MANAGED CARE FOR THE ELDERLY: A PROFILE OF CURRENT INITIATIVES

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PURPOSE

The purpose of this document is to summarize the current state-of-the-art in managed care for the elderly and to provide states with background information needed to launch their own initiatives to provide quality, cost effective care to the rapidly aging population. As you will see, attempts to truly coordinate primary, preventive, acute, and long term care have been limited, but the demonstrations that do exist show promise. As the health care reform debate unfolds, it is likely that states will seek to do more to manage care for the elderly, and we hope this document provides useful, baseline information.
ACKNOWLEDGEMENTS

The Academy wishes to thank all those who contributed so freely of their time in answering questions about the programs included in this document. Key program contacts are listed in Appendix C. We also wish to thank those who reviewed and commented upon the draft. They are: Susan Aldrich, Jennie Chin Hansen, Ann Iversen, Scotti Kluess, Walter Leutz, Lucy Nonnenkamp, Megan Roach, Linda Skinner, and Helene Weinraub. We have made every attempt to respond to each comment, but the final document is our own, and we accept responsibility for any errors or omissions.
EXECUTIVE SUMMARY

The rapid growth of the elderly population with its complex and costly health needs invites policy makers to examine better methods to care for the elderly in ways that retain their maximum independence and functioning in a cost effective manner. The facts speak for themselves:

- Elders are the fastest growing segment of the population.
- In 1989, health care spending on persons 65 and older was three and a half times greater than that on persons 19 to 64 years old. \(^1\) Forty-seven percent of all hospital stays in 1991 were for people 65 years and older.\(^2\)
- One percent of health care users spend 30 percent of all health care resources, and half of these users are elderly.\(^3\)
- The Medicaid program, one of the largest cost centers of state budgets, spent 33 percent of its resources on the elderly in 1991, although they comprised only 12 percent of enrollees.\(^4\)

But behind these cost statistics lie the complexity of needs the elderly bring to the health care system and the reality that financing systems have tended to provide institutional services at far greater rates than home care. Moreover, elderly tend to suffer from a lack of continuity of care as they experience the daily challenges of chronic illness, the need for hospitalization during acute illness, and the need for on-going and effective primary and preventive care.

The current financing and delivery of health care and the nature of specialty medicine that the elderly often require make it difficult to coordinate effectively all the care elders need and to assure that the care delivered is appropriate. For

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\(^1\)Provider-based Managed Care-- A Health Network Imperative, produced by the National Chronic Care Consortium, September 1992.

\(^2\)Provider-based Managed Care-- A Health Imperative, p. 2.


example, services for the elderly are often fragmented by the payment sources of Medicare and Medicaid. Medicare, which pays for primary and acute care, encourages hospitals to discharge the elderly quickly to nursing facilities or home care; Medicaid, which pays for many of the long term care needs of the elderly, encourages nursing homes to discharge high service-use residents to hospitals where Medicare will pay the bill. The high costs of health care for the elderly, concerns for the appropriateness and quality of that care, and fragmented funding streams have prompted states, providers, and consumer groups to investigate managed care for the elderly population.

This paper provides descriptions of three current models of managed care for the elderly and profiles exemplary programs. A matrix showing the basic characteristics of each program is provided on page 6. The Integrated Care Model attempts to combine all aspects of health care for the elderly—primary, preventive, acute, and long term care—thereby decreasing unnecessary hospital and nursing facility stays. As examples of this model, Social HMOs, the PACE projects, and Minnesota’s proposed Long Term Care Options Project are the only programs which attempt to pool both Medicare and Medicaid dollars, thus providing all primary, acute and long term care services under one financing mechanism. While Arizona’s Long Term Care System and Florida’s Frail Elderly Option provide a similar range of services, they do not pool the dollars which pay for acute and long term care; Medicare must be billed by program contractors for the services it covers for enrollees in these programs.

The Primary/Acute Care Model attempts to provide better access to primary and preventive care for the elderly, thereby reducing costly hospital admissions, but it does not coordinate long term care services. Medicare HMOs and EverCare
demonstrate these goals through providing for the Medicare-covered care needs of the elderly population, but they do little to curb the expenses of Medicaid-covered long term care. Minnesota's Prepaid Medical Assistance Plan is also classified under this model, but Medicare must be billed by participating health plans for covered services, thus presenting an opportunity for service fragmentation; there is still no formal coordination between Medicare-covered acute care and Medicaid-covered long term care.

The Long Term Care Model seeks to provide a comprehensive range of services and to reduce the costs of long term care through making home and community services available to persons who would otherwise require expensive nursing facility care. Classified under this model are Home and Community Based Care Waiver programs designed to cut long term care costs from state Medicaid budgets through providing services in settings other than the nursing facility. But the primary and acute care needs of the elderly are funded separately by Medicare and may not be included in the care management plan for enrollees in these programs.

Currently, only about 7.5 percent of the nation's elderly are enrolled in any type of managed care program. Reasons for this low participation may include difficulty encountered by states in obtaining demonstration waivers allowing for the development of innovative delivery systems, the resistance of potential members to change to managed care program physicians, the resistance of HMOs to enter or

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5Enrollment figures for many of the programs described in this paper were obtained through telephone interviews with the program directors during August and September of 1993. Enrollment figures for Home and Community Based Waiver programs were from 1991 as reported in the 1993 Medicaid Source Book. Enrollment figures for the risk and cost contract health plans was obtained from the Monthly Report of Medicare Prepaid Health Plans, September 1993. Medicare population figures were obtained from HCFA, 1993.
remain in the Medicare and Medicaid market of enrollees, disparate eligibility requirements of different programs, and the scarcity of programs with comprehensive benefit packages for which elders look.

The programs described in this guide serve different groups of the elderly population and address different care needs, but in general, most have shown cost savings to their principal payment sources. Through savings built into either their Medicare or Medicaid capitation rates as well as cost effectiveness requirements within Federal waiver applications, most programs have been able to save money in comparison to fee-for-service settings. Upon start-up, many of the programs encountered financial shortfalls in providing managed care services to their members, usually due to small enrollments. But as they have matured, most have become financially viable and continue to save money for either Medicare or Medicaid or both. Finally, through case management, most programs appear to improve coordination of care for the elderly for the services that they cover.

All of the programs continue to wrestle with the different incentives within Medicare and Medicaid to shift the burden of paying for care. Without developing innovative ways to link these two payment sources, high costs and inefficiencies will continue to plague the nation's system of caring for the elderly. Under President Clinton's proposed reform plan and through existing Federal authority in Medicare and Medicaid to waive current regulations and encourage demonstrations, states have opportunities to develop new ways of financing and delivering care to the nation's elderly so that their complex health needs, not the payment sources, are the driving force behind how care is delivered.
# National Academy for State Health Policy
## Summary of Managed Care Programs for the Elderly

<table>
<thead>
<tr>
<th># of Sites</th>
<th>S/HMO</th>
<th>PACE</th>
<th>ALTCS</th>
<th>Frail Elderly Option</th>
<th>LTCOP</th>
<th>Medicare HMO/CMP</th>
<th>EverCare</th>
<th>PMAP</th>
<th>Medicaid 1915(c) waivers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong># of Sites</strong></td>
<td>4</td>
<td>9</td>
<td>Statewide</td>
<td>2</td>
<td>--</td>
<td>106</td>
<td>2</td>
<td>4 Counties</td>
<td>44 States</td>
</tr>
<tr>
<td><strong># Served</strong></td>
<td>21,516</td>
<td>1,731</td>
<td>8,798</td>
<td>1,000</td>
<td>--</td>
<td>2,175,409</td>
<td>900</td>
<td>7901</td>
<td>134,777</td>
</tr>
<tr>
<td><strong>Eligibility Requirements</strong></td>
<td>Medicare or dually eligible for basic benefits, and NFC for chronic care benefit</td>
<td>55 years or older and NFC</td>
<td>Medicaid eligible or 300% of SSI, and NFC</td>
<td>Medicaid eligible and NFC</td>
<td>Dually eligible only</td>
<td>Medicare eligible</td>
<td>Medicare eligible and permanent resident of nursing facility</td>
<td>Medicaid eligible</td>
<td>Medicaid eligible and NFC</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td>Primary and acute Medicare covered services for all members, and chronic care/social services for NFC members</td>
<td>Social, primary, acute and long term care services</td>
<td>Social, primary, acute and long term care services</td>
<td>Social, primary, acute and long term care services</td>
<td>Social, primary, acute and long term care services</td>
<td>Primary and acute services</td>
<td>Primary and acute services</td>
<td>Primary and acute services</td>
<td>Home and community based long term care services</td>
</tr>
<tr>
<td><strong>Payment Mechanism</strong></td>
<td>Full capitation of pooled Medicare, Medicaid, and premiums</td>
<td>Full capitation of pooled Medicare, Medicaid, and premiums</td>
<td>Full capitation from Medicaid; Medicare is billed when appropriate</td>
<td>Full capitation from Medicaid; Medicare is billed when appropriate</td>
<td>Full capitation of pooled Medicare and Medicaid</td>
<td>Full capitation from Medicaid</td>
<td>Full capitation from Medicaid</td>
<td>Full capitation from Medicare; Medicare is billed when appropriate</td>
<td>Fee-for-service</td>
</tr>
<tr>
<td><strong>Service Area</strong></td>
<td>Metro areas of cities</td>
<td>Metro areas, counties, and rural areas</td>
<td>Statewide</td>
<td>Metro area of Miami</td>
<td>Statewide</td>
<td>--</td>
<td>Nursing facilities in metro areas</td>
<td>4 counties</td>
<td>Usually, by county</td>
</tr>
<tr>
<td><strong>Sponsorship</strong></td>
<td>2 HMOs, 2 long term care organizations</td>
<td>Hospitals, community health centers, long term care organizations</td>
<td>State of Arizona</td>
<td>State of Florida</td>
<td>State of Minnesota</td>
<td>HMOs, CMPs, PPOs</td>
<td>HMOs</td>
<td>State of Minnesota</td>
<td>State health departments, county health agencies</td>
</tr>
</tbody>
</table>

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1. FY 1991 Data
2. NFC = Nursing Facility Certified
INTRODUCTION

Managed care has reduced costly and inappropriate hospital use by providing greater continuity within the patient-provider relationship as well as assuring continuity of available services. Yet while elderly are the greatest users of hospital care, little managed care has developed specifically to meet their needs. State policy makers are increasingly interested in managed care for the elderly because:

- Elderly are the fastest growing sector in the population and use more health care than those younger. In 1989 the average annual health care expenditures for persons over 65 were about three and a half times as great as for persons aged 19 to 64, and for persons over 85, expenditures were almost six times as great as those for the younger population. In fact, 1 percent of all health users is responsible for 30 percent of health spending, and half of these users are elderly.

- Medicaid spending last year grew by an estimated 28.6 percent. Between 1990 and 1992 the number of aged recipients grew by 6 percent, but accounted for 24 percent of new Medicaid spending over the same period.

- While the elderly comprised only 12 percent of Medicaid beneficiaries in 1991, they accounted for 33 percent of Medicaid expenditures. There were almost four times as many children served by Medicaid in 1991 as there were aged recipients, but spending per capita on the aged was over eight times as great as that on children. Children are more likely to be targeted for enrollment in managed care programs through Medicaid Primary Care Case Management programs than are aged recipients.

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11 Medicaid Source Book, p. 834.
Managing care for the elderly presents complex challenges. Elderly often have multiple and complex illnesses and require both traditional primary and acute care services generally found in managed care plans as well as care over the long term to assist them in coping with chronic illnesses. While today's elderly are healthier than generations of aged before them, their long lives are often affected by disabilities which require care from multiple service systems. That care often requires special services and geriatric clinicians with skills to recognize and support the unique needs and capacities of elders.

The policy and practice challenges of coordinating care for the elderly is compounded by financing barriers. Little incentive exists for states to take a leadership role in developing managed care for the elderly. Of those elderly receiving Medicaid, most are dually eligible for Medicare as well. Since most of the savings in managed care comes from decreased hospital use, those savings would accrue not to the state, but to the Federal government whose Medicare program funds hospital care.

Cost and quality of care concerns motivate states to develop managed care for the elderly in a way that includes long term care. But no greater impetus for action exists than the President's proposed American Health Security Act. If enacted the plan requires states to fundamentally redesign health care financing and delivery, relying heavily upon managed care. The plan also would provide states, for the first time, the opportunity to consolidate Medicare into their reform designs and, in the short term, to receive grants from the Federal government to develop innovative methods to care for elderly dually eligible for Medicare and Medicaid.

