

The Future of Long-Term Care in Florida

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Preface 2018

This brief issue paper was written for members of the aging advocacy community in Florida in 2010. The principle purpose of the paper was to persuade advocates, members of the Aging Network, Florida Legislature and others to support an Aging Network based non-profit model of managed Medicaid Long Term Care (LTC) in Florida. This was not a successful effort even with a decades' worth of evidence from the Wisconsin Family Care (WFC) program that an Aging Network based managed LTC model could be very successful in generating high quality outcomes very efficiently. Instead the state opted to pursue a for-profit model of managed LTC administered by large corporate health maintenance organizations (HMOs) beginning in 2013.

We would change very little in this 2010 issue paper if we were writing it today (2018). We are more convinced today than we were then that the Aging Network based models of managed LTC like WFC and similar models, though without formal capitation rates, such as those administered by the Aging Networks in Oregon and Washington, are more cost-effective than the corporate Medicaid managed LTC models, like the Florida Statewide Medicaid Managed Care SMMC program. The only changes we would make if we were writing the paper today would be the following:

- 1) We would change the first challenge to reflect the fact that the Florida Medicaid LTC program is less dependent on nursing care than in 2010. The Florida system is now more balanced between nursing home and community-based care programs. The movement toward greater balance has been underway for 20 years and continued under the managed LTC program from 2013 to 2018.
- 2) We would put an even greater emphasis on the fact that the gap is growing between the need for LTC services among low income elderly and the state's capacity to provide services to meet their rapid growth in the need for care. This growing gap is reflected in the wait list for needed Medicaid LTC services, which now stands at 47,000. This is a critical issue which we are confident could be better met, that is met more effectively and efficiently, through an Aging Network based managed LTC program like WFC than the current program administered through corporate HMOs.

2010 Brief

The aging of the Baby Boom generation will greatly increase the need for long-term care (LTC) services in Florida and most other states and pressure to develop a more cost-effective system of services. Creating a more effective LTC system is likely to hinge on successfully confronting three major challenges.

The *first* challenge is the fact that the current publicly funded system is far too dependent on institutional (nursing home) care, which receives about 80% of all public funding and generates a wide gap between what we know (older people want community-based care, which we now

know how to provide cost-effectively) and what we do in long-term care (nursing home domination).

This gap needs to be narrowed in preparation for confronting the *second* challenge to long-term care policy, which is the huge projected increase in the older population over the next 30 years. This increase will cause a doubling of the need for long-term care services by 2030 and, at this point, a large majority of the states, including Florida, are poorly prepared to meet this need in a cost-effective manner.

The *third* challenge is the fiscal shortages facing the states and federal government that is likely to be chronic over a relatively long period, in part because of the projected growth in Medicaid spending on long-term care at the state level. This challenge is also related to the first challenge in that the states need to create far more balanced (community-based) long-term care systems that are more affordable and better designed to meet the growth in long-term care needs than the current nursing home dominated system.

Nationally, about 75% of all public LTC expenditures currently support nursing home care and the other 25% is used to provide LTC services in the community, mainly in-home services like home health care, personal care, homemaker, and respite services (Tritz, 2006). In Florida the percentage of LTC funds spent on nursing home care is about 85%.

The fact that we spend so much more on nursing home care than community-based care for older individuals with LTC needs is the fiscal manifestation of the still large gap between what we know and what we do in our publicly supported LTC in most states. We know that most older persons needing LTC services would very much prefer to receive in their own homes or in a community-residential setting rather than a nursing home. The relatively limited level of public funding, however, for HCBS alternatives to nursing home care in most states severely restricts their availability for those without the means to pay for them privately. This clear preference for in-home- and community-based LTC services is matched by a growing body of research which demonstrates the relative cost-effectiveness of these services, if properly administered, and the success of a few states in developing an expansive array of community-based services over the last 20 years.

Only nine states, however, now spend 40% or more on their public LTC dollars on HCBS programs. Oregon, Washington, New Mexico, and Alaska now spend 50% or more on HCBS programs, which is a threshold most states passed years ago in their programs for the developmentally disabled (CMS 64 Data, 2007). Seven of the nine states spending 40% or more on HCBS programs for the elderly are very close to or below the national per capita age 65 plus LTC spending average. This level of efficiency permits these states to meet a greater share of the need for LTC services than other states with less balanced LTC systems, while containing total LTC spending.

