

THE FLORIDA STATE UNIVERSITY

Long-Term Care Financing: Bringing Predictability to States Medicaid

Long-Term Care Systems

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PRESENTED BY: KEELEY KIMBALE EVANS

TALLAHASSEE, FLORIDA

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Keeley K. Evans
1428 Silver Saddle Dr.
Tallahassee, FL 32310
(850) 575-3107
(850) 413-8072

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Ms. LuMarie Polivka-West
Director of Policy and Quality Assurance, Florida Healthcare Association
P.O. Box 1459
Tallahassee, FL 32302-1459

RE: Financing LTC: Bringing Predictability to States Medicaid Long-Term Care System

Dear Ms. Polivka-West:

I have an opportunity to present to you *Long-Term Care Financing: Bringing Predictability to States Medicaid Long-Term Care System*. Ensuring long-term care for the elderly on both national and state levels is an important issue that needs to be addressed immediately. In order to provide the quality of care needed for this population, both national and state governments must develop a system that is cost effective as well as manageable for state governments.

After examining policies from various states and also talking to Medicaid administrators, it seems that the move towards managed care organizations is the most conducive way not only to control the expanding cost of Medicaid, but also to provide a way for states to better manage Medicaid rolls for long term care providers. The move towards managed care organizations (MCO's) has been many states' alternatives to correcting their Medicaid long-term care system. Federal initiatives such as the "Cash and Counseling" program have helped assist states in increasing an equitable balance between institutional and community based spending services. On state levels, the use of Nursing Home Diversion models, various cost-containment strategies, and Medicaid reform have also assisted states in balancing their Medicaid programs.

The option of reforming Medicaid through managed care seems quite promising. Arizona and Minnesota have used this method and proven it successful with their Medicaid Long Term Care populations. States' ability to control cost, work with provider networks, predict future budgets, and give consumers choice has been one of the many rewards. In January 2006, Florida will experience managed care with its integrated long-term care program.

Sincerely,

Keeley K. Evans
Regulatory Analyst

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Executive Summary

Public policy has influenced many aspects of healthcare including long-term care financing. Title XIX of the 1965 Social Security Act created Medicaid, which incorporated a funding source for long-term care financing. In addition, the Medicare Catastrophic Coverage Act and Balanced Budget Acts have also led the way in payment reform on national and state levels. Even though responsibility for long-term coverage relies on the implementation of public and private policy, states struggle to maintain budget neutrality, curb Medicaid costs, and bring predictability to their Medicaid programs. These challenges are demanding for states across the nation. According to Wiener and Stevenson, suggestions such as “offsetting state spending on long-term care through increased private and Medicare contributions, reforming the delivery system, and using traditional cost-control methods (cutting Medicaid reimbursement rates)” have assisted many states in lowering LTC spending (Wiener & Stevenson, 1998).

Many influences have contributed to Medicaid’s growth and expansion. Demographics in state populations, the functional needs of Medicaid recipients, and the Medicaid infrastructures are the most obvious contributors. However, prescription drug costs, prepaid/managed care plans, and home/personal care services are additional costs that have increased Medicaid spending. These issues are the reasons why states look towards budget predictability that will allow them to control costs due to increased Medicaid enrollment and increased long-term care expenditures. Critics argue that budget forecasting under the current entitlement rules are uncertain and have a considerable effect on annual expected outcome due to the compounding and changing of variables. Consequently, lawmakers are faced with the task of implementing a reformed system based on an effective budget predictability.

Arizona, Minnesota, and Florida have been confronting their challenges concerning Medicaid budgets. The anticipation of the growing aging population keeps these states examining waivers and federal initiatives to reduce their Medicaid costs and to retain their elderly and disabled populations within the communities. Arizona, Minnesota, and Florida have used consumer driven pilot projects, nursing home diversion models, and managed care to control their states' Medicaid costs. Arizona has provided twenty-three plus years of running a fully operational managed care system. Minnesota has used several pilots, such as the Minnesota Senior Health Options, to deliver care for their elderly population. Florida's Senior Health Choices will test its ability to continue providing services for their highly functional needy population in January 2006. These states are the pioneers of reform.

