETWORK'S ROLE IN THE
FUTURE OF LONG-TERM CARE

By LARRY J. POLIVKA and HELEN ZAYAC

How to provide long-term care (LTC) most cost effectively will become an increasingly urgent policy issue at both federal and state levels in the coming years. Discussions of this issue among some journalists and LTC policy experts often take an alarmist tone, generated by the perception that most states and the federal government are unprepared for the vast growth in the older population that will occur during the first half of the 21st century. LTC spending from all public and private sources, which exceeded $150 billion for people of all ages in 2005, will increase dramatically as the boomer generation ages.

Many states have improved their LTC systems for older adults by using Medicaid waivers allowing them to expand home-based and community-based alternatives to nursing homes. On average, however, states are still spending 70% to 80% of their LTC funds for older people on nursing-facility care. Few states have achieved balanced LTC systems that are responsive to the overwhelming preferences of frail elders for community-based care. But changes are emerging, and the network of services and programs in aging in the United States is well positioned to play a significant role in serving the LTC needs of America’s aging population.

The LTC system for elders in the United States involves a loosely organized and fragmented process of gaining access to care with a bias toward institutional care for publicly supported LTC consumers through Medicaid, a means-tested poverty program. This bias limits the availability of home-based and community-based services, restricts the boundaries of consumer choice and creates higher per-recipient Medicaid costs than are necessary or desirable.

Any effort to improve LTC for older individuals qualitatively—and not merely on the margins—must be prepared to address these problems by making access to information and services much easier and faster. Home and community-based services (HCBS) also need to be far more available than they are currently in most states. Fortunately, several conditions are now favorable for fostering a qualitative transformation of LTC for elders.

Consumer preference. Older people vastly prefer obtaining any assistance in community-based settings, ideally their own homes. According to a 2003 AARP-sponsored Harris Poll of a national sample of people with disabilities age 50 or older, 87% favor receiving assistance with everyday activities in their own homes, and 73% would prefer to receive even 24-hour help in their own homes, mostly from family and friends. Only 6% would rather have nursing home care for 24-hour needs.

The LTC services at home or in the community. If properly administered, the cost-effectiveness of HCBS has been convincingly demonstrated through research conducted during the past decade and by the success of a few states, which have shifted the balance of their LTC systems from institutional to
community-based care. These shifts have allowed some states, such as Oregon and Washington, to maximize the value of their LTC dollars by serving more people in HCBS programs where the per-beneficiary costs are usually much lower than in nursing homes.

The extensive community-based aging network. The aging network includes state offices on aging, 665 area agencies on aging, approximately 240 tribal organizations, thousands of nonprofit, home and community-residential service providers, as well as monitoring and advocacy groups, such as LTC ombudsmen. These programs and agencies have provided the majority of services for elders outside of institutions for three decades. The aging network has the capacity in many communities to provide a full range of consumer-oriented HCBS for those needing continuing care. A majority of the states have recognized this capacity by giving the aging network, at state and local service-delivery levels, responsibility for administering all or most of the aging-related Medicaid waiver funds for home and community-based assistance.

POOLING RESOURCES

Although these factors suggest a promising future for HCBS long-term care services and the role of the aging network in administering them, the challenge for the aging network in most states in taking full advantage of these conditions is to develop a more balanced LTC system featuring the rapid expansion of HCBS programs.

Reports on state LTC policies and practices in the past 10 years suggest that the principal lesson to be drawn from the experiences of the few states with relatively balanced LTC systems is that it will be essential for states to organize the financing and delivery of LTC by integrating the administrative and policy responsibility for LTC under a single administrative authority at the state level. This approach must be combined with access to services through single-entry systems at the local level to create organizational environments for balancing state LTC systems.

Some form of administrative consolidation has proven necessary to pool financial resources across settings, payers and programs. Pooling resources promotes flexibility and choice, maximizes service options, reduces barriers to consumer-preferred services and increases efficiency. Consolidation and resource pooling increase system capacity to target services to the right people at the right time. Services can be more efficiently provided and made more broadly available if they are more tightly targeted to the accurate and timely assessment of LTC needs.

MANAGED LTC

An alternative method of integrating LTC authority, which does not require a single state agency with complete control over policy and all LTC funds, is to develop a managed LTC program at the local or regional level. Such a program would operate under a capitated rate (a ceiling on how much providers can be paid per case) with funds from all sources, including Medicaid nursing home and general revenue funds.