One of the reasons for the relatively slow growth of home- and community-based long-term care for the frail elderly is the perception that community-based care is not cost-effective because it lacks the capacity to substitute for institutional care by diverting seriously impaired elderly from nursing home placement. Findings reported, however, in articles by Greene et al. (1995); Harrow et al. (1995); Jette et al. (1995); Miller et al. (1998); Rhoades (1998); Weissert et al. (1997); Hollander and Chappel (2002); APS Healthcare (2005); and Mitchell et al. (2006)

indicate that there is a substantial potential for cost-effective and improved LTC in the expansion of well-designed and administered home- and community-based programs.

Recent studies of Medicaid-funded HCBS programs in Florida covering a five-year period from 2000 to 2005 found that all of them were cost-effective alternatives to nursing home care (Mitchell, Salmon & Polivka, 2006); (Mitchell, Polivka & Wang, 2007). These programs ranged from one-quarter to one-half as expensive as the Medicaid nursing home program after matching the impairment and caregiver resource profiles of entrants to the HCBS programs with the profiles of the nursing home population over the three-year study period.

The Mitchell et al., 2006 study found that the difference between Nursing Home Diversion only and the least expensive HCBS waiver program (Aged and Disabled Adult waiver only) was \$640 PMPM (per member, per month costs), after controlling for frailty, chronic health conditions, demographics, living in the community, and change in living situation and functional status. Nursing Home Diversion beneficiaries enter long-term nursing home care approximately two months later than the HCBS waiver program with the lowest months until long-term nursing home entry (again, Aged and Disabled Adult Waiver only). The average Medicaid nursing home per diem was \$120. The \$7,740 in savings from delayed long-term nursing home entry come at a cost of \$36,372 over the 36-month follow-up period in total Medicaid claims for the Nursing Home Diversion only HCBS entrants compared with the Aged & Disabled Adult waiver only entrants.

A recent study by OPPAGA of Medicaid waiver HCBS programs in Florida generated findings very similar to those from the three Florida Policy Center studies. The main differences between the OPPAGA and the FPECA studies are that the former is limited to Medicaid beneficiaries with Alzheimer's or related dementia and includes a cohort of beneficiaries in the traditional Medicaid program who did not participate in one of the waiver funded programs. The OPPAGA study found that:

At the end of 36 months, elders with Alzheimer's disease or related dementia who were served by the traditional Medicaid program were much more likely to have entered a nursing home than similar elders served by any of the waiver programs. Such elders served by Medicaid had a 65% probability of nursing home entry, after 36 months, more than three times higher than that of any of the waiver programs. This difference in outcomes appears to be due to the waiver programs providing support services such as case management, respite care, adult day health care, and personal care that are not generally available under the traditional Medicaid program.

The study also found that:

The state paid, on average, from \$263 less to \$994 less per month to serve elders that participated in a waiver program than to serve similar elders who did not receive any waiver services.

Finally, while all four of the waiver programs were more cost-effective for beneficiaries with Alzheimer's or related dementia than the traditional Medicaid program, the study found that the two aging network operated waiver programs were substantially less expensive on a per person

per month basis than Nursing Home Diversion, the managed LTC program. The Aged and Disabled Adult (ADA) waiver cost \$589 less PPM than Diversion and the Assisted Living for the Elderly (ALE) waiver cost \$414 less than Diversion. The ADA waiver cost \$1387 PPM, the ALE waiver cost \$1562 PPM and the Diversion waiver cost \$1976 PPM in total federal and GR expenditures.

One of the most striking findings from this study is that the waiver funded HCBS programs are extraordinarily cost-effective alternatives to the traditional Medicaid programs which provides little if any HCBS long-term care services. This cost difference is achieved by decisively reducing nursing home use for cohorts of persons with Alzheimer's or related dementia. This is compelling new evidence for the efficacy of community-based LTC and against the notion that these programs are subject to a substantial "woodwork" effect that undermines their capacity to reduce nursing home utilization.