The most important facet to healthcare reform is quality. Defining the quality of long-term care delivery begins with the following: communication, consumer education, and transparency. Once these components are in place, the following recommendations should be considered in implementing an integrated long-term care infrastructure: (1) Invest in an effective enrollment process that anticipates confusion and questions; (2) Emphasize education of consumers about the program, providers, and enrollment process; (3) Establish a monitoring system of the program to minimize problems and monitor performance; (4) Implement a managed care program that is both sensitive and understanding to the current Medicaid environment and its providers; (5) Allow sufficient time for the implementation of the program; (6) Invest in a secure administrative structure that will be able to absorb growing costs associated with the program; and (7) Set reasonable rates that represent current Medicaid managed care populations as well as set realistic objectives. These additional factors are very important in these states' LTC infrastructure development (Wiener & Stevenson, 1998).

Historical Financial Perspective of LTC System

National and state policymakers have questioned how public policy has influenced the financing of long-term care. Important considerations include both sources for payment of care and the adequacy of the care for the aging and disabled populations. In 1965, Title XIX of the Social Security Act created Medicaid, which included a method of financing for long-term care, but only to selected individuals of the medically needy populations (Center for Medicare & Medicaid Services, 2004). Prior to the approval of Medicare in 1965, the role of the federal government entailed providing the elderly population access to health insurance, which is comparable to health coverage available to the average working American (Schlesinger, 2002). Medicare for persons 65 and older is not and has not been the primary payer for long-term care. Medicare was designed to pay for costs related to acute care and limited to skilled nursing facilities (SNFs) when the stay relates to recovery from the acute episode. According to Yee (2001), this illustrates how a benefit structure is formed by public policy and how public policy constructs the delivery and financing structure with specific limitations for coverage.

As a response to the Medicare Catastrophic Coverage Act, federal policy makers noticed costs shifting from Medicaid to Medicare with dual eligibility impact. The Medicare SNF benefit payment reform under the Balanced Budget Act of 1997 (Street, Quadagno, Parham, & McDonald, 2003) is an example of fiscal restraint public policy. The Balanced Budget Act payment reforms created the Prospective Payment Systems (PPS) for skilled nursing facilities to receive predetermined fixed rates of care. The objective of these reforms was to promote cost control and efficient delivery of care for Medicare nursing home residents. This is a prime example of how federal policy can influence the market of long-term care as well as construct the framework of current and future policy debates.

The Medicare Catastrophic Coverage Act (MCCA) of 1988 sought to expand coverage, maintain budget neutrality, and increase beneficiaries' portion of payment for services (Moon, 1996). It was the first of many considerations to propose long-term care for a larger Medicare population due to rising health care costs. The MCCA of 1988 was perceived as a "senior" tax, welcomed by some seniors and disapproved by the wealthy senior population. Even though the bill was passed and repealed within one year, it benefited the 15% of Medicare recipients eligible for Medicaid and protected spouses of nursing home residents from impoverishment.

Understanding the role of federal and state government is essential to financing and developing policies for long-term care. The debate over structure and finance of comprehensive long-term health care continues with the tension of responsibility between federal and state governments. According to Yee (2001), responsibility for long-term care falls on both public and private policy sectors; however, public policy carries the majority of the load. Through public and private policy, the long-term care 'problem' has become defined, reviewed, and developed due to actions of policymakers. The policy process in the U.S. is a visual and contextual snapshot of how health care is financed and delivered across the states. In long-term care, it is important to know where its past, its origin, its future direction; and the intricate role of public policy in health care delivery and financing. Wiener and Stevenson (1998) suggest three strategies states can use in controlling the rate of increase in long-term care spending. These include: (1) Offsetting "state spending for long-term care with increased private and Medicare contributions; (2) reforming the delivery system for provision of more efficient service; and (3) using traditional cost-control mechanisms such as managing nursing home bed supply and cutting Medicaid reimbursement rates" (Wierner & Stevenson, 1998). Although the approach to

long-term care policy may vary from one state to another, the overall objective is curbing the long-term care spending within the states.

Literature Review

Where are we now in rebuilding the long-term care system? According to the Congressional Quarterly (2004), states are being forced into bankruptcy by long-term care. Furthermore, the threat of bankruptcy is leaving many states at a crossroads with balancing nursing home care, a growing aging population, and the increased demand for home and community-based services (Congressional Quarterly, 2004). Medicaid alone in many states cannot handle the overload of expenditures. Most states, including Arizona, Minnesota, and Florida, find themselves trying to reduce Medicaid-funded nursing home beds through programs such as Florida's Nursing Home Diversion and Transition programs and nursing home waiver programs (February, 2002). Long-term care (LTC) is a complex system of public and private funding, which often leaves elderly people at risk of financial catastrophe, inadequate care, and limited housing options (Feder, Komisar, & Niefeld, 2000).

