

**Public LTC Today and Tomorrow;**  
**From the Aging Network to Corporate Managed Care?**

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## Brief History of the Formal U.S. Long Term Care (LTC) Systems

- Emergence of the current nursing homes model in the late 60s and 70s (role of Medicaid).
- Growth of Home and Community Based Services (HCBS) beginning in the 1970s and slowly increasing for the next 35 years (role of the Florida CCE program and the Medicaid HCBS waivers, after Oregon in the early 80s).

## Brief History of the Formal U.S. Long Term Care (LTC) Systems

- Most of the publicly supported HCBS programs have been administered through the Aging Network (AN) consisting of Area Agencies on Aging, over 30,000 service providers and advocacy groups.
- The initial funding for HCBS programs came largely through the Older Americans Act (OAA) and more limited state general revenue support. Since the early 1990s HCBS funding has come increasingly from Medicaid HCBS waivers.

## HCBS Began to Catch Up with Nursing Home Funding Rates after 2000

- Medicaid HCBS funding for the aged and disabled now exceeds 6.5 billion and has increased over the last decade as nursing home spending plateaued at about 46 billion.
- Over 10 states now spend more than or close to 50% of their LTSS dollars on HCBS programs. The national average is now 39%.

## HCBS Began to Catch Up with Nursing Home Funding Rates after 2000

- The states performing below the top tier will need to pick up the pace a great deal over the next several years in preparation for the huge growth in need for LTC services, especially in the community.
- The success of the top performing states should very much inspire their efforts.

Most of the Available Research Indicates that HCBS Programs are on the Whole Cost Effective. They Clearly are Preferred to Nursing Home Care by Older and Younger Disabled People

- At least 3 literature reviews (based on dozens of studies since 1990) since 2010 have supported the cost-effectiveness of HCBS programs.
- A 2010 study in Florida found that participation in Aging Network HCBS programs reduced nursing home use by 3 to 5 fold compared to similar Medicaid beneficiaries who did not participate in HCBS programs.

## The 2014 AARP LTC Snapshot Report and the National N4A Survey Documents an Extensive HCBS Infrastructure in a Large Majority of States, Administered in Most States Through the Non-Profit Aging Network

- The report shows that several states have made rapid progress in the development of their Aging Network administered HCBS LTC system over the last 10-15 years.
- The top 10 states in terms of the 26 criteria used by the AARP Team arguably constitute highly effective models of how LTSS can be effectively and efficiently administered, mostly by Aging Network organizations.

## The 2014 AARP LTC Snapshot Report and the National N4A Survey Documents an Extensive HCBS Infrastructure in a Large Majority of States, Administered in Most States Through the Non-Profit Aging Network

- Performance on the 26 criteria varies a lot across the states. The criteria are grouped by affordability, choice of setting and provider, quality of life and care, caregiver support and effective transitions.
- The top performing states outperform the low performing states by a large margin. For example, the top 5 states allocate an average of 62% of LTSS dollars on HCBS programs and the bottom 5 states only 16.7%
- The top performing states demonstrate that HMO administered MLTC systems are not necessary to achieve decisive shifts in the balance of LTC services-from nursing homes to HCBS.

This Record Notwithstanding, Several States Have Launched Managed LTC Programs, Incorporating HCBS and Nursing Home Services Administered Mostly by For-Profit HMOs

- Wisconsin administers its MLTC program through private and public agencies in the Aging Network (Wisconsin Family Care (WFC). Several studies indicate that WFC is highly cost effective.
- The only other states where comprehensive evaluations of MLTC programs have been conducted are Arizona and Florida.

## This Record Notwithstanding, Several States Have Launched Managed LTC Programs, Incorporating HCBS and Nursing Home Services Administered Mostly by For-Profit HMOs

- The Arizona Long Term Care System (ALTCS) study (1996) found that the MLTC was saving Medicaid money by reducing nursing home use. The savings, however, were far greater for the DD than ADA populations. The DD program is administered by the state agency.
- Three Florida studies conducted from 2003 till 2009 found that the Aging Network administered HCBS waiver programs were generally more cost effective than the HMO administered MLTC waiver services, costing 25 to 35% less per person served than the managed care Medicaid waiver program, Nursing Home Diversion.

## The Dual Eligible Demo Projects

- The move toward HMO administered MLTC programs has received a boost from the federal government through the current dual eligible Demonstration project that will be implemented in 15 or more states. Most of these projects are administered by HMOs under a Medicare/Medicaid capitation rate.
- Should the dual eligible population drive the development of health and long term care policy when only 4-5% of all duals are high spenders in both programs?

## The Dual Eligible Demo Projects

- One Medicare-Medicaid managed care program (PACE) has achieved impressive cost effectiveness outcomes over the last 20 years as a non-profit provider of all care in person centered care environments-see CPC PACE paper on CPC website.
- PACE, however, tends to be seen in policy circles as too small, too boutiqueish (500+ members) to be a truly comprehensive alternative model to fee for service LTC.
- I disagree. I think its just this scale that makes integrated care most cost-effective and a natural partner for the AN in the delivery of LTC services.

