Home and Community-Based Medicaid Options for Dependent Older Floridians

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In an era of widespread state budget constraints, Florida has been increasingly challenged to provide long-term care services to a growing population of older dependent persons. The high costs of nursing home care have led the state to implement care management alternatives that offer potential for cost savings along with greater consumer satisfaction through maintenance of community residence. Although these alternative care approaches represent important opportunities to contain costs, it is equally important that professional care providers and policymakers understand how such programs operate. Here the Florida experience with eight home and community-based waiver models, in addition to the Program of All-Inclusive Care for the Elderly, are summarized and a comparative analysis offered that may enlighten the efforts of other states to establish cost-effective and attractive care management models. **J Am Geriatr Soc 2010.**

Key words: care management; Medicaid waiver; home bound; Medicaid dually eligible

Medicare recipients who also meet the financial criteria to qualify for Medicaid are referred to as "dually eligible." Such recipients have higher disease burden and higher functional impairment and incur care costs four to six times as great as persons enrolled only in Medicare.[1] For dually eligible older adults, the financial burden for long-term care falls entirely on the state's Medicaid programs.

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Florida, the state with the highest percentage of older adults, has 407,000 of the nation's 6 million dually eligible beneficiaries.[2,3] Medicaid long-term care expenditures for this population totaled nearly $2 billion in 2008, a figure that is expected to triple over the next 2 decades.[4] This trend of increasing Medicaid long-term care costs has already burdened Florida and will soon affect other states. Not surprisingly, how the state can improve quality of care while controlling Medicaid costs is a concern for all citizens, not just older adults and their families.

The U.S. Department of Health and Human Services may "waive" specific Medicaid requirements to give states greater flexibility in designing and operating new Medicaid programs. One type of waiver, the section 1915(C) Home and Community-Based Services Waiver, allows long-term care services to be delivered in the community rather than in institutional settings.[5] Most section 1915(C) waivers provide services to children and adults with mental retardation and other disabilities, with a smaller number focused on frail older adults.

Florida and other state Medicaid agencies have been evaluating new care management models designed to delay or prevent institutionalization of dependent older persons. An analysis of early home and community-based waiver programs from around the country showed that they resulted in slightly lower use of nursing homes but that overall costs increased.[6] However, life satisfaction and caregiver satisfaction were much higher in older adults enrolled in one of the waiver programs.[6] Although most states have one or two programs, Florida, with its high percentage of older persons, has current experience with eight separate care management–based waiver programs.[5] In addition, Florida has considerable experience with the Program of All-Inclusive Care for the Elderly (PACE) initiative, a capitated benefit authorized by the Balanced Budget Act of 1997 that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. Because Florida's extensive experience may expedite the development of effective care management programs for Medicaid recipients in other states, this study compares the Florida models in terms of recipient age, Medicare involvement, type and degree of impairment, physician services, and other care management factors.

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PROGRAMS FOR NONINSTITUTIONALIZED DEPENDENT OLDER ADULTS

Each program uses care managers to coordinate services to empower clients and maximize their functionality and independence. The care managers are mostly nonmedical staff, with a limited number of nurses and social workers. The geriatrics expertise of the care managers may vary considerably. Contracted community providers provide nonmedical services. Before January 2006, most of these programs provided prescription medications to their members. With the advent of the Medicare Part D program, some waiver models are now responsible for providing the small list of drugs included under Medicaid but excluded under Medicare.[7] Unlike PACE, these waivers do not control the use of medical services and generally do not reimburse physician services.

Although nursing homes provide medical care and supportive care through a structured and regulated model focused on function, safety, feeding, dressing, housing, supervision, and access to additional services, the waiver programs do not have this structural and regulatory framework. The waiver programs generally provide the nonmedical services in some combination and manner that are coordinated by care managers. Differences exist with regard to the age, functional status, and entitlement benefit of the enrollees. Counties in Florida vary with regard to the Medicaid waiver programs available to older adults.

The types of services provided may also vary (Table 1). In theory, capitated programs, including PACE, are not prohibited from providing services shown as missing in Table 1. Important differences in care management processes, procedures, and benefits may exist even between providers within the same waiver program. These programs all rely on the Medicare system to provide most of the inpatient and outpatient medical services for their older adult members. In addition, the six programs listed below are responsible for none or only a small amount of the cost of care for members who go on to require institutionalized long-term care.[9]

- *Channeling Services Waiver for Frail Elders* serves people aged 65 and older who qualify for nursing home care and meet the Supplemental Security Income (SSI) requirements for Medicaid.[9] These clients do not have to be enrolled in Medicare Part A and B.

