

The Aging Network and Managed Long-Term Care

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Since the early 1980s, service providers and area agencies on aging, that is, the aging network, have developed a number of strengths as they built a community-based long-term-care system in most states. Many area agencies and providers now have the capacity to assess the needs of older persons, identify appropriate services, and administer cost-effective community programs while operating within fixed, capped budgets. They have also been able to identify and maintain roles for informal caregivers, draw on community resources through donations and the use of volunteers, and create substantial political support. In this article we argue that the aging network should draw on these strengths to develop integrated long-term-care systems designed to shift the balance of state long-term-care systems from institutional to home- and community-based services. We also argue that the nonprofit aging network, because it is made up of area agencies on aging and service providers, provides a potentially more effective framework for the integration of long-term-care resources than do proprietary managed care organizations.

Key Words: Community care, Medicaid, Services integration, Social capital

Over the past several years, many states have made improvements in their long-term-care systems for elderly persons by funding private and public nonprofit aging services organizations to provide home- and community-based alternatives to nursing home care. An accumulating body of research tends to indicate that these community programs are, on the whole, relatively cost effective in comparison with nursing home care, which now costs \$60,000 or more annually in most states (Grabowski, 2003; Wiener & Lutzky, 2001; Wiener, Tilly, Alecxih, & Mario, 2002). Most states, however, are still spending 70% to 80% of their long-term-care funds for the elderly population on nursing facility care (Kaiser Family Foundation, 2006). Relatively few states have achieved balanced long-term-care systems that are responsive to the overwhelming preferences of frail elderly persons for community-based care (Wiener, 2006). Shifting the focus of public long-term-care systems from nursing home care to home- and community-based care is the major long-term-care policy issue confronting state and federal policy makers; continuing dependence on nursing homes will make Medicaid long-term-care costs increasingly less affordable and resources for home- and community-based services (HCBS) programs less available.

The aging network represents an extraordinary, though still underutilized, resource for creating more balanced long-term-care systems through the expansion of HCBS programs. The aging network includes state aging offices, 665 area agencies on aging, approximately 240 tribal organizations, thousands of nonprofit, home- and community-residential service providers, and monitoring and advocacy groups,

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such as nursing home ombudsmen. In building community-based long-term-care systems over the past 25 years, area agencies on aging and service providers have developed a number of strengths, including the ability to assess the needs of older persons, identify appropriate services, and administer cost-effective community programs while operating within fixed, capped budgets. They have also been able to identify and maintain roles for informal caregivers and draw on community resources through donations and the use of volunteers.

In our view, the aging network should use these resources to develop integrated long-term-care systems that are explicitly designed to shift the balance of state long-term-care systems from institutional services to HCBS. The two principal models of long-term-care resource integration are (a) the consolidation of administrative authority for all long-term-care funds and service delivery into a single state agency and (b) managed long-term care (MLTC) that integrates all or most long-term-care funds under a capitated rate for all services offered by a managed care organization (MCO). The first model has been adopted by only three states (Oregon, Washington, and Vermont) and the second, at least on a demonstration basis, by seven states. The MLTC programs are operated by proprietary health maintenance organizations (HMOs), public sector agencies, and nonprofit organizations often associated with the aging network. Both models have demonstrated the capacity, to varying extents, to shift resources from institutional to community-based care.

Our major purpose in this article, however, is to build a case for an aging-network-based, MLTC model for integrating long-term-care resources as an alternative to the consolidated administrative authority model and the proprietary HMO version of the MLTC model. Although the available empirical data are too limited to support definitive conclusions about the relative effectiveness of the two MLTC models, we think it suggests that an aging network MLTC strategy could be an effective vehicle for long-term-care resource integration in many states.

Our argument for an expanded aging network role in state long-term-care systems is not limited to the available data on MLTC. We also provide a rationale for an expanded aging network role that is based on a review by Schlesinger and Gray (2006) of the research literature on the comparative advantages of proprietary and not-for-profit organizations in several health care domains, the President's Council on Bioethics (2005) report on caregiving, and a critique of Saucier, Burwell, and Gerst's (2005) case for expanding the role of HMOs in long-term care. Our rationale draws on the concept of social capital and its essential role as a public resource in a long-term-care system governed as much by an ethic of care as administrative efficiency.