The second most important finding is that the major differences among the waiver programs in terms of their relative per person monthly costs (PPM). All four of the HCBS programs are less expensive than the traditional Medicaid program, but the two programs (ADA & ALE) operated by the aging network organizations are 25 to 35% less expensive than the Nursing Home Diversion program which is largely administered through proprietary managed care organizations.

In their analysis of state spending data between 1995 to 2005, Kaye, Laphante & Harrington found that long-term care spending growth was greater in states offering limited non-institutional, community-based services than for states with large, established community-based long-term care programs. They note that expansion of home and community-based services entails a short-term increase leading to a longer term reduction in nursing home care and long-term cost savings. Although Florida does not have a comparatively large HCBS system, the OPPAGA report and the leveling off of the nursing home population since the late 1990's would seem to indicate that the state has enough HCBS capacity to generate LTC cost savings. The authors conclude by noting that:

It is clear, in any case, that states offering noninstitutional alternatives have been able to contain and even reduce costs, largely avoiding a feared "woodwork effect" in which the demand for services was predicted to grow tremendously once HCBS programs became available.

The mere availability, however, of cost-effective HCBS programs is not sufficient to maximize opportunities to create a more efficient and cost-effective LTC system. Methods of organizing, administering, and financing LTC are critical to achieving these goals. The availability of HCBS programs, however, is a necessary, if not sufficient, condition for the development of more efficient and consumer-oriented LTC systems and for closing the gap between what we know and what we do in providing LTC services in most states. Creating more balanced LTC systems by expanding HCBS programs and containing the use of nursing home care is critical to meeting the large projected growth in the need for LTC services over the next two decades in a cost-effective manner.

Many states, however, appear to be focusing less on closing the knowledge and practice gap in LTC and more on limiting the growth of their Medicaid-funded HCBS programs. A 2007 report by the Kaiser Commission found that the number of persons on waiting lists for waiver services

was increasing. In 2006, 280,176 individuals were on waiting lists for 93 waivers in 31 states, up from 260,916 individuals in 2005 and 206,427 individuals in 2004. The average length of time an individual spent on a waiting list ranged from 13 months for aged/disabled and children's waivers to 42 months for aged waivers. As noted earlier, even with the declining impairment rates among the elderly and an overall improvement in health care status, the need

for LTC is projected to increase by 50 to 100% over the next 25 years, which will put a great deal of pressure on Medicaid budgets in many states (Johnson et al., 2007).

From an administrative perspective a consolidated state LTC agency appears to be the most important single factor in facilitating the development of balanced LTC systems, in part by making the other factors associated with rebalancing more achievable. Only two states (Oregon and Washington), however, have fully integrated control over all LTC programs and funds, including the Medicaid Nursing Home Program in their state aging and adult services agencies. In other states, the management of LTC programs is split between departments of aging/senior services (home- and community-based programs) and the departments housing the Medicaid program (nursing homes and some home care). The department that houses Medicaid, in effect, controls on average 70 to 80% or more of all LTC resources. The efficacy of a fully consolidated administrative and financing structure for LTC services is demonstrated by the extraordinary success of Oregon and Washington in developing balanced LTC systems by vastly expanding their HCBS programs and containing total LTC expenditures.

An alternative method of integrating LTC authority that 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 and operate it under a capitated rate based on all major LTC funding sources, including potentially Medicaid nursing home funds. The capitation rate could be constructed through negotiation between representatives of the aging network, under the leadership of the state aging unit, and the state's Medicaid office, and incorporated into a contract. Wisconsin has taken this approach with the Wisconsin Family Care (WFC) Program.

The Wisconsin Family Care Program has two components—aging disability resource centers and care management organizations (Wiener, Tilly, Alexih et al., 2002). The resource centers serve as single points of entry into the LTC system, providing information and counseling and access to all LTC services and providers and on preventive health care and early intervention services. An important feature of the resource centers is their capacity to serve not only Medicaid-eligible consumers, but also private-pay consumers and their families.