Therefore, unique opportunities exist today for states to lead in the development of
innovative managed care programs for the nation's elderly. The National Academy for State Health Policy, through its Medicaid Managed Care Resource Center, has examined current programs of managed care for the elderly and provides this guide as a single source for state policy makers to learn more about existing projects. Through this examination, three distinct models of managed care have emerged. The first is the Integrated Care Model which attempts to coordinate all aspects of care for the elderly, primary, preventive, acute, and long term care. Programs under this model have either received waivers to pool Medicare and Medicaid funds into one capitation rate, thereby eliminating the incentives to shift the burden of care from one funding source to another, or they serve only Medicaid recipients and must bill Medicare for covered services. In both cases, however, the provision of care for the elderly is seen as a bundled group of comprehensive services.

The second model is the Primary/Acute Care Model. As its name suggests, access to primary and preventive care is the focus of this model. These services are maximized so as to reduce unnecessary hospitalizations, and savings accrue to Medicare. Since long term care is not a part of the service packages, state Medicaid budgets still have the burden of financing expensive long term care.

The final model of managed care for the elderly is the Long Term Care Model. Programs exemplifying this model provide home and community based services to persons who would otherwise need to be institutionalized. State Medicaid budgets have experienced cost savings from these programs, but Medicare-covered primary and acute care services are not part of the care management package; fragmentation of services still persists.

This guide is not an exhaustive list of all managed care programs, but rather a brief
catalog of the prominent ones that are operational today. The programs were included in the guide based on available information about service delivery, utilization, and cost effectiveness. Medicaid Primary Care Case Management programs were not included as most of these programs target younger populations. Because primary care is typically paid for by Medicare for the elderly, having this group enrolled in these Medicaid programs may not save Medicaid dollars. “Managed care” was broadly defined as a type of service delivery in which a case manager works with the individual to develop a plan of care, and the care is then contracted or delivered by the program. This case management service may be carried out in various ways according to the design of each particular program and can be performed by an individual or a case management team. Many of the programs are local, others are not easily replicable, but each offers insights about what states might do to develop managed care for the elderly.
I. INTEGRATED CARE MODEL

Through coordinating all services for the elderly from preventive to long term care, this model attempts to curb hospital and nursing facility utilization, thereby generating savings for both Medicare and Medicaid. The model focuses on all aspects of health care, including social supports, so as to provide the most appropriate care in the most appropriate setting. Social supports can be strengthened through making respite care available to caregivers and providing direct social services. By managing elders’ health care in this way, many medical conditions may be treated outside of the hospital or nursing facility. In broadening the scope of care from medical services to social services as well, the Integrated Care Model of managed care may reduce or avoid unnecessary institutionalization.

1. Social/Health Maintenance Organization (S/HMO)

The S/HMO model, developed at Brandeis University in the early 1980’s, has four Federal demonstration sites operating around the country.

Goal: To finance and deliver a comprehensive package of acute, ancillary, and community long term care services for a representative population of elderly without increasing costs for public or private payers.

Eligibility: Those who qualify for Medicare. Members are eligible for all basic Medicare-covered acute and ambulatory health care as well as preventive medical care and the expanded Medicare benefits discussed below, but only individuals assessed as nursing facility certifiable or at risk for institutionalization are eligible for the chronic care benefit. Sites can “queue”
potential new members who have one or more Activities of Daily Living (ADL) deficits so that no more than 4 or 5 percent of enrollees are in this category at the time of enrollment.\textsuperscript{13} This queuing mechanism alleviates organizations' fears of adverse selection of severely disabled members at enrollment and is designed to keep the membership population similar to the Medicare population. From a state policy standpoint, S/HMOs do not concentrate services on the populations that cost state Medicaid budgets the most, namely, the institutionalized elderly. But they do link Medicare primary and acute care with long term care services into a single, comprehensive benefit package; this is an important step toward reforming health care financing and delivery. As an insurance model, S/HMOs are designed to serve both the impaired and non-impaired so as to spread the risk and control the costs of providing care for the elderly.

Services: Medicare-covered benefits (hospital, physician, skilled nursing facility, skilled home health services, rehabilitation therapies, hospice, and durable medical equipment) as well as expanded benefits including vision, dental, physical examinations, and outpatient pharmacy services. Only those who are nursing facility certified or at risk of institutionalization qualify for the chronic care benefit package which is made up of services not traditionally covered by Medicare including but not limited to nursing facility care beyond that covered under Medicare, home health, homemaker, respite, transportation, meals, and day health. Case management services are provided to those who qualify for the chronic care benefit as well as those at risk; case-management is an administrative service and therefore not charged against the member's benefit

The demonstration sites have flexibility in designing their case management services and community long term care benefits; however, this service package must include a case manager who has primary responsibility for authorizing all community long term care services, monitoring the chronic care services and budget, as well as authorizing chronic care resource allocation. In past long term care demonstrations, the case manager had the role of screening and assessing needs and coordinating care. The broadened guidelines of S/HMO case managers allows them to order covered services rather than simply coordinate their delivery.

Funding: Through Medicare waivers, S/HMOs receive 100 percent of the adjusted average per capita cost (AAPCC); Medicare HMOs (discussed below) receive only 95 percent of the AAPCC. S/HMOs also receive the nursing home cell rate of the AAPCC for all members who are nursing home certifiable, and lower rate cells for all other community-dwelling members. The nursing home cell rate represents the amount of money that HCFA would expect to pay for the Medicare covered services of a beneficiary residing in a nursing facility. The S/HMOs receive this rate for their nursing facility certified members regardless of whether the members actually live in a nursing facility; this accounts for the services these members receive in the chronic care benefit. S/HMOs may also charge monthly premiums and copayments which are paid by members or by Medicaid if

14Greenberg et al., p. 75.
16The AAPCC represents an actuarial value of what HCFA could expect to pay per month for a Medicare beneficiary in a given category if the person received the care in a fee-for-service setting in a given geographical area. The categories, known as “rate cells,” are based on five variables: age, sex, institutional status, Medicaid eligibility, and eligibility for both Parts A and B of Medicare.
members are dually eligible.\textsuperscript{17, 18}

Legislative/Regulatory Requirements: S/HMOs operate as State and Federal demonstration projects under a §1115(a) waiver of the Social Security Act. This waiver allows for a great deal of flexibility for demonstrations in designing their eligibility standards and service packages and allows for reimbursement of expenditures not usually covered by Federal matching funds of the Medicaid program. Section 1115(a) waivers include a formal research or experimental methodology, provide for independent evaluation, and are usually limited to 3 or 4 years of operation. To operate as a S/HMO, an organization must be a part of this demonstration project. HCFA approved the development of four demonstration sites in 1982, and legislation in OBRA '90 authorized four additional sites for development.

Details: There are four demonstration sites which have been operational since 1985. They are:

- Medicare Plus II in Portland, Oregon
- Seniors Plus in Minneapolis-St. Paul, Minnesota
- Elderplan in Brooklyn, New York
- SCAN Health Plan in Long Beach, California

Two of the sites, Medicare Plus II and Seniors Plus, are sponsored by health maintenance organizations; Elderplan and SCAN Health Plan are sponsored by long-term care organizations, the Metropolitan Jewish Geriatric Center, Inc., a long-term care service provider which owns nursing facilities and home care

\textsuperscript{17}Yordi, p. 83.
agencies, and the Senior Care Action Network, a long-term care service broker, respectively. Medicare Plus II and Seniors Plus are new products offered by existing HMOs, and the other two are new HMOs formed by organizations without previous experience in managed care.\textsuperscript{19}

All demonstration sites have these four defining features:

\textit{A single organizational structure at financial risk to provide a full range of acute and chronic care services to Medicare beneficiaries who voluntarily enroll in the program and pay a monthly premium for services.} Dually eligible beneficiaries may also enroll, and Medicaid pays their premium. S/HMOs either provide the services themselves or contract with other providers to ensure that covered services are available. The S/HMOs must provide for the delivery of all Medicare-covered acute and ambulatory care as well as expanded benefit services and develop a chronic care benefit package.

\textit{A coordinated case management system to authorize long-term care for members meeting specific disability criteria.} Each demonstration site has different eligibility criteria for institutionalization as each state has its own assessment criteria for nursing home eligibility. Chronic care benefits are covered up to $7,500 to $12,000 per year in service costs, with variations between demonstration sites in benefit levels and copayments from members. The plans are allowed to limit the number of nursing facility days covered by the S/HMO. If S/HMO members exceed their chronic care benefit, for example, through using too many nursing home days or too many community care services, the members (or

Medicaid when applicable) have to pick up the difference; while the case manager works closely with the member to determine what type and how many services are to be provided, if a member desires additional services, he or she must pay for them. If a case manager orders services, the S/HMO is obligated to pay for them. Only rarely is the benefit limit exceeded by members. As the case management service is not charged against the members’ benefit limits, this service continues even if the chronic care benefit limit has been reached. The chronic care benefit is renewable at the start of the new contract year. The case management system is designed to improve access to services for certain members as well as improve the appropriateness of services.

An enrollment and service package designed to serve a cross-section of the elderly population including both functionally impaired and non-impaired people. The goal of this is to keep members healthy in order to reduce or slow the rate of impairment and disability.

A financing mechanism of a pre-paid capitation from pooled Medicare, Medicaid, member premiums and copayment funds. At all sites, Medicare pays 100 percent of the adjusted average per capita cost (AAPCC) for all members and the nursing home cell rate of the AAPCC for S/HMO members who meet their state’s criteria for nursing home admission, regardless of whether or not they use the chronic care benefit. Again, the nursing home cell rate of the AAPCC is not reimbursement for nursing facility services, but rather for what HCFA could expect to pay for Medicare covered services for a beneficiary residing in a nursing

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20Harrington et al., p. 40.
22Finch et al., p. 10
facility. The initial financial risks were shared by the S/HMOs and HCFA for the first 30 months of the demonstrations during 1985 to 1987. After that, the S/HMOs assumed full financial risk.

Evaluation: Upon start-up, it was found that first year enrollments were not as high as expected or required for breaking even at three out of the four sites. Initial enrollment was projected to be 4000 at each site. Only Kaiser’s Medicare Plus II site approached this goal having 3174 enrollees. Senior Plus had the lowest first year enrollment of 433. While the break-even enrollment of 4000 was projected for all sites, the two HMO affiliated sites actually required fewer enrollees than the new HMOs to break even. Reasons for the difficulties in enrolling new members include 1) the possibility that new members would be required to change physicians to network physicians; 2) higher member premiums of S/HMOs relative to HMOs; 3) lack of name recognition in some sites; 4) sponsors’ lack of experience in marketing and sales in some sites; and 5) the demonstration status of the program which was required to be mentioned in the marketing materials. As of September 1993, all sites had overcome most of their low enrollment problems with Seniors Plus having the highest enrollment of 6,171 and Medicare Plus II having the lowest at 4,576. All four sites enroll a total of 21,516.

Medicaid enrollments were planned to be between 12 and 20 percent of the total enrollees at each site. At the end of the first year only the SCAN site came close to this at 10.7 percent of enrollees. The other sites had much lower enrollments.

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23Greenberg et al., pp. 67-69.
of these persons, ranging from 1.3 to 4.1 percent of enrollees. Greenberg et al. hypothesized that causes of this low enrollment included “less attention to marketing to this smaller segment, the difficulties in marketing through the welfare system, and the fact that Medicaid recipients already have long term care benefits.”

One S/HMO project director attributed the low enrollment to the lack of cost sharing for Medicaid enrollees by her state’s Medicaid agency; over time, some members became eligible for Medicaid, but it was not until 1992 that dual enrollment for both acute and community based long term care was offered to Medicaid enrollees.

According to Finch et al., the first generation S/HMOs did not change the acute-care delivery system for their members in that state-of-the-art geriatric medicine was not used, and acute care and long-term care were not integrated to as high a degree as expected or desired. Contracted providers were often not aware that their patients were enrolled in a S/HMO. Case management was the best developed service as it had both a benefit-triggering and a revenue-generating function through determining when S/HMO members were eligible for nursing facility certification, thereby accessing the higher AAPCC rate regardless of nursing facility use. In an evaluation of costs and service use, Harrington and Newcomer report that case management costs were small relative to other costs incurred by the S/HMOs. In 1989, the costs for case-management were only 2 to 3 percent of the S/HMO budgets.