We recognize that an aging-network-based, MLTC strategy will not be the best method for

integrating and redirecting long-term-care resources in every community. Oregon, Washington, and Vermont have demonstrated that consolidating administrative authority for policy and budget management can be a very effective strategy for redirecting long-term-care resources, and the Arizona Long-Term Care System offers clear evidence that a statewide MLTC system, with a mix of public agencies and for-profit HMOs, can dramatically increase the availability of HCBS programs (Weissert, Lesnick, Musliner, & Foley, 1997). States may also decide, in the absence of a decisive shift in federal long-term-care policy, to continue the gradual expansion of Medicaid-funded HCBS programs rather than implement qualitative policy changes designed to shift the balance of long-term-care resources as rapidly and decisively as Oregon and Washington did for the elderly population, and as most states have done for developmentally disabled persons. This strategy, however, is not well designed to meet the rapidly growing need for long-term-care services and the associated costs within a time frame acceptable to aging advocates and many policy makers.

The Oregon and Washington experiences indicate that administrative consolidation is probably the most effective method for achieving a rapid shift in the use of long-term-care resources and maintaining the quality of services. However, for reasons we discuss later, this method is not likely to gain much traction in many states. MLTC strategies are already underway in several states, generating a trajectory that is likely to make them more politically appealing than the administrative consolidation strategy. In this context, policy makers may choose to adopt either an HMO-administered MLTC program and take steps to create a more favorable organizational environment for this approach, as recommended by Saucier and colleagues (2005), or an aging-network-based MLTC system that builds on the home and community infrastructure created by the aging network in most states over the past 30 years.

Some states may consider a mix of these two strategies, depending on their own unique circumstances. States and communities vary in the extent to which one or the other of these strategies, or some mix of them, is most feasible, depending on the administrative and financial management capacities of their aging network organizations and the experience and interest of HMOs in administering long-term-care services. Where feasible, and for the reasons discussed in this article, we think that aging network organizations should be given priority in the administration of MLTC programs.

Our case for aging-network-based MLTC is not foolproof and may not be convincing to those who wish to withhold judgment until substantially more empirical data are available. We do not think, however, that the policy debate over the future of MLTC should be postponed until conclusive empirical

evidence about the relative effectiveness of the different MLTC models is available. After all, the consensus that has emerged in support of home- and community-based long-term-care services over the past 10 to 15 years was not driven by conclusive evidence of their cost-effectiveness superiority to nursing home care (Grabowski, 2003; Wiener, 2006). Policy choices can always benefit from more empirical information, but that does not mean that the debate on policy should be postponed until research findings alone can be used to pick the best policy option. We think it is important to raise the visibility of the debate over the future of long-term care and the role of managed care; we invite others, many of whom may regard our perspective with skepticism, to join the debate and expand the range of views available to policy makers.

Integrating Long-Term-Care Financing and Service Delivery

Arguably, the principal lesson to be drawn from the experiences of the few states with relatively balanced long-term-care systems is that methods of organizing the financing and delivery of long-term care are critical. Reports on state long-term-care policies and practices over the past 10 years indicate that the integration of administrative and policy responsibility for long-term care under a single administrative authority at the state level, with access to services through single-entry systems at the local level, may be essential to the creation of organizational environments for balancing state long-term-care systems (Administration on Aging, 2005; Alecxih, Lutzky, & Corea, 1996; Fox-Grange, Coleman, & Milne, 2006; Kane, Kane, Kitchener, Priester, & Harrington, 2006).

In their analysis of efforts in eight states to create a more balanced long-term-care system by expanding community-based programs, Kane and associates (2006) found considerable variation in approaches, as well as emerging trends that tend to support organizational integration. These trends include closer articulation of all Medicaid- and state-funded long-term-care programs, program integration across multiple consumer groups, and more centralization of statewide long-term-care functions. These organizational initiatives are designed to achieve a greater “focus on the shared goals of rebalancing to pinpoint accountability for outcomes, and to render budgetary allocation and reallocation more flexible” (p. 18).

Kane and associates conclude with the observation that the most effective arrangement for creating a more balanced long-term-care system featuring the continuous expansion of community-based programs appears to be

a situation where the same entity responsible for operations develops the forecasting or fiscal analysis

on which the budget allocations are based and, moreover, has the ability to move money between institutional budgets and HCBS budgets, across programs, and across consumer groups. (Kane et al., 2006, p. 18)

