PROSPECTUS
Long-Term Care Community Diversion Project

Program Summary: The Long-Term Care Community Diversion Pilot Project (Pilot Project) allows pilot counties to contract directly with the Department of Health Care Policy and Financing to test the effectiveness of a program that uses a capitated system of care to provide Home and Community-Based Services (HCBS) as an alternative to nursing home care, in one or more counties. Pilot counties manage and coordinate each client’s care in exchange for a capitated amount of money per client each month.

Pilot counties provide medical services covered by Medicaid for long-term care for elderly, blind or physically disabled adults over the age of 18, without regards to their long term care status.

The State and pilot counties share the financial risk. Pilot Counties accept the risk for the first $1 million loss over the capitation, and the State accepts the risk for anything over $1 million.

Problem Definition
Some of the largest Medicaid expenditures in the State are for long-term care services for individuals requiring care in nursing facilities. Because of the current status of the state budget and the increasing rise in Medicaid costs for long-term care, the development of a comprehensive, cost-effective system of long-term care for the elderly is an issue of particular concern.

The rising costs of long term care is especially of concern to Mesa County. The population of individuals age 65 and older is expected to increase by 16.59% in Mesa County by 2005, compared to the state average which is expected to increase by 7.2% by 2005. (Source: Colorado Dept of Local Affairs) This indicates that our situation will only worsen in the years to come and thus highlights our need to find a viable solution. This huge demand for long-term care programs will continue to grow, and Colorado must further expand lower-cost options to expensive nursing home placement, such as assisted living care and in-home services.

A recent State audit of Home and Community Based Services identified many problems with the controls currently in place over these services, and payments for them. Many of these problems occur because the program is currently funded on a fee-for-service basis. A fee-for-service payment system inherently encourages providers to obtain authorization and bill for services that may not be medically necessary, and also presents many opportunities for abusive billing practices. Additionally, fee-for-service payment systems place all financial risk on the State. Not only is the State at risk for paying for unnecessary services, it is also responsible if more services are provided than the budget will support.
**Recommendation**

We recommend the implementation of a Long-Term Care Community Diversion Pilot Project (Pilot Project) to test the effectiveness of a program using a capitated system of care to provide Home and Community-Based Services (HCBS) as an alternative to nursing home care. Capitation payment is made to pilot counties from the state for all persons 18 years of age or older who are elderly, blind or physically disabled. This does not include those with Mental Illness or Developmental Disabilities. This includes all adults in this category, without regards to their long term care status.

The integration of managed care into long-term care has the potential to lower the costs of long-term care. By utilizing managed care concepts, pilot counties are able to control costs by diverting elders from nursing home care to more appropriate community-based settings.

Supportive services, such as home-delivered meals, health services, and intensive case management, provided to clients in their home through Home and Community Based Services (HCBS), provide an alternative to nursing home care. Our current system is one that favors the more expensive nursing home care over community-based services. The Level of Care screen to determine eligibility for nursing home level of care is less stringent than the Level of Care screen to determine eligibility for Home and Community Based Services.

Additionally, the capitated system of care allows for better coordination among health care providers and offers local control, thus preventing duplication of services, improving services to patients and allowing for seamless management of care.

- **Pilot Counties**
  This pilot would involve one or more counties. Each county contracts directly with the Department of Health Care Policy and Finance for the capitated dollars.

- **Length of Pilot**
  The pilot runs three to five years. At the end of three years the pilot is evaluated to determine if it should continue for two more years and if any necessary changes need to be made in the overall model.

- **Capitation Amount**
  Actual capitation amount is based on actuals from the previous years spending and is determined individually, for each individual pilot county.

- **Reporting**
  Pilot counties submit reports to the Department of Health Care Policy and Finance quarterly. Reports include number of clients served in nursing homes, number of clients served in the community, year-to-date costs of nursing home care, year-to-date costs of HCBS, and any other reports as determined by the legislature.
Support
This type of model has been encouraged by the State Legislature and the Office of the State Auditor. In Footnote 51 of the Fiscal Year 2002 Long Bill the General Assembly asks that the Department of Health Care Policy and Financing look at managed care models for both institutional and community long-term care. The Office of the State Auditor, in its June 2001 audit of Home and Community Based Services, encouraged the Department of Health Care Policy and Financing to begin looking at managed care models as a means for controlling the costs of these programs and minimizing the risk to the State of inappropriate payment and overspending.