25Greenberg et al., p. 69.
26Telephone interview with Lucy Nonnenkamp, Project Director of Medicare Plus II, August 11, 1993.
27Personal correspondence from Lucy Nonnenkamp, received October 22, 1993.
28Finch et al., p. 24.
29Harrington et al., p. 46.
An initial concern with the S/HMO demonstration (and other projects which enhance home based services) was the possibility that informal caregivers might give all care responsibilities to the formal care providers of S/HMOs. Studies have indicated that informal caregiving has a financial value to the health care system in that these caregivers may account for millions unpaid days of care each week.\footnote{Paringer, L. The Forgotten Costs of Informal Long term Care. \textit{Long Term Care Costs: Project to Analyze Existing Long Term Care Data}, vol. 6, report prepared for the Assistant Secretary for Planning and Evaluation, DHHS, Washington, D.C.: Urban Institute, pp. 50-91, 1983, and Liu, K., and Manton, K. G. Disability and Long Term Care. Paper presented at the Methodologies of Forecasting Life and Active Life Expectancy Workshop, Bethesda, MD, June 25-26, 1985.} Policy makers feared that increasing availability of health care supports in the home would have the overall effect of increasing costs of care for public funding sources through decreased reliance on free, informal care. However, Yordi’s evaluation of the impact of the S/HMO service delivery on informal caregiving, indicates that S/HMOs actually helped to strengthen informal support over time, when compared to a community comparison group.\footnote{Yordi, C. The Effect of the S/HMO Demonstration on Informal Caregiving. Paper presented at the annual meeting of the Gerontological Society of America, November 24, 1991, San Francisco, CA.} While informal caregiving decreased upon members’ initial enrollment, after an adjustment period, it returned to just below the original level. Informal caregiving is an important part of S/HMO care plans.

Finch et al. report that no clear pattern of decreased hospital utilization appeared for the S/HMO model of managed care in comparison to hospital utilization rates of Medicare HMOs, during the first years of operation. As illustrated in the Table 1, Elderplan and Seniors Plus experienced lower admissions per 1000 members than Medicare HMOs in their respective service areas, but both experienced longer average length of stays (ALOS.) Medicare Plus II and SCAN Health Plan had more admissions per thousand members than comparable
Medicare HMOs, but Medicare Plus II had a lower ALOS and SCAN Health Plan had a higher ALOS. From this one can see that even between the two HMO

Table 1: Comparison Between S/HMOs and HMOs in the Same Geographic Areas on Hospital Admissions and Average Length of Stay in 1989

<table>
<thead>
<tr>
<th></th>
<th>Northeast HMOs</th>
<th>Elderplan HMOs</th>
<th>Midwest HMOs</th>
<th>Seniors Plus</th>
<th>Pacific HMOs</th>
<th>Medicare Plus II</th>
<th>SCAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admissions 1000</td>
<td>279</td>
<td>245</td>
<td>267</td>
<td>207</td>
<td>246</td>
<td>308</td>
<td>308</td>
</tr>
<tr>
<td>ALOS (days)</td>
<td>8.7</td>
<td>9.3</td>
<td>7.4</td>
<td>10.0</td>
<td>6.4</td>
<td>5.8</td>
<td>6.8</td>
</tr>
</tbody>
</table>

Source: Finch et al., p. 47.

sponsored and non-HMO sponsored programs, no clear pattern of decreased hospital utilization emerged.32

It should be noted that when the S/HMOs first started, enrollments were similar to the Medicare population in terms of disability levels.33 But as current memberships have aged, they have become more disabled.34 S/HMOs were not designed to serve the very frail, but critics continue to voice concern that the program serves a population that is relatively healthy. With the chronic care benefit which is present in S/HMOs and absent in the Medicare HMOs, the populations served by these organizations may become more dissimilar as severely disabled elderly may disenroll from the Medicare HMOs. During the first five years of operation, all S/HMOs showed the trend of increased hospital

32Finch et al., p. 48.
33Greenberg et al., pp. 69-71.
use, attributable to the aging of their enrollees. Implications of this trend include the need to continually enroll younger, healthier members to help offset growing hospital costs. Recent data comparing S/HMO enrollees to the general Medicare population are encouraging as Table 2 suggests.

Table 2: Comparison Between S/HMOs and the General Medicare Population on Hospital Days/1000 and Average Length of Stay in 1990

<table>
<thead>
<tr>
<th></th>
<th>S/HMOs, 1990*</th>
<th>Medicare, 1990**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days/1000 members</td>
<td>1,891</td>
<td>2,811</td>
</tr>
<tr>
<td>ALOS (days)</td>
<td>6.7</td>
<td>9.0</td>
</tr>
</tbody>
</table>

*Data are from the Social/HMO Consortium: Management Data Set at Brandeis University and obtained through personal correspondence from Walter Leutz, received October 22, 1993. **September 1992 HCFA Statistics.

One can see that in comparison to the general Medicare population, S/HMOs appear to be able to cut down on both hospital days/1000 and average length of stay, even though the S/HMO enrollees may be more disabled than the general elderly population.

Using estimates of costs of caring for the nursing facility certified and the non-nursing facility certified population adapted from Harrington and Newcomer's 1991 findings as well as HCFA AAPCC rate data, Finch et al. concluded that while S/HMOs may have shown an overall profit, they also may have lost money on caring for members who were nursing facility certified. According to their projections, if the proportion of nursing facility certified members increases as the enrollees age, all S/HMOs will be adversely affected, given the 1991

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35Harrington et al., p. 41.
premiums charged, service delivery practices, and chronic care benefit packages.\textsuperscript{36} However, the design of S/HMOs was based on the insurance model of spreading risk over a large population which was similar in disability levels to the overall Medicare population. To increase dramatically the proportion of frail members would go against the design and goals of the S/HMO model.

Finch et al. indicate that despite queuing of chronic care benefit eligibles, favorable selection and disenrollment, and financial limits on the chronic care benefits, the first generation S/HMOs had difficulty breaking even in the first few years of providing services.\textsuperscript{37} However, as the sites have matured, all have become financially viable. Lessons from this first generation point toward using sponsors who have experience in HMO service delivery or who provide medical services rather than starting new S/HMOs from scratch.\textsuperscript{38}

It should also be noted that the most recent evaluations of the S/HMO demonstrations by external evaluators are based on data from 1985-1989. In the four years since then, developments in service delivery and financial strength have taken place. Administrators from two S/HMO sites indicated that they are planning to expand their services not only geographically, but also to explore marketing to different groups of Medicare beneficiaries.\textsuperscript{39} This suggests a certain level of financial stability in these organizations.

\textsuperscript{36}Finch et al., pp. 53-54.
\textsuperscript{37}Finch et al., p. 30.
\textsuperscript{39}Telephone interviews with Lucy Nonnenkamp, Project Director of Medicare Plus II, August 11, 1993, and Dr. Tim Schwab, Medical Director and Senior Vice President of SCAN Health Plan, August 30, 1993.
A second generation of demonstration sites has been approved by OBRA '91. Again, there are four sites to be developed, but this generation will not be allowed to share risk with HCFA during the start-up years as the first generation was allowed to do. To date, sites have not yet been determined, nor has the exact plan of the second set of demonstrations been finalized. It remains undecided at this point whether the first generation of S/HMOs will continue to operate as they do now or if changes in service delivery and administration for the second generation sites will be adopted.

2. Program for All-inclusive Care for the Elderly (PACE):

There are nine Federal demonstration PACE sites operational around the country. They attempt to replicate PACE’s original demonstration site, San Francisco’s On Lok Senior Health Services program, in different urban and rural settings.

Goal: To provide a continuum of acute care, long term care, and social services to the frail elderly in order to enable them to live as independently as possible and avoid institutionalization.

Eligibility: Frail, elderly clients who are at risk for admission to nursing homes. All participants must be certified by the state as needing nursing facility level of care. Federal legislation sets the minimum age for eligibility for PACE at 55. However, some states have set the criteria higher at 60 or 65. Variation in nursing home certification criteria may result in variations between sites in case-mix. Most of the participants in these programs are dually eligible for Medicaid and Medicare, although some sites have members who are eligible for Medicare only.
Services: All Medicare and Medicaid acute and long term care services including but not limited to the following: inpatient hospital care, skilled nursing facility, physical, occupational, and speech therapies, prescription drugs, physician services, outpatient hospital care, clinic services, ambulatory surgery, home health, hospice, laboratory, radiology, transportation, medical equipment/supplies, psychology, nurse practitioner, dental, vision, podiatry, audiology, chiropractic, personal care, private duty nurse, home/community waivers, social services, nutrition counseling, case management, homemaker, respite care, adult day care, extended personal care, extended home health aide services, companion services, caregiver training, home delivered meals, and extended home health nursing. The provider assumes the risk for the provision of services; if the cost of services provided is greater than the capitation rate for a given period, the provider must make up the difference.

Funding: Pooled Medicaid and Medicare funds for dually eligible participants and premiums paid by members who are eligible for Medicare only. Demonstration sites receive a capitated rate in return for providing or contracting all services. Rates are based on estimates of what each payor would pay for a comparable population in the fee-for-services setting. Medicare uses the AAPCC methodology used to reimburse Medicare HMOs which is based on 95 percent of the estimated average per capita costs. Rather than using the traditional rate cell adjusters for age, sex, and institutional status, PACE sites are reimbursed the AAPCC rate multiplied by a single adjuster of 2.39 to reflect the frailty of the PACE population. The Medicaid rate is based on the estimated costs to Medicaid for a long term care population, with a 5 to 15 percent savings to the state built into the capitation rate. Appendix A reproduces a table developed by On Lok, Inc., summarizing the rate setting procedures at each of the original
demonstrations.

Legislative/Regulatory Requirements: Federal and state waivers are required to participate in the PACE Demonstration Project and to pool Medicare and Medicaid funds into a capitated rate. The site must request a Medicare §222 waiver and the state must request a Medicaid §1115 waiver from HCFA. Sites will operate as demonstrations for a three year period in which they share financial risk with Medicare and Medicaid. Recent legislation allows second generation sites to be covered under a capitated rate only for those services which Medicaid normally covers while Medicare services are billed fee-for-service for up to two of the three demonstration years.\textsuperscript{40} This is to ensure that all aspects of the PACE model are in place prior to full capitation. After the two years, the funds will be pooled into a single rate, covering all PACE services.

Details: The Omnibus Budget Reconciliation Act of 1986 authorized up to ten PACE demonstration sites, but only eight sites received waivers to participate in the project. They are:

- Bienvivir Senior Health Services in El Paso, Texas
- Community Care for the Elderly in Milwaukee, Wisconsin
- Comprehensive Care Management in Bronx, New York
- Elder Service Plan in East Boston, Massachusetts
- Independent Living for Seniors in Rochester, New York
- Palmetto SeniorCare in Columbia, South Carolina
- Providence ElderPlace in Portland, Oregon
- Total Longterm Care in Denver, Colorado

\textsuperscript{40}Kane et al., p. 772.
The sponsoring organizations for each of these sites varied in type and size. The Columbia, Rochester, and Portland sites are hospital-based programs; the Denver site had roots in a private hospital but is now an independent non-profit corporation developed exclusively to be a PACE site; East Boston’s site is based in a neighborhood health center; the Bronx site is sponsored by a nursing facility; the Milwaukee site was developed by community organizations; and the El Paso site is a new entity in itself without a sponsoring organization.41,42

To continue development of the PACE model, OBRA ’90 authorized the expansion of the PACE project up to 15 demonstrations. This current second generation of sites includes:
- Coalition for Elders Independence, Inc. in Oakland, California
- Maluhia in Honolulu, Hawaii
- Sutter SeniorCare in Sacramento, California
- Umoja Care in Chicago, Illinois

Other service providers have expressed interest in becoming PACE participants and are in the process of conducting feasibility studies with On Lok. PACE proponents are expecting new legislation which would expand the number of demonstration sites even further.

PACE demonstrations have four common features:

Focusing exclusively on the frail elderly, each site offers the same array of acute

41Kane et al., p. 778.
42Telephone interviews with Scotti Klues, Project Director, Independent Living for Seniors, and Linda Barley, Executive Director, Total Longterm Care, Inc., August 2, 1993, and Rosemary Castillo, Executive Director of Bienvivir Health Services, August 18, 1993.
and long-term care services, either directly or through contract. Services include all acute and long term care benefits including: home care, primary care, restorative therapies, specialty consultations, laboratory services, nursing facility care, and hospital services.

Each is financed through both Medicaid and Medicare funds with a larger portion coming from Medicaid. Funds are pooled without traditional payment restrictions; for instance, services which usually have time or dollar limitations on them under Medicare can be continued as long as the care management team believes they help the participant.

As staff model HMOs, each uses a multi-disciplinary case-management team to coordinate and provide most services directly. The team includes all caregivers and other professionals who have personal contact with the individual including a physician, nurse, social worker, nutritionist, as well as physical and occupational therapists, aides, and drivers. Team members have special experience and training in dealing with the health and social problems of the frail elderly. The physician is not necessarily the team leader as in a typical medical model of service delivery, but instead, is part of a decision-making process which includes looking at the participants’ health status, social network, and housing needs.