Managed LTC programs have developed slowly over the last 15 years, beginning with the Arizona Medicaid Long-Term Care System (ALTCS) and Programs of All Inclusive Care for the Elderly, or PACE. Managed LTC programs are now operating in at least eight states, of which ALTCS is the largest with more than 24,000 participants statewide. Nationally, although these programs serve less than 5% of all those receiving LTC services (about 3 million), the movement toward managed LTC appears to be gaining force with the development of programs in Minnesota and Massachusetts in recent years, as well as plans to expand those in Texas, Florida and Wisconsin. (See “Wisconsin’s Managed Long-Term Care Model,” on page 3.)

Managed LTC may not be a fully adequate substitute for the kind of integrated organizational structures that Oregon and Washington use to administer all phases of their LTC systems. Their comprehensive approach has played a critical role in both states’ largely successful efforts to create well-balanced systems of LTC, including HCBS and nursing home care.

In the absence of administrative consolidation of managed care strategies, however, the Wisconsin Family Care Program represents a promising alternative approach to creating organizational vehicles for merging resources, integrating administrative authority, removing program barriers and providing services in a manner more consistent with consumer preference and choice. •

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WISCONSIN’S MANAGED LONG-TERM CARE MODEL

Among the current array of managed long-term care (LTC) programs, the Wisconsin Family Care Program (WFCP) may be the most instructive model involving aging-network programs. WFCP is administered by county service agencies in aging in the five project counties. The Milwaukee County agency is also the area agency on aging, administering programs mandated by the federal Older Americans Act. Although most states do not organize and administer their aging and LTC services through county governments, many do. For those that do not, WFCP offers many lessons useful in formulating versions of managed LTC programs.

Two important components of WFCP are the following:

**Resource Centers.** WFCP’s resource centers serve as single points of entry into the LTC system, providing information, counseling and access to all relevant services, along with information on providers, preventive healthcare and early-intervention services. The resource centers are designed to serve not only Medicaid-eligible consumers, but also private-pay consumers and their families.

**Care Management Organizations (CMOs).** Key to the success of WFCP are its care management organizations. CMOs are county-based managed care organizations that receive capitated payments for all LTC services, including nursing home care. The capitation rate includes Medicaid, state and county funds consolidated into single monthly payments averaging about $1,800 a month per member. The capitation rate constitutes a strong incentive to keep consumers in the community by minimizing nursing home care costs and to create a seamless system in which individuals’ needs dictate the services provided. The CMOs have also been able to eliminate waiting lists for eligible people in each of the five counties WFCP serves.

A comprehensive evaluation of WFCP released in 2005 demonstrated the program’s relative cost effectiveness. During the two-year study period (2003–2004), average individual monthly Medicaid costs for WFCP members outside the metropolitan Milwaukee area were $452 lower than costs for their comparison group, who were not in the managed LTC program. Also, costs for members of the Milwaukee CMO were $5 lower than for their comparison group.

Further analysis discovered that WFCP produced savings for total Medicaid costs in two ways: The program reduces costs directly by purchasing or providing services more economically, and it lowers costs indirectly by favorably affecting WFCP members’ health and functional abilities, so they have less need for services.

The findings indicate that the program’s CMOs purchased (or prompted their members to purchase, in the case of primary and acute care) more of certain lower-cost services and less of other, higher-cost services. This outcome lowered the cost of the total package for WFCP members. For example, the assessment found that average individual monthly costs for the care of Milwaukee County frail elders in community-based residential facilities was $462 more than that spent for such care for the comparison group during the study period.

Alternatively, average individual monthly costs for nursing facility care of frail elders served by the Milwaukee CMO were $1,363 less than those for frail elders in the matched comparison group. These shifts in services are a direct result of the flexibility in funding provided by the WFCP benefits package.

The study authors conclude that WFCP has been able to generate monthly savings for the current enrollment levels (9,300 people) of about $1.9 million, based on the savings estimates. This result means that for every 1,000 people enrolled in an expanded family care program, an additional $452,000 Medicaid dollars would be saved each month. The Wisconsin legislature provided funding for statewide implementation of WFCP in the 2006 legislative session. The program serves Medicaid-eligible elders, as well as adults with disabilities and those with developmental disabilities, and is operated through two major components: aging and disability resource centers and care management organizations.

The improved health status outcomes among WFCP participants compared with the matched controls demonstrate the potential of an aging-network-based managed LTC program to increase the effectiveness of not only LTC services but also acute and chronic care services.

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