Understanding long-term care is just a fraction of the bigger picture. Long-term care is mainly financed through government programs (Medicaid & Medicare), long-term care insurance and out-of-pocket expenses (Lee & Estes, 2003). Medicare is the federal program for elderly and disabled persons, which covers most acute medical costs and a fraction of long-term care. Medicaid, which is the biggest government payer for long-term care, is a joint federal-state program. However, the most important providers of long-term care are the family and friends of people with long-term needs (Holahan, Weil, & Weiner, 2003).

Long-term-care services support daily living activities of people with functional limitations, which often result from acute and chronic illnesses, as well as injuries (Jacobs &

Rapoport, 2002). LTC does not focus on the illness that may have caused the problem; instead, it brings balance to the chronic functional disability that the illness or injury has caused.

Recipients of long-term care services are the elderly and disabled under the age of 65. Each day the number of younger people in need of these services increases. Disabled young people are becoming the largest population of long-term care and in need of community-based housing. Most elderly and disabled younger people in long-term care do not reside in nursing homes, but live within the community (Jacobs & Rapoport, 2002). This is why there has been an increased demand for home and community based programs. Providers of long-term care such as residences, independent workers, nursing homes, assisted living facilities, group homes, and foster care are moving from the traditional long-term care services to the more modern and recent facilities of home-health-care and home care agencies. These programs provide long-term care in the homes of disabled persons who need assistance in their community (Jacobs & Rapoport, 2002).

The most expensive provider of long-term care is the nursing homes, which are currently in a transitional phase. Nursing home care and utilization are declining for the elderly along with occupancy rates, due to the shift of configurations of services offered by various long-term providers, nursing homes response to changes related to Medicare policies, public policy changes, and its response to the rising incomes from other care settings emerging within the market place (Congressional Quarterly, 2004). The most important fact shaping long-term care today is non-coverage by insurance. This leaves many states, providers, caregivers, and policymakers with the question of how to finance long-term care, what policies can be implemented, what alternatives states have, and how state and federal government can work together in finding a solution.

The demand for more institutional care does not come as a surprise as the baby-boomers are becoming a part of the elderly population. The elderly population is growing as well as getting older. This rapid growth is due to demographic changes in the areas of longevity, medical technology, increased awareness of the health care system, and lifestyle changes and family structures. According to the Kaiser Family Foundation, the United States elderly population for 2002-2003 constituted 89% of the Medicare beneficiaries for the 65 and older population (<http://www.kff.org>). The elderly population is defined as 65 and older; however, the population is divided into three categories: “young-old (65 -74), middle-old (75-84), and the old-old (85+)” (Atchley & Barusch, 2004).

Quadagno and Stahl (2003) reported that there is a rapidly aging population, particularly among the 85 years and older subpopulations, that will potentially lead to an increased demand for nursing home care. They further address the changing demographics related to longevity with the increasing participation of women in the labor market and smaller family sizes that reduce the pools of available informal caregivers. The aging individual is faced with three long-term care financing choices, privately funded nursing home care, publicly funded nursing home care, or provision of care at home (Lakdawalla & Philipson, 2003). Policies that create alternative financing sources for health care can also create alternative markets and increase demand for the services provided.

Even though some people feel the aging population has a strong correlation to the increase in long-term care expenditures, there are those who oppose this theory. Age is just a minor matter; population aging is nowhere near the strongest driver of demand for health care in the United States. Reinhardt (2003) research states that the aging population by itself is a minor determinant of the annual growth of health care spending and use; however, the increased

demand of healthcare services is a major factor affecting growth in spending and use. “By driving up the per capita health spending for all age groups, such increases in the unit costs of health care will naturally amplify the smallest impact that aging by itself will have on health spending and through the demand side” (Reinhardt, 2003).