The second major component of the Wisconsin Family Care Program is the care management organizations (CMOs) (APS Healthcare, 2005). The CMOs are capitated, managed care organizations for all LTC services, including nursing home care. The capitation rate includes Medicaid (nursing home and home- and community-based services) state and county funds consolidated into single monthly payments that average about \$1,800 a month. The capitation rate constitutes a strong incentive to keep consumers in the community (nursing home care costs much more) and to create a seamless system in which individuals' needs dictate the services provided, rather than program eligibility criteria.

A comprehensive evaluation of Family Care found that the program has generated significant savings, high consumer satisfaction, and changed the kinds of services provided (APS

Healthcare, 2005). The CMOs 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 WFC community-based residential facility (CBRF) was \$462 more than that spent for CBRF care for the comparison group. On the other hand, 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 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.

Managed LTC strategies clearly have the potential, if properly administered, to reduce fragmentation in LTC services, enhance access to consumer preferred services, and improve overall efficiency (Kane et al., 2008) describe some of the steps needed to insure that managed LTC programs are effectively administered:

Managed LTSS, often introduced as part of overall managed Medicaid services can be used to encourage community care and rebalancing if: the state is clear on incentives for community care; a mechanism is available to ensure that consumer choice of living situation is respected, and consumers are offered consumer-directed models; and assisted living settings are not over-utilized. Managed LTSS is more likely to carry incentives for HCBS if the providers are at financial risk for nursing-home care and/or incur penalties when nursing home residents disenroll.

A few states (Minnesota, Massachusetts, and Wisconsin) have developed Medicare and Medicaid managed care programs designed to integrate acute, chronic, and LTC services. These initiatives are based on lessons learned from the PACE Medicare/Medicaid program which was created over 20 years ago and now operates in over 20 states. The relative cost-effectiveness of these relatively early-stage programs has not yet been clearly established but their potential is very promising. Most states, however, may be better served by integrating their LTC systems before implementing Medicare and Medicaid managed care programs (Polivka, 2005).

One of the best ways for the aging network to play this role is to create a managed LTC system which integrates LTC funds (state and federal) and services (community-based and nursing home care) in advance of any effort to integrate long-term care and acute care. This approach would strengthen the aging network's ability to use managed care to expand community-based services (shifting resources from institutional to community-based programs) and to prepare mechanisms for "downward substitutions" when more fully integrated systems (long-term care and acute care) are implemented (Wiener and Skaggs, 1995).

Long-term Care Policy in Florida

Florida has made substantial progress over the last 20 years in the development of an HCBS system of LTC services. The HCBS infrastructure includes over 30,000 slots funded through Medicaid waivers and GR resources distributed across in home and community residential

programs. The state has also recently implemented a nursing home transition program designed to routinely move carefully identified nursing home residents into HCBS programs.

The state, however, still spends over 80% of its long-term care funds on nursing home care and serves over two thirds of those receiving assistance in nursing homes. These percentages place Florida in the bottom quartile of states in terms of providing a cost-effective balance of LTC services. The pressure to create a more balanced LTC system will increase rapidly over the next decade with the growth of the age 75 plus and 85 plus populations needing LTC services. Current projections indicate that this increasing need for LTC services will occur simultaneously with increasing stress on the state's fiscal capacities caused by uncertain economic and demographic trends and continuing needs across the board (education, corrections, transportation, health care) for more state resources. The interaction of these trends has clear implications for the future of LTC policy in Florida. The state needs to accelerate the development of a more cost-effective balance between home and community-based LTC services and nursing home care and it needs to create this better balance in the most cost-effective manner possible.

As shown in findings from the Florida Policy Center on Aging and OPPAGA studies discussed earlier, it does not appear that the HCBS policy and budgeting strategy that has been in place for the last decade is the most cost-effective approach to balancing Florida's LTC system. Although the Nursing Home Diversion Program has received over 90% of new HCBS funding since 2000 the evaluation research conducted since 2003 shows that it is substantially less cost-effective than every other Medicaid waiver program administered during the last 10 years. For example, after controlling for consumer characteristics the Aged and Disabled Adult waiver program costs \$7,000 less per person per year than the Diversion Program which means the ADW waiver is over 50% more cost-effective.