In most states, the management of long-term-care programs is split between departments of aging or senior services (home- and community-based programs) and the departments housing the Medicaid program, which control, on average, the 70% to 80% of all Medicaid long-term-care dollars spent on nursing home care. As we noted earlier, only three states, that is, Oregon, Washington, and Vermont, have fully integrated control over all long-term-care programs and funds, including the Medicaid Nursing Home Program, in a single state aging agency. Each of these states have been able to achieve a more balanced system of long-term-care services than was available prior to the consolidation of administrative and funding authority into a single agency structure. Oregon spends a higher percentage of its total Medicaid long-term-care budget on HCBS (54.9% in 2006) than any other state, and Washington is second at 54.6%; the national average is 28.6% (Form CMS 64, 2007). The expansion of HCBS spending has allowed these states to contain nursing home expenditures well below the national average between 1995 and 2005. Sparer (2003) notes the following:

The statewide [Oregon] nursing home census declined from 8,400 to 6,880 between 1981 and 1997, despite significant growth in the state's elderly population. The number of persons who received home- and community-based services increased during that same period from 3,000 to 26,200. . . . Oregon ensures that the aged receive long-term care management but has chosen to do so without using health plans, capitation, or competition. (p. 2)

These three states have used consolidated organizational arrangements to move money between institutional budgets and HCBS budgets and create more integrated long-term-care systems designed to better serve the interests of the long-term-care consumer by expanding service options in the community. Oregon completed the reorganization of its long-term-care system in the early 1980s, and Washington completed its own reorganization by the early 1990s. Since then, only Vermont has followed this route; there is no sign that many states are likely to do very soon. State Medicaid offices are relatively powerful units with strong legislative constituencies who expect them to be rigorous managers of all Medicaid funds, including nursing home dollars. They are also expected to keep a watchful eye on the administration of home- and community-based waiver resources by the state unit on aging and

local service providers. They are not, as a rule, expected to be strong advocates for the expansion of HCBS programs, a role normally reserved for the state aging units. Furthermore, the nursing home industry is still an influential player in the politics of long-term-care policy in most states and is likely to resist giving authority over the administration of nursing home Medicaid funds to a single long-term-care agency with control over all public long-term-care funds.

An MLTC Approach to Long-Term-Care Integration

An alternative method of integrating long-term-care authority that does not require a single state agency with complete control over policy and all long-term-care funds is to develop a MLTC program at the local or regional level and operate it under a capitated rate with funds from all sources, including Medicaid nursing home and general revenue funds. Saucier and colleagues (2005) describe part of the rationale for MLTC strategies by pointing out the following:

Long-term care users need a variety of services across numerous settings (e.g., home, doctor's office, hospital, day center, nursing home), but in the Medicaid and Medicare fee for service systems, no single person or organization is responsible for or can impact all needed care, resulting in services that are often characterized as fragmented, uncoordinated and rife with unintended financial incentives. State home- and community-based services (HCBS) programs almost always provide case management, but the management does not extend into the hospital or nursing home when someone is admitted. Often, a community case manager learns about a hospital discharge after the fact, with no ability to ensure a smooth transition across settings. Avoidable hospital admissions, unnecessary use of nursing home care, and education mismanagement are among the risks faced by the population. [This is why] The application of managed care strategies to aged and disabled long-term care beneficiaries holds intrinsic appeal. (p. 2)

This appeal notwithstanding, MLTC programs have developed slowly over the past 15 years; the first MLTC program was the Medicaid Arizona Long-Term Care System, which began in 1991. The Arizona system operates statewide and, with over 24,000 participants, is still one of the largest MLTC programs in the country. The Minnesota Senior Health Options (MSHO) and Massachusetts' Senior Care Options programs are the only other statewide MLTC programs. Unlike the Arizona Long-Term Care System program, these two programs are designed to operate under a Medicaid–Medicare blended capitation rate that supports the integration of acute and long-term-care services.

This approach to the financial integration of Medicaid and Medicare was first implemented in the Program of All Inclusive Care for the Elderly and the Social HMO program in the early 1990s (Branch, Coulam, & Zimmerman, 1995; Kane et al., 1997; Stevenson, Murtaugh, Feldman, & Oberlink, 2000). Several other MLTC initiatives have emerged over the past several years, the most prominent of which are the Texas Star Plus Program, The Florida Diversion and Elder Care Programs, the Wisconsin Family Care and Partnership Programs (the latter of which is a Medicare–Medicaid integrated project), and several relatively small MLTC programs in New York. Although these programs serve less than 5% of all those receiving long-term-care services, the movement toward MLTC appears to be gaining ground with the development of the MSHO and Massachusetts' Senior Care Options programs, and with plans to expand the Texas Star Plus, Florida Diversion, Wisconsin Family Care, and the New York programs.

