

The Future of Long-Term Care: The Aging Network and Managed Care

Larry Polivka, Ph.D.
School of Aging Studies
Florida Policy Exchange Center on Aging
University of South Florida
Gerontological Society of America
Orlando, Florida
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Managed LTC—Current Status (extent of MLTC)

- Small part of the LTC system (2-3% of LTC pop.)
- Only a few states have extensive MLTC programs—AZ, TX, FL, WI, MA, MN, NY.
- Only MN (MSHO), WI (Wisconsin Partnership Program), MA (SCO), and the PACE sites have managed care Medicaid/Medicare integrated programs—may change with SNPS program (MMA).
- Other states are interested in MLTC given its theoretical potential to contain costs/or make them more predictable through risk bearing arrangements.

Current Status—Major Players

- Most MLTC programs are operated by non-profit providers, serving sub-state regional areas
- Evercare, and to a lesser extent Americare, however, are major players in FL, TX and are active in AZ.
- The Wisconsin Family Care Program is the major, most systematically organized aging network-based MLTC program (5 yrs. old), although aging network providers play a major role in NY (10 sites) and area agencies are an integral part of the Massachusetts program.

Current Status—Costs and Outcomes

- Few systematic evaluations have been completed, including the 1997 ALTCS evaluation (Weissert), the 2005 Family Care Evaluation (APS) and the more limited studies conducted in Florida (2004/05).
- ALTCS evaluations—The program reduces costs by containing nursing home admissions—relatively rigorous client assessment and referral process and expansive use of HCBS. ALTCS has made effective use of managed care incentives.

Current Status—Costs and Outcomes (cont'd)

- Family Care Evaluation—The program has eliminated waiting lists, has lower per-person costs than the conventional fee-for-service waiver-funded HCBS program, and has higher consumer satisfaction outcomes.
- The Florida HCBS Evaluation—As shown earlier, there is no evidence yet that the major MLTC program (Diversion) is less expensive or produces better outcomes, given the limited measures used, than the fee-for-service HCBS programs operated by the aging network.

MLTC—The Future

- Absent a major federal initiative, MLTC is likely to continue its slow growth trajectory. The SNP programs could accelerate growth by enticing more HMOs to serve the dually eligible population.
- State variations in models of MLTC are likely to be the norm, reflecting differences in LTC infrastructures and political realities (relative influence of nursing home industry, HMOs, advocates for the elderly, and aging network organizations).
- Within a decade, however, MLTC is likely to be as common as fee-for-services LTC with both HMOs and AN-based organizations playing major roles, but mostly in different states, depending on the political and organizational sophistication of the state's aging network.

The Role of State and Federal Governments

- The relative cost-effectiveness of MLTC will largely depend on the ability (willingness) of CMS and state legislatures and Medicaid agencies to establish and actively maintain accountability systems based on the collection and reporting of accurate cost and outcome data, which can be used to set capitation rates and ensure quality.
- This will require more analytical and administrative capacity and autonomy than CMS and most state agencies now have.