Each is based on a day health care model that is integrated with primary care. Participants attend an adult day health center, with transportation provided as needed, for supportive, rehabilitative, and social programs.
While in the developmental stage, services in the first generation sites were provided on a fee-for-service basis. This was to ensure that all the features of the PACE model, including the day health center, were in place prior to capitation. In addition to fee-for-service funding during development, several of the first generation sites received grants up to $700,000 from the Robert Wood Johnson Foundation. Five out of the eight sponsoring organizations also contributed large sums of money to the start-up phase of the project. Many of the directors of the PACE sites indicated in interviews that this funding was crucial to the start-up and continued success of their programs.

The developmental phase of the PACE project has been modified for the second generation demonstration. Now, sites that are interested in becoming a part of the PACE project conduct a feasibility study in conjunction with On Lok and their state Medicaid agency, and they are allowed to operate for a period of time under Medicaid capitation only while Medicare services remain reimbursable through the fee-for-service system. When the site has developed a stable multi-disciplinary team and achieved a break even census, the site and state can apply for the PACE dual waivers to pool Medicare and Medicaid into a single capitated rate.

Evaluation: Kane et al.\(^\text{43}\) report that enrollment has been less than expected due to the potential clients' resistance to change physicians as well as resistance to the day care model which is central to the PACE approach to health care delivery.

\(^{43}\text{Kane et al., pp. 771, 778.}\)
Some sites have had difficulty in assembling all components of the PACE model and developing a stable care management team. This has delayed implementation of the PACE services under full capitation for one site. Kane et al. report that the development of the Medicaid rate has resulted in variation between sites; variability in comparison groups chosen by the states for Medicaid rate setting process has resulted in significant differences in Medicaid rates across states. Most choose to compare participants to nursing facility residents, but a few states use a ratio of community care clients to nursing facility clients.

Adequate housing is an important component in keeping members in the community. On Lok and some sites have developed this as an added service outside of PACE to help keep members at home; housing is not a reimbursable service under PACE. As some potential members do not have adequate housing, enrollments can be restrained by the requirement that new members be able to live in the community.

While all sites must provide the same types of services, delivery differs by site. Variations as to how a site provides or contracts for the provision of some services may be attributed to the relationships with the sponsoring organization and the availability of services in the community. However, the key components of day care and primary care are provided directly at all sites.

Data compiled by On Lok, Inc. has shown that inpatient hospital utilization rates for the frail elderly PACE enrollees are much lower than those for a comparable frail population, and hospital days per thousand PACE enrollees are fewer than

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44Kane et al., p. 773.
of the general elderly population. Table 3 illustrates the PACE program’s ability to keep utilization of hospital care down in comparison to the general Medicare population and to those served by S/HMOs. Note that the different years limit the comparability of the data, but the overall low average length of stay and similar hospital days per thousand enrollees for the extremely frail population in PACE in comparison to a relatively healthy population is remarkable.

Table 3: Comparison of Hospital Days/1000 and Hospital Average Length of Stay Between PACE, Medicare, and S/HMO Programs

<table>
<thead>
<tr>
<th></th>
<th>PACE, 1992*</th>
<th>Medicare, 1990**</th>
<th>S/HMO, 1990†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days/1000 members</td>
<td>2,777</td>
<td>2,811</td>
<td>1,891</td>
</tr>
<tr>
<td>Hospital ALOS/1000 members (days)</td>
<td>5.4</td>
<td>9.0</td>
<td>6.7</td>
</tr>
</tbody>
</table>

** September, 1992 HCFA Statistics.
†Data are from the Social/HMO Consortium: Management Data Set at Brandeis University and obtained through personal correspondence from Walter Leutz, received October 22, 1993.

Nursing facility use is also lower than expected for such a frail group of persons.45

The cost effectiveness of the PACE program has been examined by the Long Term Care Data Institute, and the results are favorable.46 The researchers

compared 1990 PACE data to 1984 National Long-Term Care Survey data and found that in comparison to a fee-for-service setting, the PACE program provides Medicare with a 9 to 34 percent savings. The range of savings experienced depends upon the assumptions made in analyzing the data and upon which of the sites are examined. PACE is also cost effective for Medicaid as a 5 to 15 percent savings is incorporated in the rate setting process in all but one state.

3. The Arizona Long Term Care System (ALTCS) [part of the Arizona Health Care Cost Containment System (AHCCCS)]

ALTCS began serving the elderly and physically disabled on January 1, 1989. This program was developed through incorporating long term care services into the basic AHCCCS program which provides care for Medicaid eligibles through prepaid contracts with providers.

Goal: To provide incentives for the delivery of appropriate long term and acute care services, including mental health, through a managed care system which serves the elderly and persons who are physically or developmentally disabled in the least restrictive setting.

Eligibility: Those who have income levels at or below 300 percent of SSI and who are determined to be a risk for institutionalization through a pre-admission screening (PAS) process. Functional, medical, nursing and social criteria are utilized in the PAS tool.

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47Information on the Arizona Long Term Care System was obtained from “Attachments for Implementing Medicaid Managed Care Quality Assurance Reform: A Multi-State Demonstration” in AHCCCS Proposal to the National Academy for State Health Policy, December 1992.
Services: Case management, home and community based services such as home health care, adult day care, and homemaker services, as well as nursing facility care, acute care, and mental health services available under AHCCCS. Case managers act as gatekeepers to the most appropriate and cost-effective services for all ALTCS enrollees. Unlike case management reimbursement under S/HMOs, case management is included in the capitated rate paid to participating health plans.

Funding: Capitated Medicaid funds pre-paid to program contractors through a negotiated contract. Program contractors are required to provide acute care services to ALTCS enrollees but must bill Medicare for these services for dually eligible enrollees.

Legislative/Regulatory Requirements: Arizona has delivered services to its Medicaid population under a HCFA demonstration §1115(a) waiver since 1982. It has been able to use Medicaid funds to provide care for these persons in a risk-sharing capitated setting through AHCCCS. However, ALTCS, which specifically addresses the long term care needs of the Medicaid population, was not operational until 1989. Unlike the §1915(c) Home and Community Based Service (HCBS) waivers discussed below, HCBS in the ALTCS are provided for under the §1115 demonstration waiver. The Health Care Financing Administration restricts the amount of money spent on HCBS for the elderly and people with physical disabilities through capping the number of HCBS “slots” available to persons in these categories at 30 percent of the total number of elderly and people with physical disabilities covered by ALTCS.
Details: In 1989, Medicaid service coverage available through AHCCCS was expanded to include long term care. By law, Arizona’s two largest counties, Maricopa and Pima, have reorganized their health agencies into AHCCCS program contractors. Because ALTCS is a part of AHCCCS, this means that these agencies, in addition to providing care for AHCCCS enrollees, must provide long term care and acute care services to individuals enrolled in the ALTCS program.

As of October 1, 1993, three other rural counties have elected to serve as program contractors. The remaining 10 counties’ governments have not opted to become AHCCCS program contractors; they have the opportunity to act as program contractors, but they are not required to do so. If a county government chooses not to act as an program contractor, the AHCCCS administration seeks competitive bids from area HMOs to provide covered ALTCS services.

The prepaid capitation rate for ALTCS HMOs covers all services available under AHCCCS as well as ALTCS. This system encourages the coordinated delivery of primary, acute, and long term care. The ALTCS rate has three components: long term care, acute care services, and mental health. Since the acute care services for ALTCS members may be covered by Medicare, a weighted rate reflecting the percentage of enrollees eligible for Medicare is figured into the overall rate. It is up to the program contractor to maximize collection of Medicare reimbursements on behalf of ALTCS members.48

Although HCBS is open-ended for persons with developmental disabilities, the federal government limits the number of HCBS “slots” available to the aged and

48Skinner, L., p. 11.
people with physical disabilities participating in ALTCS in the hopes of curtailing expenditures on these services. HCFA is concerned that if more slots are available, then more people will use them than are actually nursing facility certified; this is known as a "woodwork" effect, but so far, the ALTCS PAS tool has succeeded in avoiding this problem.\textsuperscript{49} The limit has been expanded each year, so that as of October 1, 1992 it was up to 30 percent of the total number of elderly and people with physical disabilities covered by ALTCS.\textsuperscript{50} To be eligible for ALTCS, a person must be at risk for institutionalization. Since this is the case, it is uncertain whether a greater number of participants allowed to have home and community based services would actually use these services and reduce the cost of institutionalization.\textsuperscript{51}

In ALTCS, a case manager serves as a gatekeeper to coordinate the delivery of the most appropriate and cost-effective services. Typically, each member’s primary care physician and case manager jointly develop and authorize services; these two professionals work together on the overall care plan of the member to ensure the right care is delivered. The case manager’s duties include ensuring the appropriate placement of the individual into the proper care setting, documenting the services provided and their cost effectiveness, ensuring the data collected for the ALTCS Client Assessment and Tracking System is accurate, and periodically re-evaluating the individual’s care needs according to a given time schedule for the individual’s care setting.\textsuperscript{52}


\textsuperscript{50} Telephone interview with Linda Skinner, Administrative Services Officer II at AHCCCS, August 16, 1993.

\textsuperscript{51} AHCCCS Proposal to the National Academy for State Health Policy, p. 28.

\textsuperscript{52} Skinner, pp. 4-5.
Skinner points out the strengths of the program include statewide consistency in quality and quantity of services due to mandatory monitoring of program contractors, excellent development of provider networks even in rural areas, and a cost effective PAS tool allowing the individual to reside in the least restrictive care setting.

An area for concern is the phenomenon that some ALTCS members’ health status improves so much that they no longer are at risk for institutional care, and therefore become ineligible for ALTCS services. This means they will not be able to receive the intense case management and community services, causing a break in their care plan. Another area for concern is the ALTCS risk pool which is smaller than for the general AHCCCS program and, by definition, sicker. This may be a consideration for HMOs who are at risk for providing cost effective services for these individuals when bidding for ALTCS contracts.

A third area of concern is the current nursing facility rate setting process. Program contractors can “game” the system through underestimating the number of persons they can serve with home and community based services and overestimating those they can serve in a nursing facility setting. The resulting capitation rate will account for a higher number a persons in the more expensive institutional setting, but in reality, the contractor will be able to serve them through less expensive home and community care, thereby increasing the contractor’s profit margin. Currently, AHCCCS sets a minimum number of HCBS slots for each county to avoid this problem. A final area for concern is establishing managed care programs on American Indian reservations. While
AHCCCS is phasing in managed care on reservations, issues regarding provider network problems and pass through funding need to be resolved.53

Evaluation: An evaluation of the overall AHCCCS program conducted by Laguna Research Associates in 1993 compared the long term care program costs of ALTCS with a traditional Medicaid program.54 A traditional program’s costs were estimated using data from other states’ Medicaid programs which use similar eligibility criteria and have reliable and complete data. The results of the comparison indicated that ALTCS costs were 6 percent less in fiscal year 1990, and 13 percent less in fiscal 1991 than the costs of a traditional long term care program. However, the per capita costs of caring for the elderly and people with physical disabilities in ALTCS were higher than those of the traditional program.

The researchers attribute the overall savings of the program to the cost savings incurred by serving persons with developmental disabilities. Cost per individual in these categories was 30 percent less in fiscal year 1990 and 44 percent less in fiscal year 1991 in comparison to the estimated costs of a traditional program. These savings in conjunction with fewer elderly being served by the ALTCS program due to a stringent PAS tool lead to the apparent overall cost savings of the program.55 While people who are developmentally disabled are included in ALTCS, the administration of services for this group is headed under a different branch from that which coordinates services for the elderly and people with physical disabilities.

53Personal communication with Linda Skinner, October 26, 1993.
55McCall et al., p. 104.
Hospital utilization data of ALTCS compiled by McCall et al. show that in comparison to all Medicare enrollees, ALTCS members had lower utilization of hospital services in 1990. Table 4 illustrates this and gives comparison data on S/HMO utilization.

<table>
<thead>
<tr>
<th></th>
<th>ALTCS, 1990*</th>
<th>Medicare, 1990*</th>
<th>S/HMO, 1990†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital days/1000 person-years</td>
<td>2,118</td>
<td>2,811</td>
<td>1,891</td>
</tr>
<tr>
<td>Admissions/1000 person-years</td>
<td>282</td>
<td>314</td>
<td>292</td>
</tr>
<tr>
<td>ALOS (days)</td>
<td>7.5</td>
<td>9.0</td>
<td>6.7</td>
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</tbody>
</table>

*ALTCS and Medicare data are from McCall et al., pp. 188-189.
†Data are from the Social/HMO Consortium: Management Data Set at Brandeis University and obtained through personal correspondence from Walter Leutz, received October 22, 1993.