Table 1. Home and Community-Based Waiver Program and Program of All-Inclusive Care for the Elderly (PACE) Services for Older Adults[8]

Service	Aged and Disabled Adult Waiver	Assisted Living for the Elderly	Channeling	Frail Elder Program	Long-Term Care Diversion Program	PACE
Adult companion	X	X	X		X	X
Adult day health care	X		X	X	X	X
Assisted living		X			X	X
Attendant call system		X				
Behavior management		X			X	X
Case aide	X				X	X
Case management	X	X	X	X	X	X
Chores	X	X	X		X	X
Consumable medical supplies	X			X	X	X
Counseling	X		X		X	X
Environmental accessibility adaption	X		X		X	X
Escort	X			X	X	X
Family training	X		X		X	
Financial risk reduction	X		X		X	
Home-delivered meals	X			X	X	X
Home health aide	X		X		X	X
Homemaker services	X	X		X	X	X
Medication administration		X			X	X
Nutritional risk reduction	X				X	X
Occupational therapy	X	X	X		X	X
Personal care services	X	X	X	X	X	X
Personal emergency response	X		X	X	X	
Pest control	X				X	
Physical therapy	X	X	X		X	X
Respite care	X		X	X	X	X
Skilled nursing	X	X	X		X	X
Specialized medical equipment	X	X	X		X	X
Speech therapy	X	X	X		X	X
Therapeutic social and recreational services		X				X
Transportation						X

- *Frail Elder Project* provides care management and home health services to enrollees who are aged 21 and older, are receiving SSI, and meet requirements for nursing home level of care.
- *Assisted Living for the Elderly* provides care management, assisted living services, and incontinence supplies to people aged 60 and older who have less-severe impairment in ADLs (activities of daily living) than required for nursing home care.[10,11] This program is a fee-for-service model, so the amount Medicaid pays depends on the number of services provided.
- *Aged and Disabled Adult Waiver* is also a fee-for-service waiver program providing care management and other services to older adults and persons with disabilities aged 18 and older. Enrollees have less-severe impairment in ADLs than required for nursing home care and may apply to the state's Consumer Directed Care Plus Program, which allows individuals to purchase needed services themselves with a monthly cash allotment.[12]
- *Adult Day Health Care Waiver* serves people aged 75 and older. Residents must live with a caregiver and be frail enough to meet nursing facility level of care.
- *Alzheimer's Disease Waiver Program* provides care management and other specialized services to persons aged 60 and older who have a diagnosis of Alzheimer's disease made or confirmed by a memory disorder clinic, a neurologist, or a "physician with experience in neurology."[13] Members must meet criteria for nursing home level of care and must live with a caregiver.

Florida also offers other, non-waiver-based care management programs. One of these is Community Care for the Elderly, which provides community-based services to frail adults aged 60 and older. In this program, members are charged a copayment based on their ability to pay for services received.

MOVING TOWARD A CAPITATED MODEL

The waiver programs described bear only a limited financial risk for the Medicaid costs incurred when one of their members requires institutionalized nursing home care. The frailest members may be discharged from the program shortly after they are institutionalized. In these cases, Medicaid assumes the obligation to pay for institutionalized nursing home care. Thus, there is no direct financial incentive for the programs to invest in processes and programs that can compensate for functional decline in order to extend the community tenure of frail older adults. For a state legislature looking to limit its future Medicaid liabilities, the models discussed above do not guarantee that costs will not continue to increase. As a partial answer to concerns about rising Medicaid costs, Florida has three models, compared and summarized in Table 2, that provide capitated payments to organizations that assume full risk for all Medicaid expenses.

The first model is PACE. Members must be aged 55 and older and meet requirements for nursing home level of care.[13] Similar to PACE programs in other states, Florida's program receives capitated Medicare and Medicaid payments and is responsible for providing all medical and long-term care services. PACE transports its members to an adult day care setting where medical professionals assess and treat medical problems. Access to primary care physicians is restricted to physicians contracted to or employed by PACE. PACE has been able to demonstrate lower mortality, lower Medicare costs, higher patient satisfaction, and a lower rate of hospital use.[14] However, Medicaid costs may actually be higher.

PACE has successfully expanded to multiple sites across Florida and has recently begun to provide services to older adults living in rural and suburban areas. Because it is focused on an adult day care setting, the creation of a PACE program is well suited for an urban setting where there is a high density of older adults who live nearby. An analysis of nonurban PACE programs is currently being conducted. In addition, many older adults may be reluctant to give up their doctors and switch to a PACE physician.