These studies raise important policy questions about the current mix of programs in terms of differential growth rates over the past several years and whether or not a greater percentage of the need for care could be met through increased funding for two aging network operated waiver programs (Aging and Disabled Adults and Assisted Living for the Frail Elderly); neither has grown much over the last five years. A different apportionment of available slots across HCBS programs could increase the number of Medicaid beneficiaries receiving needed HCBS services and potentially divert more of them from nursing home placement.

Administrative integration of LTC services appear to be as important as expanding HCBS funding in creating a balanced LTC system. Oregon and Washington have enhanced the efficiency with which they administer their expansive waiver-funded programs by creating and integrating organizational structures at the state and service delivery levels to administer all public long-term care resources—nursing home and HCBS funds. This gives them the capacity to manage all long-term care funds, including Medicaid nursing home resources, and is probably the most important single factor in the development of HCBS-oriented long-term care systems according to several recent assessments of state initiatives to create more balanced long-term care systems (Kassner, Reinhard, Fox-Grage, Houser & Accius, 2008; Kane, Kane, Priester & Homyak, 2008; Alecxih, 2008; Gage, Brown, Katutsky, Moore and Auerbach, 2002; and Eiken, Nadash & Burwell, 2006). The efficacy of a fully consolidated administrative and financing structure for long-term care services is demonstrated by the extraordinary success of Oregon and

Washington in developing balanced long-term care systems by vastly expanding their HCBS programs.

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 managed long-term care program at the local or regional level and operate it under a capitated rate based on all major long-term care funding sources, including Medicaid nursing home funds. The capitation rate could be constructed through negotiation between representatives of the aging network, under the leadership of the state agency unit, and the state's Medicaid office, and incorporated into a contract. Wisconsin has taken this approach with the Wisconsin Family Care (WFC) Program.

The 2010/11 Legislative budget for HCBS programs implicitly recognized the superior cost-effectiveness of the aging network waiver programs (ADW & ALE). The Legislature provided modest increases in the ADW & ALE Medicaid waiver programs and no new funds for the Diversion Program. This is the first time these programs have ever received increases when the Diversion Program did not. These funding decisions reflect the growing perception among some policy makers that the aging network based HCBS programs are more cost-effective than the Diversion Program and are more likely to provide a better return on expenditures (serve more people per dollar spent). This is an increasingly critical consideration as the state encounters increasing fiscal pressure and a growing need for LTC services over the next several years. These developments should be recognized by aging network organizations as creating an opportunity to shift the trajectory of LTC policy in Florida toward the expansion of LTC services provided through the network and an opportunity to build on the successes of the network in creating an HCBS infrastructure over the last 30 years. The network should take advantage of the results of the 2010 Legislative session by organizing a group of representatives from the network for purposes of preparing a proposal for the qualitative expansion of network based LTC services over the next several years; a proposal designed to maximize the proven cost-effectiveness potential of the network's HCBS programs and help the state manage its long term fiscal crisis.

A proposal, however, based on a simple expansion of the network's Medicaid waiver and GR funded programs is not likely to gain much traction with the Legislature and the Governor's office, however cost-effective these programs have in fact proven to be across numerous studies. The Legislature seems committed to managed care strategies in the Medicaid program including LTC. This does not mean, however, that the only feasible managed LTC option is the Diversion Program. The aging network, in fact, has been administering a form of managed LTC services since the inception of the CCE/HCE programs in the mid 1970's and the Medicaid waiver program in the mid 1980's; a form of managed LTC services that is more cost-effective than the more fully developed form offered by the capitated Diversion Program. This experience along with lessons from the successful aging network based managed LTC program operated by the Wisconsin Family Care (WFC), which is based on a conceptional design first developed in Florida 15 years ago (the 1994/95 Pinellas Pasco LTC Project) gives the aging network resources that can be used to formulate a Florida model of aging network based managed LTC for consideration by the 2011 Legislature. The 2010 Legislature created the opportunity for this kind of initiative and it is now up to the Florida aging network to take advantage of it by developing a proposal by this Fall (2010) that uses a managed care design to maximize the

network's demonstrated cost-effectiveness in delivering LTC services to a growing population of frail elders.