Concerns about quality of care were raised as a result of part of the Laguna Research Associates evaluation. Quality of care in the ALTCS program was found to be lower in comparison to New Mexico’s state program, but higher in comparison to national evaluations of quality of care in Medicaid programs. Questions still remain as to the limitations of the data and methodology used by the researchers in this study.\(^{56}\)

\(^{56}\)McCall et al., pp. 291-292, and personal communication with Linda Skinner, October 27, 1993.
4. The Florida Medicaid Prepaid Health Plan/HMO Frail Elderly Option

Goals: To provide care for the state’s frail elderly Medicaid population through integrating medical and social services so as to delay or avoid institutionalization.

Eligibility: SSI/Medicaid eligibles who are enrolled in a participating plan which receives a capitated rate from the state to care for Medicaid recipients. As of September 1993, the Frail Elderly Option was operational in only two Medicaid contract plans. Members who desire this option are evaluated by the Comprehensive Assessment and Review for Long Term Care (CARES) team to determine the level of care needed by the member. If the member is nursing facility eligible and can be cared for through community services, he or she receives the Frail Elderly Option benefits, and the plan receives a higher capitation rate for that member than the standard SSI rate discussed below.

Services: Nursing facility coverage as well as social support services that may include but are not limited to: homemaker/personal care, special home delivered meals, housekeeping/chore services, minor physical adaptations to the home, consumable medical supplies, home health aide, companion, adult day care, respite care, medical/alert response system, caregiver training/support, special drug and nutritional assessments and financial education and protection. Services available to all Medicaid recipients enrolled in a participating health plan include inpatient and outpatient hospital services, physician services, lab and x-ray, prescription drugs, early and periodic screening, diagnosis, and treatment (EPSDT), therapy services, home health care and durable medical equipment.
Funding: Medicaid. The capitation rate for the plans serving Medicaid eligibles are calculated by the state for each county using claims data of a comparable group of Medicaid recipients. There is an enhanced capitation rate for the Frail Elderly Option as these enrollees typically use more services than their healthy counterparts. The Frail Elderly Option capitation rate is determined using claims data from both the community setting and the nursing facility setting. Some of the services offered to all Medicaid enrollees in health plans are covered by Medicare for the elderly enrollees. Since Medicaid is the payor of last resort, Medicare must be billed by the participating health plan for these services.

Legislative Requirements: Currently, the Frail Elderly Option does not have to operate under a federal waiver. The plan was first developed in the 1980’s as a Federal competition demonstration project. Through a §1915(b) waiver of the statewidensness provision of the Social Security Act, Florida was able to target its Medicaid managed care program to the elderly in Palm Beach County. This waiver allowed Florida to waive the requirements that the scope of services for all categorically needy persons in the state be the same and that the Medicaid program operate uniformly throughout the state.

To obtain a §1915(b) waiver, a state program must meet cost effectiveness criteria as well as show that the restrictions imposed on the enrollees by the waiver will not hinder their access to quality medical services. After the Federal demonstration project came to an end, the Frail Elderly Option services were incorporated into the existing Medicaid health plan contract at Mount Sinai Medical Center in Miami Beach, the original project sponsor.
Details: Florida operates a Medicaid Prepaid Health Plan for its AFDC and aged and disabled SSI recipients in eleven counties, most of which are in the southern tip of the state. This program covers all state plan Medicaid services but, in general, does not focus different types of services on the different groups of recipients. The Frail Elderly Option, as a part of Florida’s Medicaid Prepaid Health Plan, targets appropriate services to the select group of frail elderly. This option is currently operational at two Medicaid contract health plans, CAC ElderCare and Lourdes Health Plan and has approximately 1,000 enrollees. Other plans have expressed interest in developing this service package as well.

Capitation rates are calculated by the state for health plans contracting to serve Medicaid members. Four standard rates are determined for four different groups of Medicaid recipients: AFDC, SSI/No Medicare, SSI/Medicare part A, and SSI/Medicare part A and B. Community and institutional experience data are utilized to calculate an enhanced capitation rate for the Frail Elderly Option. This rate is lower than institutional rates, but it is higher than the standard community rate for a comparable fee-for-service population. This higher rate accounts for the enriched services that nursing facility eligible members use.

The health plans are not TEFRA risk contractors (discussed below), but they do manage Medicare benefits for their dually eligible members. The capitation rates do not pool Medicare and Medicaid monies, but Medicaid pays the Medicare premiums and deductibles for the dually eligible enrollees. Like HMOs in ALTCS, it is the responsibility of the health plans to bill Medicare for any services provided that are covered by Medicare.
The health plan receives the enhanced rate for as long as members utilizing the Frail Elderly Option continue to meet eligibility requirements. Once the individual no longer qualifies for the benefits through improved health status, but remains Medicaid eligible, the rate returns to the standard community capitation rate applying to his or her eligibility group. If the individual can no longer be maintained outside of a nursing facility, the health plan is responsible for covering nursing facility care for the remainder of the contract year. The CARES team reassessment, the written statement of the member’s primary care physician, or the written statement of the administrator of the nursing facility in which the member will reside must be given to the Department of Health Services for approval and then, the health plan may disenroll the individual at the end of the contract year.57

At the heart of the Frail Elderly Option is intense case management which provides access to the support services necessary for each enrollee to remain outside of the nursing facility. Thus, it is similar in its goals to the S/HMO and PACE demonstrations, but it does not pool Medicare and Medicaid funds into one capitated rate.

5. Minnesota's Proposed Long Term Care Options Project (LTCOP)

This program is still in its design phase and not yet operational.58

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58 Information on the Long Term Care Options Project was obtained from an unpublished paper entitled: “Background Statement: Long Term Care Options Project,” produced by the State of Minnesota Department of Human Services, March 24, 1993.
Goal: To encourage the coordination of long term care and acute services for the dually eligible elderly, and to provide incentives for delivering preventive care as well as the lowest-cost appropriate services.

Eligibility: Medicaid/Medicare dual eligibles only. Participants must be at risk for institutionalization either through having chronic illness, functional difficulties, or are advanced in age, or they must be current residents of nursing facilities.

Services: Long term care, home care and other services covered by Medicaid as well as primary and acute services covered under Medicare. Home and community-based services which help individuals at risk for nursing home placement remain outside of institutions are also covered.

Funding: Pooled Medicaid and Medicare funds in a capitated rate paid to managed care networks. Currently, the development of the project is being funded by a planning grant from the Robert Wood Johnson Foundation.

Legislative/Regulatory Requirements: A §1115 Federal demonstration waiver must be obtained to pool Medicare and Medicaid funds.

Details: In the early 1980’s, HCFA called for proposals from states for §1115 demonstrations which would examine cost effective alternatives for paying for and delivering Medicaid services; Minnesota was one of the five original states selected to participate in this “competition demonstration.” The outcome of Minnesota’s project was the Prepaid Medical Assistance Program (discussed below) which covers some of the needs of the elderly on Medicaid in certain counties. But the Long Term Care Options Project (LTCOP) currently being
developed will change the service package that the state has purchased from HMOs for caring for the Medical Assistance elderly.

The LTCOP will pool Medicaid and Medicare funding to provide social, primary, acute, and long term care services for frail dually eligible elderly. Currently, different funding sources for care of the elderly encourage cost-shifting between the Medicare and Medicaid programs. Medicaid-covered long term care encourages discharging nursing facility residents to hospitals while Medicare encourages admitting elderly patients for short stays in the hospital and swiftly discharging them to a nursing facility. Pooled financing under a capitated system is believed to eliminate cost shifting and to provide incentives for coordinating all aspects of care and for providing the least expensive appropriate services.

The LTCOP, rather than providing care in a piecemeal fashion, would encourage coordination of services. The state would function as a contract manager while managed care networks such as HMOs would provide or arrange for the provision of services. The contracts would be capitated and risk based; as the program matures and is refined, more risk will be assumed by the networks.

All services covered by Medicaid and Medicare will be available to dually eligible elderly, and those who are assessed as being nursing facility certified will be able to receive home and community based services. This eligibility standard differs from the PACE and ALTCS eligibility requirements in that all participants do not have to be nursing home certified.

The LTCOP model differs from the S/HMO model as well. S/HMOs may invoke limitations on the proportions of frail individuals at enrollment and do not cater
their services to the dually eligible population. Due to a lack of a contract with the state, one S/HMO site must disenroll members who are institutionalized and spend down to Medicaid levels of eligibility.59

Some Minnesota providers already have experience in providing care for the Medical Assistance eligible elderly population through the Prepaid Medical Assistance Program. But the LTCOP program will help provide better incentives for these health plans to give the appropriate care at the most reasonable cost to the dually eligible population. The LTCOP, through its pooled capitation rate will provide an incentive to coordinate Medicare covered primary and acute care services with long term care services traditionally covered by Medicaid.

II. PRIMARY/ACUTE CARE MODEL

As its name suggests, the Primary/Acute Care Model focuses on coordinating the delivery of primary and acute care medical services. Ensuring access to primary care and minimizing unnecessary hospitalizations are some of the goals of this model. Home and community based services may still be utilized, but they are mostly limited to health related services such as home health care rather than those which strengthen social supports. In general, long term care services are not part of the care management process in this model. Thus, most of the savings generated by the Primary/Acute Care Model accrue to Medicare.

1. Medicare HMOs and Competitive Medical Plans (CMPS)

Goal: To provide Medicare covered benefits in a managed care setting so as to coordinate beneficiaries' care and help curtail health care expenditures.

Services: All Medicare-covered primary and acute care services available in the HMO or CMP service areas. The services must be delivered by Medicare-certified providers.

Eligibility: All Medicare beneficiaries in the HMO or CMP’s service areas may enroll in the plan. Special enrollment procedure requirements must be adhered to by the HMO. These requirements include at least a 30-day open enrollment period.

Funding: Medicare capitation rate based on the AAPCC for the service areas of the HMO or CMP.

Legislative/Regulatory Requirements: A TEFRA Medicare risk contract from HCFA. HMOs must be federally qualified and CMPs must be determined as eligible in order to apply for a risk contract.

Details: In 1973, Title XIII of the Public Health Service Act, or the HMO Act as it is commonly called, was passed to encourage the proliferation of managed care as a form of service delivery through the dual choice mandate.\(^6\) Again in 1982,

\(^6\) The dual choice mandate requires that employers offer the option of joining an HMO if the following conditions apply: 1) the employer employs 25 or more persons; 2) employees reside in an HMO’s service area; and 3) the employer offers health benefits to which the employees contribute. This mandate was a part of Title XIII of the Public Health Service Act and was to alleviate the marketing problems faced by HMOs in the early 1970’s.
Congress provided an incentive for managed care to expand by creating Competitive Medical Plans to serve Medicare beneficiaries. Previously, this population had not been targeted by managed care providers as it is generally sicker than the younger segment. Competitive Medical Plans, or CMPs, were given more flexibility in the provision of services to beneficiaries than federally qualified HMOs. The hope behind this legislation was to build up managed care for the elderly through establishing regulations that gave CMPs the status of being federally approved health care providers without having to meet the strict service delivery requirements of HMOs. The resulting regulations gave CMPs the approval process of becoming “federally eligible” to serve Medicare beneficiaries. Part of being an eligible CMP is serving Medicare beneficiaries; if a CMP wishes to stop serving Medicare beneficiaries, it loses its eligibility status.

A CMP is defined in the Code of Federal Regulations §417.407 as a state licensed organization which provides care on a prepaid capitated basis primarily through physicians who are employees or partners in the organization; the organization must assume full financial risk on a prospective basis with provisions for stop loss, reinsurance, and risk sharing with providers, as well as meet the Public Health Service Act requirements of protection against insolvency.

Handley (1993) summarizes the differences between CMPs and HMOs in the following way:61

CMPs

- May be community or experience rated
- Have more flexibility in benefits design than HMOs

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• May limit benefits with regards to time and cost
• Provide services primarily through CMP health professionals; 49% may be provided by out-of-plan providers
• Are not subject to the dual choice mandate

HMOs

• Must be community rated with some flexibility
• Have comprehensive benefits requirements
• Have few limitations with regards to time or cost of benefits
• Provide services almost solely by HMO health professionals; up to 10% of basic health services may be provided by out-of-plan providers
• Are subject to the dual choice mandate by employers

In order to obtain a Medicare risk contract for caring for Medicare beneficiaries, CMPs must be awarded eligibility status by HCFA. This is slightly different from the HMO requirement of becoming federally qualified. There are different applications which must be filed with HCFA by these different types of entities. Both CMPs and HMOs must be state licensed organizations to become eligible or qualified for Medicare risk contracts.