In response to these concerns, the state of Florida created the Long-Term Care Diversion Program (LTCDP). Through this waiver program, private companies receive a per-member, per-month capitation payment to manage and coordinate the enrollee's full continuum of long-term care needs. The care managers are mostly nonmedical staff who work closely with nurses from various home health agencies. LTCDP does not have an adult day care focus and thus can operate in suburban and rural areas.

Care managers perform an extensive in-person evaluation of new members using a state-mandated assessment form that focuses on the member's functional needs, caregiver support, and risk for geriatric syndromes. Care management training is not standardized. The care managers

Table 2. Comparison of Florida Medicaid's Capitated Home and Community-Based Waiver Programs

Component	PACE	Long-Term Care Diversion	Florida Senior Care
Age requirement	$\geq$55	$\geq$65	$\geq$60
Medicare requirement	None	Parts A and B	None
Required impairment	Nursing home eligible	Nursing home eligible	None
Care management	Yes	Yes	Yes
Home health benefits (nonskilled)	Yes	Yes	Yes
Medical benefits	Full	Limited	Full
Medicaid reimbursement	Capitated	Capitated	Capitated
Medicare reimbursement	Capitated (if member has Medicare)	None	None
Medicare liabilities	Full	Copayments	Copayments
Physician involvement	Employed by PACE	Limited	Reimbursed by plan

generally receive several days of formal training in the assessment process as new employees, as well as periodic follow-up training. After the initial assessment, the care managers use contracted providers for the services that members need. The care managers provide regular follow-up with members, in person and on the telephone. Depending on the company, the case load may vary from 45 to 80 members per care manager. Social workers and nurses are available should the care managers have concerns about safety, neglect, or failure to thrive.

Reimbursement is capitated at a rate that varies depending on the plan, the county in which the person resides, and the frailty of the member base. All members must be aged 65 and older and enrolled in Medicare Part A and B. Income and assets must meet the levels required to be in a nursing home under Medicaid. In addition, enrollees must be at a nursing home level of care.

Older adults who meet eligibility requirements may choose from among the companies that offer the program in their county. During the 2008/09 fiscal year, 16 companies were providing services to approximately 14,000 members in 32 Florida counties. Members enrolling in an LTCDP continue to receive care from their primary care and specialist physicians. The care management company functions as the secondary payor for Medicare Part A and B and is responsible—and is thus at risk—for the Medicare Part A hospital deductible, annual Part B deductible, hospital costs after members have used all of their reserve days, and copayment for emergency services.

If members need institutionalized intermediate care, the program assumes full financial risk for those expenses. Thus, the LTCDP companies have financial incentives for developing processes that minimize functional decline.

In 2006, the state developed Florida Senior Care (FSC), a full-risk demonstration project in several counties that coordinates medical and home-based Medicaid benefits for beneficiaries aged 60 and older.[15] FSC goes one step further than the other models by coordinating the features of a 1915(C) waiver program with the features of a managed care medical plan. Whereas the LTCDP focuses on those frailest seniors who already qualify for nursing home care, FSC offers the potential to provide preventive services and to intervene before frailty advances.

DETERMINING ELIGIBILITY FOR MEDICAID SERVICES

Under Florida Medicaid, the Comprehensive Assessment and Review for Long Term Care Services Program (CARES) determines eligibility for institutionalized or home-based services. CARES is a nursing home preadmission assessment program administered statewide by the Department of Elder Affairs. The assessment focuses on the person's cognitive and functional status and is performed by a CARES nurse or social worker with medical review by a physician before approval. If the person does not have Medicaid, the state's Department of Children and Families performs a financial assessment. Depending on the results of the assessment, CARES will determine whether one of the home- and community-based waiver programs or PACE can meet the person's needs. Although the programs may have different selection criteria, some older adults may, in theory, meet criteria to receive services from more than one program. In these cases, factors such as waiting lists and freezes on state funding may influence the CARES recommendation for a specific program.

ASSESSING MEDICAID WAIVER PROGRAMS

The question remains whether these waiver programs save the state money and provide better or even preferred care. A variety of factors make it difficult to compare the healthcare outcomes and cost-effectiveness of the Medicaid waiver programs with those of traditional nursing home care.[15] The increasing number of home healthcare and long-term care options in recent years has confounded the comparison of a waiver program with traditional long-term care. Many seniors belong to a Medicare Advantage Plan that may provide additional services. Therefore, using a "traditional" nursing home population as a control group may not be the ideal group for comparison with the waiver group.