Additionally, this model is supported by the Mesa County Commission and the Mesa County Department of Human Services as an appropriate project to piloted in Mesa County. Costs and types of care available for long term care needs is high on the priority list for AARP for the 2003 legislative year and they fully support this pilot model.

Opposition
Some opponents of this model would argue that HCBS services are already available. However, due to budget constraints there is a current freeze on all new HCBS clients. Additionally, HCBS is limited to only serving clients who meet the level of care screen for HCBS, which is more stringent that the level of care screen for nursing home care, as previously mentioned. By discontinuing the use of the MINS (Most In Need of Services) screening tool, we are able to serve clients before they reach the higher level of care, and that we are able to delay nursing home placement for a longer period of time. For each month that we are able to delay the nursing home placement, we will save money and improve the quality of life of the individual.

Additionally, HCBS services currently covered are limited in scope and this model allows for more flexible spending, thus allowing for creative ways to further delay nursing home placement. The flexibility allows us to address the many social problems of low income persons which effect their health; additional types of equipment such as cameras to monitor the client, medication reminders, etc.

Some opponents would argue that nursing homes are the most cost effective choice for long term care. While this might be true for approximately 600 clients state wide, these cases are the minority. In those cases, nursing home care is often not even an alternative, rather the choice is between expensive HCBS or hospitalization. In these cases, in order for the client to find an appropriate institutional setting, they have to leave the community and their families. By and large, because this model allows more flexibility it allows more opportunities to provide good, cost-effective case management.

Other Models
Other States’ Medicaid programs have faced similar problems with fee-for-service systems and have been able to overcome many of the problems by moving to a capitated system of care approach for providing services to recipients.

Because many states have seen positive results from enrolling certain Medicaid
populations in array of managed care models for the delivery of primary and acute care, states are also looking to managed care as an opportunity to better coordinate health and long-term care services, improve access to needed care and better control Medicaid costs.

**Oregon**

In the late 1970’s and early 1980’s Oregon faced a tremendous financial crisis in At that time, the state was in a major recession due to a significant downturn in wood products, the state's major industry. Oregon was also experiencing unsustainable growth in its nursing facility expenditures. From 1974 to 1979, Oregon's nursing facility caseload increased more than 30 percent, while the population of Oregonians aged 75 and older was growing by only 14 percent. The rate of inflation in nursing facility cost was over 100 percent, while medical inflation was about 80 percent.

These stark financial realities forced Oregon's Legislature to take a long and hard look at the Medicaid long-term care program. There was no way that this growth could be maintained while the state coffers were shrinking. In 1981, the state legislature took action and consolidated the state's unit on aging and its Medicaid long-term care program. Shortly after the creation of this new division, Oregon received a Title XIX waiver that allowed the state to spend Medicaid nursing facility dollars on community-based care.

Far exceeding the initial goal of serving half of their clients in nursing facilities and half in the community, DHS now serves 75 percent of their Medicaid clients in home and community-based care settings. Despite a 98 percent growth in total caseload since 1985, Oregon's nursing facility caseload has dropped almost 9 percent, while the percentage served in home-and community-based care has grown 224 percent.

Oregon's success in developing community-based care and discouraging unnecessary institutionalization of seniors has been built on their case management system. Through their case management system, consumers get information and assistance, assessment, and planning.

**Arizona**

One example of an innovative state designed managed long-term care model is Arizona’s Long-Term Care System (ALTCS). This program is currently the only statewide capitated managed long-term care system that exists in the country.[88] Implemented in 1989, the program is targeted to persons with income up to 300% of SSI ($1,482 per month) who have been assessed by state employed screeners and assessors as needing at least three months of nursing facility level care. Results of a recent independent evaluation estimated that substitution of home and community based services for this very frail population cost about 35% of otherwise expected nursing home costs for this population.[89] Also, savings generated have been sustained over multiple years.

Key program design features contributing to the success of this program included:
- carefully developed capitation rates. Rates were established at a level such that those plans that did not make home and community care a priority would lose
money as a result of using more nursing home days that the capitated rate accommodated.

- carefully developed targeting criteria and eligibility determination procedures. Assessments are conducted by trained staff independent of providers at risk to avoid the potential "woodwork" effect and subsequently reduced cost efficiency.
- putting providers at risk for some skilled nursing facility care to further promote home care options.
- a broad array of long-term care service options were allowed to increase the potential of meeting care needs through home and community based services.[90]

**North Carolina**

North Carolina is in the process of implementing a managed long-term care research and demonstration project in the Northeast section of the state. Initially, five counties will participate (Pasquotank, Perquimans, Currituck, Chowan, Camden). A second demonstration site will be implemented in the counties of Caldwell, Burke, Catawba, Alexander, commonly referred to as the "Unifour" area.