There are two types of applications which an HMO may file depending on its qualification status. If the HMO is applying for qualification to be certified by HCFA as a managed care provider as well as applying for a Medicare risk contract, it can do so with one application. If the HMO is already qualified and is applying to expand its services to Medicare beneficiaries, it can do so through filing the Qualified HMO Medicare Contract Application. Handley identifies the advantages of HMO qualification as: 1) increased credibility among employers; 2) opportunities for increased market share through the dual choice mandate; 3) a shortened Medicare risk-contracting process; and 4) a critique of the strengths and weaknesses of the organization by the HCFA review team.62

62Handley, p. 417.
Like the HMO qualifying application, the CMP eligibility application has a Medicare risk contract application built in. The same advantages of qualification apply to gaining eligibility status. Unlike an HMO which can withdraw from serving Medicare enrollees while still remaining federally qualified, a CMP loses its eligibility status if it no longer serves Medicare beneficiaries. The regulations defining CMPs were created expressly for the purpose of expanding managed care services to Medicare beneficiaries. If a CMP no longer serves these individuals, it no longer is in compliance with the regulations regarding eligibility.

To obtain a TEFRA Medicare risk contract, an HMO or CMP must be federally qualified or designated as eligible by HCFA, state licensed, and meet several requirements regarding membership, services, enrollment procedures, marketing practices, assumption of risk, administration, quality, record keeping, and confidentiality. The following is a brief synopsis of these requirements. Further information can be found in Zarbozo and LeMasurier’s chapter in *The Managed Health Care Handbook* as well as in the federal regulations themselves.63,64

**Membership**

At least 5,000 prepaid capitated members for non-rural organizations. The 50/50 rule requires organizations not have more than 50% of their members qualified for Medicare and Medicaid combined.

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64 Section 1876 of the Social Security Act delineates the law governing Medicare risk and cost contracts with HMOs and CMPs. Regulations for HMOs and CMPs are listed in Title 42 of the Code of Federal Regulations. Federal HMOs are covered under §417.100-418.180; cost contracting HMOs and CMPs are covered under §417.400-417.694; and health care prepayment plans (discussed below) are covered under §417.800-417.810.
Services

All Medicare services available in the organization's service area. Medicare-certified providers must be used. HMOs must be able to provide 24-hour emergency services, as well as be able to pay for emergency services obtained outside the service area. HMOs must render service promptly and have a record-keeping system to ensure continuity of care.

Enrollment procedures

Must have at least a 30-day open enrollment period every year and open its enrollment to Medicare beneficiaries who have disenrolled from another Medicare HMO in the area either as a result of contract non-renewal or termination. Must enroll any Medicare beneficiary in the service area who wishes to enroll during the open enrollment period. Dual eligibles may enroll.

Marketing practices

Must use materials approved by HCFA and market the plan throughout the service area specified by the contract.

Risk

Must be able to bear the financial risk incurred by the Medicare contract.

Administration

Must have administrative ability to fulfill the terms of the Medicare contract.

Quality

Must have a quality assurance program.

Record keeping

The government may inspect financial, service, and enrollment records of the organization. Entities relating to the organization may be inspected as well.

Confidentiality

Must follow the provisions of the Privacy Act and maintain confidentiality of medical and nonmedical records of its Medicare enrollees.

To provide flexibility in contracting procedures, HMOs and CMPs are allowed to drop or add counties in their service area at the end of a contract year. This allows them to take advantage of AAPCC rates that are higher in some counties than in others.

Another option HMOs and CMPs have in providing services to Medicare beneficiaries is the ability to charge different premiums for different groups of Medicare enrollees. However, there are limits as to how much can be charged.
This limit is the adjusted community rate calculated for approval of the Medicare contract. A plan is not allowed to charge Medicare enrollees more than this rate, but is allowed to charge less in order to encourage enrollees to choose staff physicians or to compete with other plans in the area.

For organizations who are risk-averse, cost contracting is another means of providing care to Medicare populations. There are two different regulations providing for reasonable cost reimbursement, one under §1876 of the Social Security Act, and the other in a fragment of a sentence in §1833 of the Medicare law. But these two sections result in different types of organizations.

A contractor under §1876 must follow all the regulations pertaining to federally qualified HMOs and CMPs, whereas under §1833, the contractor is known as a Health Care Prepayment Plan, or HCPP, and has greater flexibility in operating. An HCPP has permission to conduct health screening of potential members, is not required to have open enrollment periods, and is not required to provide the full range of Medicare services that risk-contracting HMOs and CMPs must provide. Given these liberal regulations, as of August 1993 there were 57 HCPPs operating with cost reimbursement agreements under the Medicare law, but only 23 HMOs and CMPs cost contracting under the more restrictive §1876. The total number of Medicare beneficiaries enrolled in HCPPs was over three and a half times as great as those enrolled in cost contracting HMOs and CMPs. Still, there were fewer than one million enrollees in either of these types of entities.65

Evaluation: Participation in Medicare risk contracts has not been as great as was expected when the TEFRA legislation was passed. But it appears that enrollments are increasing. In 1991 only 3% of Medicare beneficiaries over age 65 were enrolled in a Medicare risk HMO, Zarabozo and LeMasurier, 1993. As of September 1993, enrollments were up to roughly 5% of the aged Medicare population.66

The August, 1993 Monthly Report of Medicare Prepaid Health Plans reported that HMOs and CMPs in only 26 states had Medicare risk contracts. Approximately one-half of all Medicare enrollees who were members of a risk contract HMO or CMP live in Medicare Region 9 which includes only Arizona, California, Hawaii, and Nevada. The next largest concentration of enrollees was in Region 4 which includes Florida, Alabama, Georgia, Mississippi, North Carolina, South Carolina, Tennessee and Kentucky; but the only HMOs serving Medicare beneficiaries were in Florida and Kentucky. In these regions, managed care has become a prominent fixture in health care delivery and financing, so it is not surprising that these programs have been able to tap into the Medicare market.

Many HMOs have found that managing the health of an elderly population to be much more difficult than anticipated. Some of these HMOs, rather than abandoning the Medicare population, have undertaken the task of developing a care delivery system which maximizes the benefits of managed care while

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66This was calculated using 1993 HCFA estimates of aged Medicare beneficiaries for 1993. September, 1993 enrollment of aged Medicare beneficiaries in risk contract HMOs was estimated by assuming 90% of all Medicare enrollees in risk contract HMOs were aged and 10% qualified for Medicare on other criteria.
focusing on the complex health needs of the elderly. One such plan is United HealthCare Corporation’s EverCare plan.

2. EverCare

EverCare is a service product developed by the United HealthCare Corporation and is operational at two sites.

Goal: To control medical costs for the Medicare program as well as for enrollees; improve the quality of care and health outcomes for enrollees; increase beneficiary and family satisfaction with care and quality of life; develop practice guidelines and care management protocols for the frail elderly; and gather data and information for the successful replication of this model in other areas of the country.

Eligibility: Medicare beneficiaries receiving both parts A and B and who are permanent residents of a nursing facility. Those who are dually eligible for Medicare and Medicaid may enroll as well.

Services: Primary care, specialty care, and hospital services. A geriatrician and a geriatric nurse practitioner (GNP) team is assigned to each nursing facility where EverCare enrollees reside; the team develops a care plan for each enrollee based on an assessment performed by the GNP. Primary and specialty care are usually provided within the nursing facility, and constant communication between the GNP and facility staff provides a clear picture of the overall health of enrollees.

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Information on EverCare was obtained from the EverCare Demonstration Proposal developed by United HealthCare Corporation.
When a hospital admission is necessary, the GNP discusses the patient’s particular needs with hospital staff to ensure appropriate care is given. EverCare does not pay for the room and board services within the nursing facility.

Funding: Medicare. EverCare receives a capitated rate from Medicare to provide Medicare covered services. Medicaid covered services, such as nursing facility care, are not covered by EverCare. EverCare does not pool Medicaid and Medicare funds; it simply provides Medicare covered services in a case management setting. As in Medicare HMOs and CMPs, Medicaid pays the Medicare premium for dually eligible enrollees.

Legislative/Regulatory Requirements: Must operate under an established HMO’s risk contract. Since HMOs serving Medicare beneficiaries must enroll all Medicare beneficiaries who want to join, the only way EverCare can limit the members they serve to permanent nursing facility residents is to be a separate benefit package of a Medicare HMO. This arrangement allows the parent HMO to restrict who of its Medicare enrollees receives the EverCare package of services to permanent nursing facility residents. Future Federal demonstrations of the EverCare system will be allowed to operate as separate entities and restrict who is enrolled without being a part of a parent HMO.

Details: EverCare coordinates the primary and acute care services for permanently institutionalized Medicare beneficiaries so as to reduce inpatient hospital costs and emergency room use. Physicians are paid for all visits to the nursing facility, rather than being limited to only 18 visits by the standard Medicare program. EverCare encourages family participation in the care planning process through paying physicians when they hold family conferences. To eliminate costly
transportation fees as well as stress on patients, EverCare pays providers to visit the resident in the nursing facility if an urgent visit is required.

Currently, there are two EverCare sites, one in Minneapolis-St. Paul and the other in Chicago. Both are managed through the United HealthCare Corporation in Minneapolis. The two sites must operate under a parent Medicare HMO; Minnesota site operates under Medica’s risk contract, and the Illinois site operates under Share Senior Care’s risk contract. Nine Federal demonstration sites are now being selected to replicate the EverCare program. These sites will not be required to have an enrollment composition limit of 50 percent Medicare or Medicaid enrollees and 50 percent commercial enrollees, since all participants, by definition of the EverCare product, will be eligible for Medicare. A second phase of this demonstration project will be to extend eligibility to functionally disabled persons living at home or in assisted living or congregate housing settings.

Evaluation: While no formal independent evaluations have been conducted on the two EverCare sites, United HealthCare researchers have presented some intriguing data. Since its beginning in 1987, EverCare’s enrollment has steadily increased while its hospital admissions/1000 members/year and hospital average length of stay have all decreased, and Table 5 illustrates these data. The researchers note that the national average of hospital days per 1000 nursing home residents in 1991 was 3,462 days.68

68Malone et al., p. 54.
Table 5: Comparison of Average Monthly Enrollments, Hospital Days/1000 Members per Year, Hospital Admissions/1000 Members per Year, and Average Length of Stay Between 1987 and 1991 of the EverCare Program

<table>
<thead>
<tr>
<th></th>
<th>1987</th>
<th>1991</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average monthly enrollment</td>
<td>107</td>
<td>534</td>
</tr>
<tr>
<td>Hospital days/1000 members per year</td>
<td>2,238</td>
<td>1,582</td>
</tr>
<tr>
<td>Hospital admissions/1000 members per year</td>
<td>404</td>
<td>377</td>
</tr>
<tr>
<td>ALOS (days)</td>
<td>5.4</td>
<td>4.2</td>
</tr>
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3. The Minnesota Prepaid Medical Assistance Program (PMAP)

Goals: To test the feasibility of a prepaid capitated approach for the Medicaid population; to contain Medicaid costs through effectively managing health care delivery; to provide a more predictable budgeting process in the Medicaid program; to test administrative processes within a prepaid capitated approach; and to provide access to quality health care for enrollees.

Eligibility: Residents of four counties in Minnesota who are qualified for Medicaid under AFDC or SSI aged criteria, or are needy children. There are some groups of Medicaid recipients who are not eligible for PMAP services due to

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69Information on PMAP was gathered largely from the Minnesota prepaid Medical Assistance Status Report which was prepared by the Minnesota Department of Human Services Division of Health Care Administration Managed Care Unit, May 1, 1992.

70From a description of PMAP produced by the Minnesota Department of Human Services Division of Health Care Administration Managed Health Care Unit, July 1, 1991.
participation in other types of health care programs such as the Refugee Assistance Program, or those who have private health care coverage through a qualified HMO. In the first two years of operation, SSI blind and disabled populations participated in the program, but they were disenrolled at the start of the third year due to the withdrawal of a major health plan and a desire to create a managed care model which would address the specific needs of this population.

Services: All Medicaid services except nursing facility services are covered under a rate paid to participating health plans. All Medicaid services are covered for nursing facility residents except the residential per diem costs.

Funding: Medicaid pays a capitated rate to participating health plans for each PMAP enrollee. Different rates are paid according to the enrollee’s classification on the following factors: age, sex, Medicare status, institutional status, category of eligibility, and county of residence. As in ALTCS and the Frail Elderly Option, Medicare is billed by health plans for covered services provided to Medicare beneficiaries.