Even though they share similar goals, it is also difficult to compare different home- and community-based waiver programs. There is significant variation between the waiver programs with regard to the types of patients covered, services provided (Table 1), and method of reimbursement. Because enrollment, benefits, and reimbursements tend to change over time, the comparison is unstable. The fact that reimbursements vary for each program and change at least yearly based on state budget allocations complicates any cost analysis. There is also considerable heterogeneity operationally, both with regard to how care is coordinated and how interactions are managed between the care managers and the community-based physicians.[16,17] This heterogeneity exists between different programs and even between providers within the same program.[18]

Despite difficulties in conducting studies, something has been learned about the effect of these programs. Studies comparing Medicaid costs of frail older adults entering a waiver program show higher costs in the year after enrollment in one of these programs.[9] The explanation for this observation is that there is often a significant event, such as an acute illness, that preceded the person's enrollment.

However, if the program prevents a nursing home admission, then the savings for Medicaid are substantial. A study using data from fiscal year 2007/08 compared the cost of LTDCP with that of Medicaid nursing home care.[19] The average monthly Medicaid cost for clients in the LTDCP was $1,624, compared with $3,839 for residents in a nursing home. Both groups had similar levels of functional impairment, dementia, and urinary incontinence. However, this analysis measured only Medicaid costs and did not take Medicare costs into account.

A study comparing enrollees in the LTCDP with dually eligible community-dwelling older adults who met Medicaid criteria for nursing home care found that 12% of the LTCDP and 48% of the nonwaiver seniors required a nursing home stay of at least 30 days over a 24-month period.[20] The mortality rate was 18.5% in the LTCDP and 36.5% of the nonwaiver seniors.[20]

A study using 1999/2000 fiscal year data found that the LTCDP, at a monthly reimbursement of $2,342 per month, was not as cost-effective as other waiver programs.[18] Two more-recent reports comparing the LTCDP (at its reduced

reimbursement rate) with other Florida Medicaid waiver programs found that the LTCDP is more expensive but provides a more-comprehensive set of services (Table 1) to a frailer subset of the elderly population.[8,19] The distinction is consistent with a previous study of a community-based waiver program in Connecticut that found that clients with more ADL dependencies had higher healthcare expenditures.[1]

The Florida Senior Care program was put on hold even before member enrollment began. The low reimbursement rates resulted in a lack of managed care providers willing to contract with the Florida Agency for Healthcare Administration. There were also concerns from the state's Medicaid managed care initiative about the potential for limited access to specialists, restricted medication formularies, and patients' poor understanding of their entitled benefits.[21,22]

No studies have determined whether LTCDP enrollees have a lower incidence of emergency department and hospital admissions. Similarly, total costs to Medicare have not been analyzed. The fact that there is much regional variation in costs across the state of Florida complicates measuring healthcare costs. For example, a recent report found that Medicare rates per enrollee in Miami were the highest in the nation.[23] Similarly, 90% of Florida's Medicaid home health costs originate in Miami–Dade County.[24]

POTENTIAL BARRIERS TO EFFECTIVE CARE MANAGEMENT

Because these programs (with the exception of PACE) do not provide direct medical care, it may be difficult for care managers to have a significant influence on healthcare issues, such as physician practice patterns and medication prescribing.[25,26] Similarly, none of these programs uses a formal geriatric medical approach to care. Even the coordination of medical services can be difficult because none of the waiver programs provides transportation for provider visits.

Some hospitals, nursing homes, and skilled nursing facilities may be reluctant to work with care management companies to coordinate care for persons admitted to their facilities. Although the waiver programs focus on keeping persons in their homes, hospitals and some skilled nursing facilities may have a financial incentive to admit patients. For the care managers who visit dozens of different hospitals and nursing homes, the adoption of electronic medical records can impede their access to the medical records of their members, because systems may differ from place to place.

CONCLUSION

Florida's home- and community-based Medicaid waiver programs offer a variety of options for vulnerable older adults who previously thought that they had no choice other than to go to a traditional nursing home. Although all of the programs focus on coordinating services for dependent older adults, there is much heterogeneity with regard to client selection, services provided, care coordination processes, and monetary reimbursement by the state. Moving forward in an era of tightening state budgets, there is an expectation that full-risk care management models must be cost-effective and provide high-quality services. It is likely that future models will coordinate medical and long-term care services. Such models will probably require a greater emphasis on interdisciplinary care coordination processes and additional care management training.

However, the current difficulties involved in assessing and comparing the different programs make it hard for legislators to know how to allocate limited funding resources appropriately. Similarly, patients and healthcare professionals are provided with little information about these programs other than the types of services provided.

To address the research limitations discussed in this article, studies need to be developed in which clients are randomized to enroll in one of several programs. Randomized studies within specific programs are also needed to identify which specific operational factors of the care management process are associated with lower costs and lower healthcare utilization. Without such studies, understanding of the potential benefits of these innovative programs will remain limited.

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