Key design features of the demonstration include:

- through a managed long-term care network, establish better linkages with the health care system
- establish centralized Information/Referral and Case Assistance for persons in need of long-term care information and access to supportive services
- standardized system for accessing Medicaid covered home and community based long-term care services for Medicaid eligible older adults with plans to expand system to include publicly funded adult care home and nursing home care (option for private pay population to participate in managed long-term care model established)
- testing more flexible benefits with emphasis on home and community based care and ultimately putting managed long-term care organizations at risk for long-term care services provided to Medicaid beneficiaries
- use of a multi-county structure for access/information as well as managed long-term care entities

**Florida**

Through the Long-Term Care Community Diversion Project, Florida utilizes managed care concepts to control costs by diverting elders from nursing home care to more appropriate community-based settings. Recently, the University of South Florida conducted a preliminary evaluation of the program and found that it was generally successful. As the program progresses, it should provide more information about the success of using managed care and capitated rates to control the cost of long-term care in Florida.

**National Conference of State Legislatures**

A number of states have used creative approaches to expand the options for frail elders and people with disabilities to receive services and supports that enable them to live in their homes and communities rather than be institutionalized. The National Conference of State Legislatures (NCSL) produced a report tracing state long-term care policy developments in 2001, looking backward to the late 1990s and forward to 2002. That report is available at
http://www.ncsl.org/programs/health/forum/ltc/ltcmain.htm to add context to the issues discussed in this report.
Definition of Terms

**Capitation** - health insurance payment mechanism in which the provider automatically receives a fixed payment per enrollee over a specified period to cover a defined set of services, regardless of actual services provided.

**Demonstration waiver** - an exemption from certain federal rules that allows policymakers to experiment with Medicare and Medicaid program innovations on a pilot study basis. It is time limited and permits policymakers to expand the knowledge base underlying a program through research and program experimentation. An 1115 Medicaid waiver is a demonstration waiver.

**Dual eligibility** - ability to qualify for both Medicaid and Medicare benefits. Nearly all Medicaid beneficiaries who are age 65 and older qualify for Medicare benefits and approximately one third of Medicaid recipients under the age of 65 who are disabled also are dually eligible.

**Fee-for-service** - the traditional form of payment in which the patient or insurer pays for each visit or service provided

**Formal support system** - the physicians, community-based service providers, and other providers which provide paid care to individuals. See also informal support system.

**Home and community-based services (HCBS)** - services delivered to functionally or developmentally disabled persons in their home or community to help meet their needs for health care and social support. The services enable individuals to achieve or maintain an optimal degree of independence and to improve their quality of life.

**In-home health services** - services provided in the home by a general or specialty home health agency or by a residential services agency that may be provided by personal care attendants, home health aides hired privately and informally or through staff agencies or registries.

**Institutional care** (institutional health services) - health services delivered on an inpatient basis in hospitals, nursing homes, or other inpatient facilities.

**Independent living** - a term used to suggest independence from residential care, i.e. living in a setting without the need for continuous professional staff.

**Informal support system** - spouse, children, relatives, friends and others that provide care (generally unpaid) for individuals in order for them to remain in their own homes and communities.

**Medicaid Section 1115 Waiver** - a federal demonstration waiver authorized under Section 1115 of the Social Security Act. This section pertains specifically to experiments and demonstrations sponsored by state Medicaid agencies and provides authority to waive federal Medicaid requirements, including statewide applicability; amount, duration and
scope of services covered; eligibility definitions; level of care certification; freedom of choice of providers; and provider qualifications

**Managed care** - a health care financing and delivery arrangement designed to provide appropriate, effective, efficient health care through organized relationships with health care providers. It controls or coordinates use of health services to contain health expenditures and/or improve quality. Managed care ranges from indemnity plans with utilization review and high-cost case management to fully capitated staff model HMOs.

**Pre-paid health plan** - a health plan that provides a specified set of health benefits to a subscriber or group of subscribers in return for a periodic premium.

**Respite care** - services provided in the home, at a day care center, or by temporary nursing home placement to functionally disabled or frail individuals to provide occasional or systematic relief to informal caregivers.

**Seamless management** a strategy to provide a range of health and social services in a variety of settings that provides services appropriate to the level of care and service intensity required.