

MEMORANDUM

To: Interested Parties
From: Department of Elder Affairs
Date: November 29, 2001
Re: Preliminary Evaluation of the Managed Long-Term Care Programs

In accordance with the General Appropriations Act for 2001-2002 the Department of Elder Affairs, with the approval and cooperation of Agency for Health Care Administration, contracted for an evaluation of the effectiveness of the managed long-term care programs. The department contracted with the University of South Florida Policy Exchange Center on Aging to complete this task. Attached is a copy of the evaluation.

Managed Long-Term Care Programs – Original Goals and Objectives

- To test the effectiveness of managed care and outcome-based reimbursement principles when applied to long-term care.
- Provide the amount, intensity, scope, and flexibility in delivering services to meet people's needs.
- Cutting out the layers of administrative bureaucracy. One HMO provides all long-term care services instead of multiple programs providing similar services.
- Targeting services to the people most in need.
- Integration and coordination of acute and long-term care.
- Holding providers more accountable.

Current System - Concerns	How the Programs Address Concerns
The supply of community-based services does not keep pace with the increasing demand.	The programs use a capitation payment methodology that allows the HMOs to provide an enriched set of services including preventative health, home health care, DME, dental, and pharmaceutical counseling, and the flexibility to create new and innovative approaches in providing the type and quantity of care people need.
Multiple programs provide similar services to similar groups of people requiring multiple administrative needs.	One HMO is responsible for providing clients' complete LTC needs. Furthermore, since the Department is able to contract directly with providers there is no need to have the administrative layers of local and governmental agencies.
It is a challenge to target services to the people most in need.	The department is using its CARES unit staff to insure proper targeting of the program to the people most in need. Having CARES perform all screening and enrollment activities prevents "cherry picking" of the healthiest members by an HMO.
Services are not integrated across programs, acute and long-term care services are provided without regard for one another. Physicians do not	The integration of medical and long-term care is critical to achieving a continuum of care. The program is designed to have one HMO provider responsible for a client's complete long-term care and the coordinating of

Current System - Concerns	How the Programs Address Concerns
know what long-term care services their patients' are receiving, case managers do not know when their clients go to hospitals or nursing homes.	their acute care. In recognition, the managed long-term care programs have taken the first steps toward integration by requiring cooperation and coordination between case managers, physicians, home health aids, specialists, hospitals, and nursing homes.
Providers should be held accountable for outcomes and cost-efficiencies.	Although the department has instituted outcome measures in the traditional waiver system, HMOs participating in the programs are capitated and placed at full risk for providing all services including nursing home care. This insures that the HMOs are accountable and have every incentive to maintain individuals in the community and not place them in nursing homes. The use of capitation also removes incentives to overcharge, over-supply and over-utilize care.

Evaluation - Goals and Objectives

- Respond to the legislative requirement to test the effectiveness of the programs– taking into account the time limited experience of the programs.
- Establish a base line from which to comprehensively evaluate the programs.
- Comply with Medicaid waiver requirements to evaluate quality of care, access to care, and cost-neutrality as compared to nursing home care.
- Respond to the Robert Wood Johnson Foundation's request to document the programs' implementation, successes, and challenges.
- Identify areas of success and those that need further involvement or attention.
- Compare performance of existing providers enrollments, client characteristics, etc.
- Analyze service mix and consumer-based outcomes.
- Make recommendations for a comprehensive evaluation.

Evaluation – What this short-term evaluation did not cover taking into account the time-limited experience of the programs.

- Comprehensively evaluate and review the medium and long-term goals of the programs.
- Provide an actuarial analysis of the program's capitation rate.

Evaluation - Highlights

- The programs serve a frail population. The clients served in the program are more impaired than the typical Medicaid elder and more impaired than the traditional Medicaid waiver population.
- The programs are cost-effective versus the cost of Medicaid nursing home care.
- Case managers operate as advocates for their clients. They maximize and coordinate Medicare and Medicaid benefits.
- The capitation rate methodology allows for flexibility to combine and expand services to meet people's needs. Program contractors provide services outside the traditional Medicaid waiver programs.
- All three-program contractors are involved in developing emergent long-term care quality assurance clinical practice guidelines.

- Clients were generally more satisfied with the programs than with the traditional Medicaid waiver.
- The programs provide insight into the critical value of keeping client record systems. Systems should be computerized for tracking, sharing records, billing and reporting.
- Potential expansion of programs to include private pay clients.

Evaluation - Areas Requiring Further Attention

- Better understanding of reasons for disenrollments
- Expanding provider networks and client choices
- Improving program service utilization reporting
- Ongoing training of case managers
- Hasten the Medicaid eligibility process

Recommendations for Further Evaluation

- Conduct a comprehensive evaluation of the programs' medium and long-term goals including an actuarial analysis of the long-term care capitation rates
- Compare outcomes (such as slowing the rate of decline or improvement in impairment, hospitalizations, nursing home placements, etc.) between the managed long-term care programs and the traditional Medicaid waiver programs
- Develop clinical and financial outcome measures and incentives
- Compare and contract all long-term programs
- Compare client characteristics, utilization data, and overall operations between managed long-term care programs and the traditional waiver programs