These programs vary considerably in terms of target populations, the range of funding sources in addition to Medicaid, geographical scope, benefit packages, voluntary versus mandatory participation of eligible populations, and protection of traditional, nonprofit providers, which has been a major concern of aging network advocates in most of the states with MLTC initiatives. For example, Saucier and associates (2005) report the following:

[In Wisconsin,] When the State Department of Health and Family Services released its plan for long-term care reform based on the Partnership model of fully integrated acute and long-term care, aging and disability advocates organized strong opposition at a series of public hearings. They were concerned that integrated plans would be dominated by medically oriented HMOs, and the aging network would lose its role in the system. The Department withdrew its plan, and the Family Care program was developed instead, featuring a prominent role for counties and limiting the program to long-term care. In Massachusetts, a network of Aging Services Access Points (ASAPs) serves a number of roles. Several are designated Area Agencies on Aging, and several are providers of care coordination, home care, and other long-term care services. . . . In Florida, certain long-term care providers are statutorily eligible to become diversion program contractors by virtue of their state provider licensure status. (pp. 12–13)

MLTC programs also vary in terms of the kinds of organizations administering the programs. Proprietary organizations, however, are extensively involved in several MLTC programs, especially in Texas, Florida, Arizona, and Massachusetts, which have large MLTC programs.

The evaluative research on MLTC is not yet extensive enough to determine precisely the relative

cost effectiveness of managed care versus fee-for-service long-term-care programs or of different managed care strategies, including HMO and aging network administered programs. Some of the findings, however, from these initial studies suggest that MLTC has substantial potential to increase service efficiency and expedite the shift to a more community-based long-term-care system. An evaluation study by Weissert and colleagues (1997) of the Arizona Long-Term Care System found that the state had substantially reduced nursing home use by expanding the availability of Medicaid-funded HCBS through the MLTC program. Overall, the authors concluded that the expansion of community-based services helped enrollees avoid over 270,000 nursing home days and saved the state an estimated \$4.6 million between 1991 and 1995.

An evaluation by Mitchell, Salmon, Polivka, and Soberon-Ferrer (2006) of Medicaid waiver-funded HCBS programs for the aged in Florida found that, in terms of relative cost effectiveness, the programs were bracketed by the state's two MLTC programs with the three fee-for-service programs in between. The Frail Elderly Program was the most cost-effective program and the Diversion Program, with a much higher capitation rate and much larger population, was the least cost-effective program, when the authors controlled for a wide range of participant characteristics. In fact, the Diversion Program, which serves a population of 11,000, cost the state Medicaid program about \$900 more on a per member, per month basis than the largest aging network fee-for-service Medicaid waiver-funded program, which services about 13,000, when total Medicaid claims, including nursing home care, are counted. These findings indicate the importance of setting capitation rates at the appropriate levels for achieving increased efficiency.

An evaluation by Kane and colleagues of MSHO, a Medicare-Medicaid integrated managed care program (Kane, Homyak, Bershady, Lum, & Siadat, 2003; Kane et al., 2005), found few significant differences in services received and outcomes (function, satisfaction, caregiver burden) between the sample of MSHO enrollees and two control groups of matched samples. The authors note the following:

Ideally, a managed-care program would improve quality and reduce costs. The potential for the latter is determined by the capitation rate. In the case of MSHO this rate was strongly influenced by the existing Medicaid capitation payment approach and the Medicare capitation rate-setting approach. Any gains in efficiency (and hence, reduced utilization) accrued to the managed care organization, not to the sponsoring public programs. Overall, we found little evidence that the MSHO model produced substantially higher quality. Taken together with the modest effects on utilization and other outcomes reported earlier, one has to question whether the

coordination of funding streams has produced a new program that adequately addresses the problems of the dual eligible high-risk population. (Kane et al., 2005, p. 502)

An evaluation of one of the New York MLTC programs (Nadash, 2004) found that it performed reasonably well in comparison with the fully integrated Program of All Inclusive Care for the Elderly program, with higher hospital and lower nursing home use.

The evaluative information on the Wisconsin Family Care program is relatively extensive, with formative assessments by The Lewin Group (2000, 2001, 2002, and 2003) and a comprehensive evaluation by APS Healthcare (2005) for the Wisconsin Legislature. Because we consider the Wisconsin Family Care program to be the most instructive example of an aging-network-based MLTC program and essential to our argument in support of this approach to integrating and redirecting the use of long-term-care resources, we think it is appropriate to describe the findings and conclusions of the evaluation at some length.