## Well, Has the Train Left the Station?

- Does the future belong to HMO administered MLTC? Is the Aging Network on the cusp of becoming a LTC side show over the next decade? Has “the train left the station”?
- I have anticipated the arrival of MLTC for over 20 years, beginning with the Pinellas/Pasco project in 1994. The project made the case for an AN based MLTC system, 3 years ahead of WFC.
- Since then, the AN administered HCBS systems have grown considerably in most states and MLTC programs have been implemented in several states, including Florida.

## So, Has the Train Left the Station?

- In some states the answer would appear to be yes. In these states the HMO MLTC infrastructure is established and the Aging Network (AN) has either become a limited player in HCBS LTC or was never a major (LTC) player (Arizona, Texas, and New Mexico).
- In several states where the (AN) has become a well organized and relatively sophisticated manager of HCBS, the train is not likely to show up, or at least not to the extent that HMOs would displace and marginalize Aging Network organizations as major LTC players (Oregon, Washington, and a few other states (WFC?).
- In other states, mixed models of LTC, versions of which already exist in some states, are likely to emerge over the next decade (Massachusetts, Minnesota, and Ohio). These models could provide opportunities for extensive partnership between HMOs and Aging Network organizations. Florida?

## Maintaining and Strengthening the Role of the Aging Network in LTC

- Whatever strategy policymakers may adopt in the future they will be under increasing pressure to adopt it fast and move quickly in the face of unprecedented growth in the need for LTC.

## In My View it is Important to Maintain and Strengthen the Role of the AN in Medicaid Supported LTC Services for Several Reasons

1. The AN has historically been a relatively low cost provider of community based services (5-6% overhead) which should be a major consideration in planning the future of LTC. The number of older and younger impaired persons will grow enormously over the next 20-30 years making every dollar count more and more. In our Florida studies we found that AN HCBS waiver programs were the most efficient across 3 different costs and outcome studies.

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2. In addition to cost-effectiveness the AN's ability to strengthen and maintain informal caregiving networks offers another important rationale for preserving and strengthening the role of non-profit aging network agencies in LTSS.
  - LTSS are labor intensive and, at best, depend on close interaction between formal (paid) and many forms of informal (unpaid) care provided by family members, friends, neighbors, and members of voluntary organizations.
  - The social capital (community trust and support) of non-profit organizations in the AN is essential to building and maintaining the formal-informal caregiving network.
  - The Hospice experience since 2000 may be instructively compared to LTC policy and funding. Increasing costs, poorer outcomes as for-profit forums increase in Medicare.

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3. Unlike most of the rest of the U.S. health care system, much of LTSS is still administered by a large number of non-profit organizations, most of which are part of the aging network.
  - These organizations, with their extensive community support and high levels of volunteer participation are a major reason community based LTC is still reasonably affordable in most parts of the country.

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4. Furthermore, strengthening networks of formal and informal care is important to meet not only the growing need for both privately and publicly supported LTSS but also to avoid the potential crisis of caregiving:

...the danger that some old people will be abandoned or impoverished, with no one to care for them, no advocate to stand with them, and inadequate resources to provide for themselves (The President's Council on Bioethics, 2005).

A smaller number of potential caregivers combined with an increasing number of baby boomers who will not have children or spouses to help provide care suggests a growing caregiver challenge and increasing the potential role of the AN.

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Reasons

5. (A) An AN based LTSS system that is deeply embedded in the community could become an essential part of a more comprehensive, community based, ethic of care governed rather than corporate, model of integrated, person centered care encompassing all domains of care from preventative and acute care services to LTSS for the huge number of elderly who will need help by 2035.

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- (B) In most states the aging network organizations are essential and widely supported parts of their local communities. They are well positioned to serve as hubs for community based, integrated health and LTSS system.
- The displacement of the aging network by HMOs would, in my judgment, represent a lost opportunity in the development of such systems of community based and person centered systems of care.
  - I also think it would be a lost opportunity to nurture resources to create strong communities that can provide supportive environments for older people and other vulnerable groups.
  - The Aging Network is a great civic asset whose benefits radiate throughout communities and contribute to the creation of strong communities with a sense of control over their own fates.

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- I hope that even in those states that move toward comprehensive HMO administered MLTC systems, AN organizations, including providers, will be able to adapt/evolve in a manner conducive to survival and, to the extent possible, to thriving in modified roles.
- This is unlikely, however, in the absence of a serious discussion/debate about LTC policy at the federal and state levels and a renewal of aging advocacy activity, which has faded over the last 20 years.

## Conclusion

- The need for LTC (public & private) will double by 2030-35.
- Public LTC is changing rapidly as MCOs become involved.
- The AN organization that built the HCBS LTC system in most states are under increasing political and fiscal pressure.
- Organizational shifts (AN to corporate LTC) vs. qualitative changes (Medicare LTC-HCBS, Medicare for all, etc.). Claude Pepper/Bob Graham.