Legislative/Regulatory Requirements: The PMAP operates under several waivers of Title XIX of the Social Security Act as a result of being a §1115 demonstration project. By virtue of being a §1115 demonstration, Minnesota is able to restrict recipients’ freedom of choice of provider, to provide different services in certain counties, and to include certain expenditures incurred by the demonstration project as expenditures of the Minnesota Medicaid Plan for the duration of the project; such expenditures include those permitting the state to contract with organizations not meeting the 75/25 Medicare/Medical Assistance enrollment limitation specified under §1903 (m) (2) (A) (ii) of the SSA, those permitting the
state to restrict enrollees from disenrolling on demand, and those permitting the state to contract with non-HMOs on a prepaid, capitated basis.

Details: The program began in July 1985 as a State and Federal demonstration project that was to last three years. In 1989, Minnesota received permission to extend the demonstration until 1996. The program is not solely for the elderly and does not merge both Medicaid and Medicare dollars into one capitated rate. As of August 1993, the elderly made up less than 10 percent of the program.71

Services provided through PMAP include those which are a part of the State Medicaid Plan with the exception of nursing facility care. Medicaid recipients who reside in nursing facilities are enrolled in PMAP, but the capitation rate for these persons does not cover the per diem rate of the nursing facility; all other services are covered and provided by the contracting health plan and are included in the capitation rate. As an incentive to disinstitutionalize, future contracts will require plans to cover 90 days of long term care.72

Evaluation: State evaluations of fiscal years 1990 and 1991 indicated there were cost savings experienced by the program when compared to similar fee-for-service populations.73 In 1990, there was a 7 percent savings experienced by the program when compared to what total estimated fee-for-service costs would have been for the same populations; in 1991, this savings dropped to 6 percent. But these savings were generated by caring for the AFDC/Needy Children populations;

71 Telephone interview with Kathleen Schuler of the State of Minnesota Department of Human Services, September 3, 1993.
72 Schuler, telephone interview, September 1993.
caring for the elderly was actually more expensive in comparison to estimated fee-for-service costs for the same population. Fiscal year 1990 data showed the program was 43 percent more expensive than estimated fee-for-service costs for the elderly population. The evaluators attribute this to four factors:

1. Calendar Year 1990 fee-for-service data rather than Fiscal Year 1990 data was used to trend the capitation rates, resulting in six months more inflation in the prepaid rates than was in the historical fee-for-service comparison costs. 2. There was a three month overlap that the Medicare Catastrophic Act effect was in the prepaid rates but not in the fee-for-service costs. 3. The enrollment of the Aged fell short of the enrollment target by 20%, thereby, keeping more clients in fee-for-service and lowering the per person per month cost of that program. 4. Finally, a health plan dropped out September 30, 1990, and as a result, Aged clients could choose fee-for-service or a different health plan in Hennepin and Dakota Counties. 74

The elderly comprise such a small percent of the program that the cost of care for them is offset by the savings of caring for the AFDC and Needy Children groups. The same evaluation of the 1991 fiscal year data showed similar results. While the program experienced overall savings in 1991, caring for the elderly under PMAP still cost 9 percent more than estimates of fee-for-service costs of care for the same population. This shows a favorable trend over the two years toward becoming cost effective, but there is room for improvement.

One source of inefficiency in caring for the elderly is that currently there is little coordination between the services covered by Medicare and those covered by Medicaid; the capitation rates paid to participating health plans do not pool these monies for dually eligible persons. Medicare provides an incentive to hospitals to quickly discharge their elderly patients to nursing facilities, while Medicaid provides encouragement to discharge them to hospitals. These different incentives result in a fragmentation of services for the elderly through shifting

the burden of caring for them among different types of providers. The fragmentation of services for the elderly is one of the reasons that the Long Term Care Options Project is being developed. The LTCOP will become an alternative choice of care for the elderly living in the four counties where PMAP is operational.

III. LONG TERM CARE MODEL

This model focuses on the long term care needs of the elderly. Through providing reimbursement for home and community based services, long term care can be provided for certain individuals in a home setting rather than in an institution. Management of primary and acute care services is not typically provided under this model.

1. Home and Community Based Services Waiver Programs 75

Goal: To provide in home or community based services as substitutes for more costly institutional care or to help avoid institutionalization altogether.

Services: Vary between programs but can include case management, homemaker services, personal care, day care, habilitation services, and respite services.

Eligibility: A specific case-load of aged or disabled persons who are eligible for Medicaid services. The participants must be certified as needing institutionalization.

75The information on home and community based waivers was obtained largely from Medicaid Home and Community Based Services Waivers for the Elderly, a publication produced by the National Eldercare Institute on Long Term Care, December 1992.
Funding: Medicaid. In most programs there is a limit on the number of persons who can be eligible for these services, however, there is no explicit cap on expenditures.

Legislation/Regulatory Requirements: Most states must receive waivers under Section 1915(c) of the Social Security Act. This allows the states to use Medicaid funds to provide in-home and community based services, previously not covered by Medicaid, to a specified caseload of persons who are aged or disabled and nursing facility certified.76

Details: Medicaid Home and Community Based waiver programs are in operation in 44 states around the country. One can see from the services listed above that social and medical services can be covered by the HCBS waivers. These waiver programs are classified separately form the Integrated Care Model model programs due to their lack of comprehensive care benefits. The integrated model programs may have components of HCBS waivers, but they cover and manage the acute care and nursing facility needs of enrollees as well. The HCBS waiver programs cover those services which will enable the participants to avoid institutionalization. Participants may be eligible for Medicare or Medicaid-covered acute care services, but the HCBS waivers do not necessarily provide incentives for coordinating these services in addition to coordinating the home and community services. A description of services provided through HCBS programs which serve the elderly is included in Appendix B.

76The only state-based HCBS program not operating under a §1915(c) waiver is Oregon which received a waiver under §1915(d) of the Social Security Act. This allows Oregon to provide HCBS to persons aged 65 and older who are nursing facility certified. This waiver does not impose a cap on the number of persons who can receive these services, but there is an overall cap on Medicaid-financed long term care services for the elderly in Oregon. This includes both institutional and community-based services.
While the waiver programs must meet specific cost-effectiveness standards set by HCFA, none of the HCBS programs listed in the attached appendix operates under capitation. The only limit on expenditures in these programs, with the exception of Oregon’s plan, is through limiting the number of elderly and people with disabilities eligible for these services.

Data reported in the 1993 Medicaid Source Book 77 indicate that since the waiver authority was enacted in 1981, expenditures on home and community based services for the Medicaid population have increased from $3.8 million in fiscal year 1982 to $1.7 billion in fiscal year 1991. Home and Community Based Waiver expenditures in FY 1991 accounted for 4.7 percent of long term care spending and 1.9 percent of total Medicaid payments. The aged and disabled populations comprised 73 percent of persons served by HCBS programs, but accounted for only 31 percent of expenditures. The majority of expenditures of these programs were on caring for persons with mental retardation and developmental disabilities.

The portion of home and community based services in the Arizona Long Term Care System operates under capitation as a part of the prepaid health plans developed for ALTCS. But as in the other HCBS programs, the federal government limits the number of elderly eligible for these services so as to control expenditures on these services.

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771993 Medicaid Source Book: Background Data and Analysis. p. 400.
IV. ISSUES AND CONCERNS

While each program described in this guide is different, several common themes have emerged in our review. The type of services provided by each program appears to be directly related to the principal funding source. Elders tend to have high utilization rates in hospitals and nursing facilities, accounting for rising costs of care. To better coordinate acute and long term care, however, requires linking two discrete programs, Medicare and Medicaid. Of all the different programs described above, the only ones which combine both Medicare and Medicare are the S/HMO, PACE and LTCOP demonstrations; it is not an accident that these programs provide the most comprehensive services ranging from Medicare-covered primary and acute care to Medicaid-covered long term care. But these demonstrations are limited in the both the number of sites available and the number of elderly served.

Improving the coordination and continuity of care and curtailing health care expenditures for the elderly will require the elimination of cost shifting from the hospital to the nursing facility and back again. Through joining the two payment sources, the incentives to transfer individuals from one setting to another will be taken away and replaced with incentives to coordinate care regardless of setting, hopefully resulting in the most appropriate care given in the most appropriate environment. But as S/HMO and PACE program directors point out, linking Medicare and Medicaid is not a simple process. Waivers must be obtained to receive a capitated payment from both sources, and a rate setting process must be developed. Both S/HMOs and PACE have different rate setting technology, and it is almost certain that Minnesota’s LTCOP will provide another. But as more
programs attempt to bring these two financing mechanisms together, expertise is gained to inform future innovation.

Another common theme which arose through interviews with many directors of the programs discussed above is the obstacle of overcoming the belief that institutionalization is the only means of meeting the long term care needs of the elderly. Many project directors encountered this long term care ideology when they first began operating. But as the programs have matured and demonstrated financial savings, they report that many state policy makers, licensing boards, and health departments have become convinced that long term care needs can be met outside the nursing facility.

The institutional bias in the nation's long term care system has been demonstrated by the difficulty in obtaining waivers to provide home and community based services; but progress has been made in simplifying the procedure. The National Governors’ Association has been working closely with President Clinton and HCFA to streamline the waiver application process so that §1915(b) and §1915(c) waivers are easier to obtain as well as keep. HCFA has contracted with Research Triangle Institute and the National Academy for State Health Policy to investigate additional approaches to improve the §1115 waiver process and to provide technical assistance to states. Such simplifications may encourage future demonstrations.

Another barrier faced by many of the programs is the lack of community housing. When using eligibility criteria in the nursing facility certification tool that include social support and community housing availability, programs find that some of their members are nursing facility eligible because they have
inadequate housing; they may not need skilled nursing facility care, but since they may not have a home in which to receive home care services, they must be institutionalized. This problem has two results depending on the requirements of the managed care program: 1) higher costs for the Medicaid program through having to house these persons in the expensive institutional setting; or 2) having to turn potential members of a managed care program away due to the inability to house them in the community. If programs must turn potential members away, enrollments are kept down, risk pools may be too small, and fixed costs per enrollee may be too big.

V. CONCLUSIONS

The total enrollment in the programs described above including all cost and risk contract health plans is roughly 2.43 million persons, or about 7.5 percent of the estimated number of Medicare beneficiaries over 65 years old in 1993. Total enrollment in programs other than the cost and risk contract health plans is roughly 180,000 persons.\textsuperscript{78} Despite this low enrollment, the programs have shown that care for the elderly in managed care settings can be both cost effective and of high quality. But the models have been limited in their design, and it remains unclear which path managed care for the elderly should take.

The programs in existence today target very different segments of the older population, from the relatively healthy in Medicare HMOs and CMPs to the very

\textsuperscript{78}Enrollment figures for many of the programs described above were obtained through telephone interviews with the program directors during August and September of 1993. Enrollment figures for Home and Community Based Waiver programs were from 1991 as reported in the 1993 Medicaid Source Book. Enrollment figures for the risk and cost contract health plans was obtained from the Monthly Report of Medicare Prepaid Health Plans, September 1993. Population figures were obtained from HCFA, 1993.
frail in the PACE, ALTCS, Frail Elderly Option, and EverCare programs, and cost savings may not always be clear. S/HMOs appear to be able to make a profit, but one evaluation indicates that increases in the proportion of very impaired members could impact the financial stability of the programs, particularly if stronger disability adjustments are not added to the reimbursement rate. Most PACE sites are able to provide cost effective care for the members they serve, but they tend to enroll only about 2 percent of those eligible in their service areas, serve the very frail, and require a day care center as their means of service delivery; it is unknown at this point if their cost effectiveness would continue with larger enrollments.

EverCare appears to be able to cut down on hospital admissions and hospital days for institutionalized elderly through increased access to physician care within the nursing facility; but some suggest that this is just good nursing facility care, not a breakthrough in managed care for the elderly population. While the Federal government may reap the benefits of decreased Medicare expenditures, state expenditures are virtually unaffected as Medicaid must pay for nursing facility care for dually eligible members.

Delivery systems such as ALTCS, Florida’s Frail Elderly Option, PMap, Medicare HMOs, EverCare, and Home and Community Based Service Waiver programs point to the inefficiencies of fragmented payment sources. The ALTCS and the Frail Elderly Option are supposed to cover everything from preventive care to long term care for a very frail population; but the program contractors do not receive a capitation which covers both Medicare covered primary care and Medicaid covered long term care. Great strides are made by these programs as they attempt to merge all services into one delivery system, but with multiple
payment sources it is unclear how well the different services are truly coordinated. The other programs are not generally designed to coordinate the broad range of services; they focus on either Medicare covered primary and acute care or Medicaid covered long term care, leaving the door open for shifting the burden of paying for care from one source to another. Only S/HMOs, PACE, and LTCOP combine Medicare and Medicaid into one funding source, thereby providing the incentive to find the lowest cost, most appropriate care setting.