The Wisconsin Family Care program is administered by county agencies in the five project counties. The Milwaukee County agency is also the Area Agency on Aging. Although most states do not organize and administer their aging and long-term-care services through county governments, many do, and for those that do not, the program may still offer lessons they could use in formulating their own versions of MLTC.

The Wisconsin Family Care Program serves the Medicaid-eligible elderly population, disabled adults, and developmentally disabled populations (9,300 total participants in 2005). It is operated through two major components—aging and disability resource centers and care management organizations. The resource centers serve as single points of entry into the long-term-care system, providing information, counseling, and access to all long-term-care services, and information on providers, preventive health care, and early intervention services. An important feature of the resource centers is that they are designed to serve not only Medicaid-eligible consumers but also private-pay consumers and their families.

The care management organizations are county-based MCOs that receive capitated payments for all long-term-care services, including nursing home care. The capitation rate includes Medicaid (nursing home services and HCBS), state, and county funds consolidated into single monthly payments that average about \$1,800 a month, \$250 to \$300 of which is used for case management. 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, rather than program-eligibility criteria (Wiener et al., 2002).

The state of Wisconsin and the care management organization share financial risk for 3 years. If the care management organization delivers care to its members at an average per-person cost that is less than the capitated rate, it retains and reinvests earnings, which are used to expand services. If the average per-person cost of care provided to its members exceeds its capitated rate, the organization loses money until it can rebalance costs and revenues. The five Wisconsin Family Care demonstration counties have been able to manage their finances without relying on the shared risk provision. They have also been able to eliminate waiting lists for eligible persons in each of the five counties.

The APS evaluation (APS Healthcare, 2005) found that the program has generated significant savings, produced high consumer satisfaction, and changed the kinds of services provided. The care management organizations purchased (or prompted their members to purchase, in the case of primary and acute care) more of some lower-cost services and less of other higher-cost services, with the result that the cost of the total package was lower for the Family Care members than for a matched comparison sample of individuals receiving Medicaid-funded services who were not in the Family Care Program. For example, average individual monthly costs at the end of the study period for a Milwaukee County frail elder's care in a community-based residential facility (CBRF) was \$462 more than that spent for community-based residential facility care for the comparison group. In contrast, average individual monthly costs for nursing facility care of frail elders served by the Milwaukee care management organization were \$1,363 less than those for frail elders in the matched comparison group at the end of the study period. These shifts in services are a direct result of the flexibility in managing resources through the Family Care benefit package. As a result of these findings, the legislature decided in 2006 to extend the program statewide.

Rationale for Aging-Network-Based MLTC

Several factors are likely to make managed care approaches to the integration of long-term-care finances and services increasingly appealing to state policy makers interested in making their long-term-care systems more efficient and HCBS oriented. Many state policy makers are already familiar and comfortable with the extensive role played by proprietary MCOs in the Medicaid acute care programs in most states. In order to compete in this emerging environment, aging network organizations will need to prepare their own MLTC proposals and advocacy campaigns, drawing on the capacities they have developed in providing community-based care for over 30 years with general revenue, consumer fees, and Medicaid HCBS waiver funds.

In addition to the demonstrated capacity to administer long-term-care services, the potential value of a nonprofit aging-network-based approach to MLTC is suggested in a recent article by Schlesinger and Gray (2006) on the roles of not-for-profit and for-profit health care organizations in the American health care system. The authors reviewed 275 empirical studies covering a wide range of services, including hospital, nursing home, home health, hospice, and managed care plans. These studies examined several attributes of services, including cost, quality, and accessibility to indigent clients; trustworthiness of organization practices; pricing policies; and stability of service provision over time. The authors found that several attributes were consistently related to ownership type. For-profit organizations more aggressively mark up prices over costs and otherwise maximize revenue. Nonprofit organizations appear more trustworthy in delivering services, being less likely to make misleading claims, to have complaints lodged against them by patients, and to treat vulnerable patients differently from other clientele. Nonprofits are typically the incubators of innovation (e.g., HMOs during the 1930s or hospice three decades ago), using philanthropy and cross-subsidies to finance the development of services for which there is not yet a market. These three consistent differences constitute advantages for nonprofit organizations.

The fourth major difference is that nonprofit health care providers are slower to react to change, expanding capacity less quickly when demand rises and dropping services or withdrawing from markets less frequently when profitability declines. This last attribute would appear to favor for-profit providers. Schlesinger and Gray, however, express considerable ambivalence about whether this apparent advantage works well for patients:

Providers that constantly alter their service mix or market areas can disrupt vital relationships between patients and providers, and changing insurer practices can undermine patients' financial security. Recent experience with private health plans in the Medicare+Choice program illustrates such concerns. Frequent plan withdrawals and unstable benefits—both more pronounced among for-profit plans—left millions of seniors confused, without medical care, and with uncovered expenses. (Schlesinger & Gray, 2006, p. 298)

Preserving and strengthening the role of nonprofit agencies in long-term care may be even more important than maintaining their presence in the acute care system for the reasons described by Schlesinger and Gray (2006)—more important, because long-term care is labor intensive and, at its best, depends on close interaction between formal (paid) and many forms of informal (unpaid) care provided by family members, friends, neighbors, and

members of voluntary organizations. This caregiving network is more likely to thrive under the leadership of nonprofit, mission-driven organizations than for-profit organizations with a primary focus on generating shareholder value. The social capital (community trust and support) of nonprofit organizations is essential to building and maintaining networks of formal and informal care that are increasingly important in meeting the growing need for both privately and publicly supported long-term-care services and avoiding the potential crises of caregiving identified by the President's Council on Bioethics (2005):

The first is 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 second danger is the complete transformation of caregiving into labor, creating a situation where people's basic physical needs are efficiently provided for by "workers," but their deeper human and spiritual needs are largely ignored. (p. 48)

The risk of abandonment is likely to grow along with the large population of baby boomers who will not have children or spouses to help provide care. Furthermore, recent research indicates that individual social networks, including friends and family members, have declined sharply over the past 20 years (McPherson & Smith-Lovin, 2006). These trends indicate that the frail elderly persons of the future will be increasingly dependent on community support. Communities will be pressed to generate the levels of social capital that will be required to prevent the abandonment of those older persons who cannot pay for their own long-term care. The danger of commodifying long-term care is more likely to be avoided if the nonprofit, ethic-of-care-oriented aging network is able to survive and play a more comprehensive role in the delivery of long-term-care services.

In making the case for an HMO-based approach to MLTC, Saucier and colleagues (2005) raise a number of what they call "supply side issues" that need to be addressed in order to make long-term care an attractive investment opportunity for proprietary MCOs. According to the authors, these issues have to be resolved in a manner designed to reduce the role of local provider-sponsored MLTC plans in order to create more opportunities for proprietary MCOs. This perspective is contrary to our view that aging-network-based organizations (local providers) should play a major role in MLTC. The authors make this statement:

In some states, providers have applied political pressure directly to legislatures to ensure a role in a managed care program. In other states, the implementing agency deliberately creates a role for

provider-based plans to ensure that traditional infrastructure does not evaporate, to attract an adequate supply or to take advantage of the long-term care expertise in those provider organizations. The challenge is to regulate entities that generally have very little experience managing risk and very little capital to establish reserves. Continued reliance on provider-sponsored plans may result in the market being dominated by many small plans with low enrollments. . . . [V]enture capitalists are more interested in developing managed long-term care products that can be more easily replicated across states. Managed long-term care programs that are so state-specific that they cannot be leveraged in other markets will not be as attractive to investors. (pp. 25–26)

Small plans with relatively low enrollments may not generate all of the economies-of-scale advantages that presumably accrue to large, multistate plans, but modestly scaled, not-for-profit agency-administered plans offer advantages that we think are more important. These advantages include the capacity to reinvest savings (profits) in local or regional long-term-care services and greater responsiveness to the unique characteristics (strengths and needs) of local long-term-care systems, which is essential to generating and effectively utilizing social capital. Furthermore, local aging-network-based plans may be able to collaborate with contiguous local plans to create larger, regional plans with enrollments large enough to achieve significant economies of scale in their operations without forfeiting their embeddedness in local communities.

Saucier and colleagues also question the viability of county-based, aging-network-based models of MLTC: "While county-based plans appear to be viable suppliers in states with a history of county involvement, their further development remains local by definition and does not increase the number of suppliers who are active on the national market" (Saucier et al., 2005, p. 26).

This observation, like the one just quoted, raises these questions: What is the appropriate scale for long-term-care systems? What are the kinds of organizations that are best prepared to administer appropriately scaled systems? The fact that national MCOs are primarily interested in developing multi-state, uniformly structured MLTC systems does not mean that this should be the primary policy goal of policy makers and long-term-care advocates. As we have noted, long-term-care systems should be as integrated (embedded) into local and regional communities as possible; community embeddedness should be a more important criterion in determining the scale of long-term-care systems than the proprietary interests of large MCOs. We should also not lose sight of the fact that community embeddedness and the potential it creates for the generation of social capital helps protect local and state-specific

long-term-care systems against the unpredictable and often: “abrupt Medicaid policy changes that can occur, especially during periods of state fiscal stress” (Saucier et al., 2005, p. 26).