Most of the mature programs described in this paper have been able to save money in some way for the nation’s health care system, either through decreasing costly hospital or nursing facility use or through having the savings built into their capitation rates. But most programs also have had difficulty in starting operations due to a complex waiver application process, lack of support and funding from states and sponsoring organizations, and recruiting health care professionals who are dedicated to serving the complex health needs of the elderly.

With the aging of the population, states may be faced with even greater Medicaid expenditures, and President Clinton’s reform plan gives an opportunity to state policy makers to take the lead in health care reform. But focusing only on Medicaid long term care programs may not result in decreased costs over the long run. Through inattention to preventive and primary care services, many chronic conditions faced by the elderly can lead to debilitating acute and long term care episodes. Through managing all aspects of care from preventive to long term care, future programs may result in improved quality of life for the elderly and lower costs for the entire health care system; consumers, providers, states, and the Federal government could win.
APPENDIX A
Program for All-inclusive Care for the Elderly
Rate Comparisons and Methodology
### Program for All-inclusive Care for the Elderly
**RATE COMPARISONS & METHODOLOGY**

<table>
<thead>
<tr>
<th></th>
<th>California</th>
<th>Colorado</th>
<th>Illinois</th>
<th>Massachusetts</th>
<th>New York (Bronx)</th>
<th>New York (Rochester)</th>
<th>Oregon</th>
<th>South Carolina</th>
<th>Wisconsin</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PACE Rate</strong></td>
<td>$2,049</td>
<td>$1,203</td>
<td>$1,197</td>
<td>$1,839</td>
<td>$4,442 (SNF)</td>
<td>$2,445 (ICF)</td>
<td>$2,928</td>
<td>$1,447</td>
<td>$2,678</td>
</tr>
<tr>
<td><strong>Avg. Nursing</strong></td>
<td>$2,532</td>
<td>$2,163</td>
<td>$2,132</td>
<td>$2,983</td>
<td>$4,690 (SNF)</td>
<td>$3,070 (ICF)</td>
<td>$3,080</td>
<td>$2,254</td>
<td>$1,951</td>
</tr>
<tr>
<td><strong>Home Rate Rate</strong></td>
<td>81%</td>
<td>56%</td>
<td>56%</td>
<td>62%</td>
<td>95% (SNF) 80% (ICF)</td>
<td>95%</td>
<td>64%</td>
<td>137% ^2</td>
<td>96%</td>
</tr>
<tr>
<td><strong>RATE METHODOLOGY (FOR KEY ISSUES)</strong></td>
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<tr>
<td><strong>Comparison Group</strong></td>
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<tr>
<td>Nursing Facility</td>
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<td>Nursing Facility &amp; HCBS</td>
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<td>Nursing Facility, Foster Care &amp; HCBS</td>
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<td><strong>Comparison Group</strong></td>
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<tr>
<td>Study &amp; N.Y.'s Long-Term Health Care Program</td>
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<td>Comparison Group</td>
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<td><strong>Case Mix Adjustment</strong></td>
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<tr>
<td>Case mix adjustment for age and sex applied to each of six rate components.</td>
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<tr>
<td>No. Assumed to be equal to case mix of comparison group.</td>
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<td>Yes. Two different rates paid based on ICF vs. SNF level of care at intake.</td>
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<tr>
<td>Yes. Long-term care component weighted based on frailty score at time of initial assessment.</td>
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<td>No. Assumed to be equal to case mix of comparison group.</td>
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<tr>
<td>Yes. Long-term care component weighted based on ICF/SNF mix at time of Initial assessment. Other costs adjusted for age mix of enrollees.</td>
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<td><strong>Total Costs</strong></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No. Based on nursing home rate only.</td>
<td>Yes</td>
<td>Yes</td>
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<td><strong>Adjustment for</strong></td>
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<td><strong>Patient Share of</strong></td>
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<td><strong>Costs</strong></td>
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<td>Nursing Facility vs. Community Population</td>
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<td>Yes. Method based on state's net expenditures for comparison group.</td>
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<td>N/A. Comparison group also lives in community.</td>
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<td>No. Possible offset for costs excluded (see above).</td>
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<tr>
<td>Yes. Nursing Facility rate adjusted by avg. state-wide payment liability of nursing home resident.</td>
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<tr>
<td><strong>Discount</strong></td>
<td>15%</td>
<td>5%</td>
<td>5%</td>
<td>N/A. Negotiated rate between estimated cost of community &amp; institutional populations.</td>
<td>5%</td>
<td>5%</td>
<td>0% (Comparison group already provides savings.)</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
</table>

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1 To estimate the net Medicaid cost, adjust rate upward for Medicaid drugs, supplies, co-payment and deductible for hospital care and downward for share of cost paid privately by the resident.

2 Due to high percentage of Medicaid-only and low average share of cost of nursing facility population in South Carolina, PACE rate © of comparison group's total costs is higher than nursing facility rate. Medicaid covers all acute care costs for Medicaid-only elderly.

APPENDIX B

Home and Community Based Service Waiver Programs
# HOME AND COMMUNITY BASED SERVICE WAIVER PROGRAMS

<table>
<thead>
<tr>
<th>STATE</th>
<th>SERVICES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>Case mgmt, homemaker, respite, personal care, adult day health</td>
</tr>
<tr>
<td>Arkansas</td>
<td>Homemaker/chore, home delivered meals, personal emergency response systems, adult day care, adult foster care, respite</td>
</tr>
<tr>
<td>California</td>
<td>Case mgmt, adult social day care, housing assistance, in-home support services, respite, transportation, meal services, protective services, special communication</td>
</tr>
<tr>
<td>Colorado</td>
<td>Case mgmt, homemaker, personal care, adult day care, respite, transportation, minor home modifications, electronic monitoring or communication devices</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Case mgmt, adult day health, chore companion, elderly foster care, home delivered meals, homemaker, mental health counseling, personal emergency response systems, respite, transportation</td>
</tr>
<tr>
<td>Delaware</td>
<td>Case mgmt, homemaker, adult day care, respite, emergency response systems, medical equipment, supplies, appliances</td>
</tr>
<tr>
<td>Florida</td>
<td>A. Case mgmt, adult day health respite, escort, transportation, home mgmt/homemaker, health support, counseling, personal care, placement services</td>
</tr>
<tr>
<td></td>
<td>B. In Dade County: case mgmt, skilled nursing, homemaker/personal care, home delivered meals, housekeeping/chore, home adaptations, consumable medical supplies, home health aide, companion, adult day care, respite, mental health services, physical, occupational, and speech therapy, medical alert/response system, caregiver training/support, special drugs, nutritional assessments, financial education/protection</td>
</tr>
<tr>
<td>Georgia</td>
<td>Case mgmt, home health aide, personal care, therapies, nursing, medical supplies, equipment, and appliances, therapeutic activities, medical social services, homemaker aides, respite, emergency response systems</td>
</tr>
<tr>
<td>Hawaii</td>
<td>A. Case mgmt, homemaker, personal care, adult day health, habilitation, respite, home delivered meals, home maintenance, moving assistance, nutritional counseling, emergency alarm response system, environmental modifications, transportation, skilled nursing</td>
</tr>
<tr>
<td></td>
<td>B. Case mgmt, homemaker, personal care, respite</td>
</tr>
<tr>
<td>Idaho</td>
<td>Personal care</td>
</tr>
<tr>
<td>Illinois</td>
<td>Homemaker, adult day care, chore/housekeeping</td>
</tr>
<tr>
<td>Indiana</td>
<td>Case mgmt, homemaker, respite, personal/attendant care, adult day care, home delivered meals, home modifications, adaptive devices</td>
</tr>
<tr>
<td>Iowa</td>
<td>Adult day care, homemaker, respite, home health aide, nursing, emergency response systems</td>
</tr>
<tr>
<td>Kansas</td>
<td>Case mgmt, wellness monitoring, adult day health, nonmedical attendant, night support, respite, habilitation, residential care and training, medical alert, homemaker, residential personal care, transportation</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Case mgmt, respite, homemaker, personal care, assessments, reassessments, adult day, living quarters adaptations, respiratory therapy</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Adult day care</td>
</tr>
</tbody>
</table>

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This list is part of a matrix produced by the National Eldercare Institute on Long Term Care and found in the publication *Eldercare in the Home and Community Long Term Care Information: Medicaid Home and Community Based Services Waivers for the Elderly*, December, 1992.
<table>
<thead>
<tr>
<th>State</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maine</td>
<td>Case mgmt, adult day health, personal care, homemaker, home health, transportation, emergency response systems, mental health services</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Case mgmt, chore, homemaker, social day care, respite</td>
</tr>
<tr>
<td>Michigan</td>
<td>Chore, adult day care, supervision of personal care, respite, foster, care payments, private duty nursing, counseling, training, environmental modifications, home delivered meals</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Case mgmt, homemaker, extended home health services, extended personal care assistance, adult day health, respite, adult foster care, companion, caregiver training/education, home delivered meals, extended medical supplies/equipment, assisted living, residential care services, electronic home monitoring</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Case mgmt, adult day care, respite, homemaker, home health</td>
</tr>
<tr>
<td>Missouri</td>
<td>Homemaker/chore, respite</td>
</tr>
<tr>
<td>Montana</td>
<td>Case mgmt, homemaker, personal care attendant, adult day health habilitation, respite, transportation, medical alert, environmental modifications, nutritional services, respiratory therapy, private duty nursing</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Respite, adult day health, transportation, chore, day care, independence skills mgmt</td>
</tr>
<tr>
<td>Nevada</td>
<td>Case mgmt, adult day care, in-home attendant care, respite, homemaker, adult companion services</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Case mgmt, adult day health homemaker, home health aide, respite, nursing, emergency response systems</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Case mgmt, home health, homemaker, social adult day care, transportation, medical day care, respite</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Case mgmt, homemaker/personal care, private duty nursing, in-home respite</td>
</tr>
<tr>
<td>New York</td>
<td>Respite, medical social services, nutritional counseling, respiratory therapy, meals, social day care, moving assistance, transportation, housing improvements, home maintenance</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Case Mgmt, transportation, respite, homemaker, home health aide, personal care chore, adult day care</td>
</tr>
<tr>
<td>Ohio</td>
<td>Adult day care, adaptive/assistive equipment, chore, counseling/social work, home delivered meals, personal care, homemaker, home medical, equipment/supplies, home modifications, respite, occupational therapy, transportation, nutritional consultation</td>
</tr>
<tr>
<td>Oregon</td>
<td>In-home services, residential care facilities services, adult foster care, minor home adaptations, home delivered meals, specialized living facilities</td>
</tr>
</tbody>
</table>
| Rhode Island    | A. Case mgmt, home maker, adult day care, devices to adapt home environments, minor assistive devices, transportation  
B. Case mgmt, adult day care, homemaker, home modifications, minor assistive devices |
<p>| South Carolina  | Case mgmt, personal care, medical day care, are, home delivered meals, respite, physical therapy, occupational therapy, speech therapy, medical social services |
| South Dakota    | Homemaker, private duty nursing, adult day care                           |
| Tennessee       | Case mgmt, persona are home modifications, home delivered meals           |
| Utah            | Case mgmt, respite, homemaker, personal emergency response systems, adult day care supportive maintenance, transportation, home delivered meals |
| Vermont         | Case mgmt, home care, adult day care respite                               |
| Virginia        | Personal care, adult day health, respite                                  |
| Washington      | Case mgmt, personal care, congregate care, licensed adult family home services, respite |
| West Virginia   | Case mgmt, homemaker, chore services                                     |</p>
<table>
<thead>
<tr>
<th>State</th>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wisconsin</td>
<td>Case mgmt, respite, adult day health, personal care, habilitation, adaptive aids/devices, home modifications, transportation</td>
</tr>
<tr>
<td>Wyoming</td>
<td>Case mgmt, personal care, respite, adult day health, transportation, emergency response systems, home delivered meals</td>
</tr>
</tbody>
</table>
APPENDIX C

Program Contacts
The following people can be reached for more information on the different programs described in this guidebook.

**PACE Contacts:**

**Jennie Chin-Hansen**  
Director  
On Lok Senior Health Services  
1441 Powell Street  
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**Jean Masland**  
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Rochester, NY 14609  
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Director of Geriatric Services  
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617-567-5801

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414-536-2105

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716-325-1991

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Comprehensive Care Management  
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Judy Baskins
Project Director
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Linda Barley
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Presbyterian/St. Luke’s Medical Center
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Lucy Nonnenkamp
Project Director
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Center for Health Research
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503-335-6794

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Medical Director and Executive V. P.
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310-435-0380

PMAP/LTCOP Contacts:

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St. Paul, MN 55155-3854
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