This fundamental reality of Medicaid funding and reimbursement policy creates considerable uncertainty in long-range profitability and the always-present possibility that proprietary MCOs would exit the long-term-care market, leaving only locally or regionally administered community-embedded long-term-care programs, if they still exist.

Conclusions

Many state aging service units, area agencies, and providers may be reluctant to take responsibility for all long-term-care services through the kind of managed care approach represented by the Wisconsin Family Care Program. Aging networks differ in their capacities to undertake the kinds of organizational and financial management tasks inherent in a managed long-term-care initiative (Nadash & Ahrens, 2004). Nonetheless, it is time for national aging organizations, state units, and area agencies to use information generated by the Wisconsin Family Care Program and other managed long-term-care programs to move toward the goal of establishing statewide, integrated, long-term-care programs within the next 10 years. This does not mean that all long-term-care funds should be integrated into a single capitated fund. States may decide to include only Medicaid funds (nursing home and community program funds) in a single, integrated fund and use their general revenue and Older Americans Act (OAA) funds to support early intervention and prevention-oriented services for a broader population of consumers than just those who are Medicaid eligible.

MLTC 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 long-term-care systems and that have played a critical role in both states’ successful efforts to create well-balanced (HCBS and nursing home care) systems of long-term care. As we noted earlier, however, it does not appear that many more states are prepared to implement similar systems of consolidated administration any time soon. In the absence of administrative consolidation, Wisconsin Family Care represents a promising aging-network-based, managed care 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.

Changing the direction of long-term care will be difficult. The task, however, of creating a more consumer-oriented, community-based long-term-care system will not be as difficult, either politically or fiscally, as trying to maintain the current system.

If the aging networks in communities across the country do not use their unique resources to create a mission-driven, ethic-of-care-oriented approach to integrating long-term-care services and expanding access to home- and community-based care, then for-profit MCOs are likely to take the lead in the development of comprehensive, capitated systems of long-term care.

The Special Needs Program created by the Medicare Modernization Act provides a potentially strong incentive for Medicare MCOs (Medicare Advantage) to incorporate long-term-care services for the Medicaid–Medicare dually eligible population. The success of the Special Needs Program probably depends on the ability of Medicare MCOs to convince many more dually eligible beneficiaries to join their plans. They must also convince state Medicaid officials and policy makers that Medicare costs will not be contained by shifting them to Medicaid. These are significant challenges to the development of the program on a wide scale. The program, however, is conceptually appealing and a clear indication that health care integration is becoming a federal priority (Gold, Hudson, & Davis, 2006). It is also an indication that the aging network needs to step up its efforts to create its own integration strategies, including MLTC, or risk becoming marginalized in the development of new approaches to long-term-care financing and service delivery over the next several years.

References

- Administration on Aging. (2005). *Creating more balanced long-term care systems: Case studies on the role of the national aging services network*. Washington, DC: U.S. Department of Health and Human Services.
- Alecxi, L., Lutzky, S., & Corea, J. (1996). *Estimated cost savings from the use of home- and community-based alternatives to nursing facility care in three states* (prepared for AARP Public Policy Institute). Des Moines, IA: The Lewin Group.
- APS Healthcare, Inc. (2005, October 7). *Family care independent assessment: An evaluation of access, quality and cost effectiveness for calendar year 2003–2004*. Silver Springs, MD: APS Healthcare for Wisconsin Family Care. Retrieved March 10, 2006, from <http://dhfs.wisconsin.gov/LTCare/index.htm>
- Branch, L., Coulam, R., & Zimmerman, X. (1995). The PACE evaluation: Initial findings. *The Gerontologist*, 35, 349–359.
- Form CMS 64. (2007, August 10). *Distribution of Medicaid long-term care expenditures for A/D services: Institutional vs. community-based Services, FY 2006*. Washington, DC: Center for Medicaid and State Operations.
- Fox-Grange, W., Coleman, B., & Milne, D. (2006). *Pulling together: Administrative and budget consolidation of state long-term care services*. Washington, DC: AARP Public Policy Institute.
- Gold, M., Hudson, M., & Davis, S. (2006, November). *2006 Medicare Advantage benefits and premiums* (prepared for AARP). Washington, DC: Mathematica Policy Research.
- Grabowski, D. (2003). *The cost-effectiveness of home- and community-based long-term care services: Review and synthesis of the most recent evidence*. New York: Center for Home Care Policy & Research.
- Kaiser Family Foundation. (2006, December). *Medicaid 1915(c) home and community-based service programs: Data update*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured. Retrieved January 18, 2007, from <http://www.kff.org>
- Kane, R. L., Kane, R. A., Finch, M., 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, 101–107.

- Kane, R. L., Homyak, P., Bershadsky, B., Lum, Y.-S., & Siadat, M. (2003). Outcomes of managed care of dually eligible older persons. *The Gerontologist*, 43, 165–174.
- Kane, R. L., Homyak, P., Bershadsky, B., Lum, T., Flood, S., & Zhang, H. (2005). The quality of care under a managed-care program for dual eligibles. *The Gerontologist*, 45, 496–504.
- Kane, R. L., Kane, R., Kitchener, M., Priestler, R., & Harrington, C. (2006, December). *State long-term care systems: Organizing for rebalancing* (Contract No. 500-00-0053). Washington, DC: Centers for Medicare and Medicaid Services.
- Lewin Group. (2000, November). *Wisconsin family care implementation process evaluation report* (prepared for the Wisconsin Legislative Audit Bureau). Des Moines, IA: Author. Retrieved August 29, 2007, from <http://lewin.com/newsevents/publications/>
- Lewin Group. (2001, August). *Wisconsin family care implementation process evaluation report II* (prepared for the Wisconsin Legislative Audit Bureau). Des Moines, IA: Author. Retrieved August 29, 2007, from <http://lewin.com/newsevents/publications/>
- Lewin Group. (2002, November). *Wisconsin family care implementation process evaluation report III* (prepared for the Wisconsin Legislative Audit Bureau). Des Moines, IA: Author. Retrieved August 29, 2007, from <http://lewin.com/newsevents/publications/>
- Lewin Group. (2003, June). *Wisconsin family care final evaluation report* (prepared for the Wisconsin Legislative Audit Bureau). Des Moines, IA: Author. Retrieved August 29, 2007, from <http://lewin.com/newsevents/publications/>
- McPherson, M., & Smith-Lovin, L. (2006, June). Social isolation in America: Changes in core discussion networks over two decades. *American Sociological Review*, 71, 353–375.
- Mitchell, G., Salmon, J., Polivka, L., & Soberon-Ferrer, H. (2006). The relative benefits and cost of Medicaid home- and community-based services in Florida. *The Gerontologist*, 46, 483–494.
- Nadash, P. (2004). Two models of managed long-term care: Comparing PACE with a Medicaid-only plan. *The Gerontologist*, 44, 644–654.
- Nadash, P., & Ahrens, J. (2004, Fall). *Bringing managed care home to the long-term care population* (Policy Brief). New York: Center for Home Care Policy and Research.
- President's Council on Bioethics. (2005). *Taking care: Ethical caregiving in our aging society*. Washington, DC: Author.
- Saucier, P., Burwell, B., & Gerst, K. (2005). *The past, present and future of managed long-term care* (prepared for the Office of the Assistant Secretary for Planning and Evaluation, Contract HHS-100-97-0019). Washington, DC: U.S. Department of Health and Human Services.
- Schlesinger, M., & Gray, B. (2006). How non-profits matter in American medicine, and what to do about it. *Health Affairs*, 25, 287–303.
- Sparer, M. (2003). Managed long-term care: Limits and lessons. *Journal of Aging and Health*, 15, 269–291.
- Stevenson, D., Murtaugh, C., Feldman, P., & Oberlink, M. (2000 Fall/Winter). *Expanding publicly financed managed long-term care programs to provide greater access to home- and community-based care* (Policy Brief). New York: Center for Home Care Policy and Research.
- Wiener, J. (2006). It's not your grandmother's long-term care anymore! *Public Policy & Aging Report*, 16, 28–35.
- Wiener, J., & Lutzky. (2001). *Medicaid home and community-based services for older people and younger persons with physical disabilities in Wisconsin* (prepared for the Health Care Financing Administration). Washington, DC: Urban Institute. Retrieved January 19, 2007, from <http://www.urban.org/publications/410376.html> and from <http://www.urban.org/expert.cfm?ID=Steven>
- Wiener, J., Tilly, J., Alexih, L., & Mario, B. (2002). Home and community-based services for older persons and younger adults with disabilities in seven states. *Health Care Financing Review*, 23, 89–114.
- Weissert, W., Lesnick, T., Musliner, M., & Foley, K. (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, 1329–1357.

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