As consumers begin to demand more, policies regarding long-term care will change as well. The shaping of the aging industry is due to the demographics. Nearly 50% of all Americans after age 65 will spend some time in the nursing home, and 75% will have the need for home care services (Duffy & Duffy, 2002). Nevertheless, the financial risks and consequences of failure to plan for long-term care continue to grow and remain a serious threat to many families. Knowing that the diverse needs of the aging population, as well as the economic and market conditions, will continue to shape the long-term industry should have people pre-planning for long-term care. One way to prepare for the future is to know what alternatives potential clients have in financing LTC: government programs of Medicare and Medicaid, LTC insurance, and out-of-pocket expenses finance long-term care.

Long-term care and services for older adults represent a major share of the total health care spending in the United States and have become a growing concern for many state policymakers. As Quadagno & Stahl (2003) stated, demographic changes due to increased longevity, family structure changes, and the influence of the elderly population on public policy also contribute to the environment of long-term care. This paper looks at Arizona, Minnesota, and Florida long-term care experience in controlling Medicaid costs while ensuring access to care. This paper also examines the methods by which these states bring predictability to their Medicaid budget, explores expert recommendations, and concludes with recommendations for

the implementation of a model long-term care system that is cost effective in controlling Medicaid costs.

States Roles in Long-Term Care

States' roles in controlling, distributing, and managing Medicaid long-term care budgets are both challenging and demanding. Many states resorted to managed care capitation programs to achieve budget predictability in the 1990's. Capitation alone does not achieve budget predictability. A factor such as "rapid growth in the number of eligibles from the optional program categories has contributed too many budget shortfalls over the past several years"

(<http://www.ahcccs.state.az.us/site>).

In order to achieve greater budget predictability, future measures include "enrollment caps on optional populations, program flexibility with benefit packages, and cost sharing by the beneficiary" (Wierner & Stevenson, 1998). Specifically, Arizona, Minnesota, and Florida will be analyzed in confronting the challenge of controlling their respective Medicaid budgets.

Arizona provides the most in depth managed care model for a state controlling its Medicaid budget; Minnesota has successfully piloted different Medicaid managed care models; and Florida is proposing two legislative alternatives to test a managed long-term care model. Each of these demonstrations will be analyzed for its ability to control future Medicaid budget growth.

Overview of the Arizona Managed Care Program:

The Arizona Health Care Cost Containment System (AHCCCS) has a national reputation, which can be attributed to its unique relationship between AHCCCS and the federal government, which began in 1982. In 1982 AHCCCS was established as a Medicaid 1115 Research and Demonstration waiver, which exempted it from the many federal regulations. After twenty-three years, it continues to operate under this special status. Currently the AHCCCS has a five-year

extension that will expire September 30, 2006, and will be considered for negotiations for an extension of services with the Center for Medicare and Medicaid (CMS) (<http://www.ahcccs.state.az.us/site>). Second, “most AHCCCS beneficiaries have always been required to enroll in managed care. AHCCCS operates the nation’s oldest and most comprehensive Medicaid managed care initiative. Third, the system under which managed care plans compete for Medicaid contracts is considered a national model. Observers often attribute the state’s ability to contain Medicaid costs to the implementation of its system of competitive bidding” (Sparer, 1999).

Prior to 1982, Arizona was “the only state in the nation that had declined federal Medicaid funds for low-income women, children, aged, blind, and the disabled” (<http://www.ahcccs.state.az.us/site>). Rather than accepting federal funds for health care, the state allowed individual counties to provide indigent health care. Long before Medicaid managed care was visible, Arizona required most beneficiaries to enroll in managed care. It was created to defray the cost of indigent health care as result of not accepting Medicaid funds. “Over time, Arizona has shifted from outlier to trendsetter. The state is no longer considered regressive or revolutionary; other states now seek to emulate much of the Arizona model. Before AHCCCS, there was a cap on the County-Based System, and the system made only minimal efforts to ensure that the poor had access to health care. The assumption was that the local governments would provide a medical safety net to so-called deserving poor” (Sparer, 1999). Arizona as well as local governments elsewhere established public hospital, public health clinics, and other services. Despite the state’s efforts to cater to the needs of the poor, the health care system was underdeveloped and inadequate, especially without federal and state funding. In addition, without federal and state leadership, the medical safety net would become extremely weak. The

enactment of Medicaid was intended to improve health care for the poor. State governments had the flexibility to design their health insurance programs for their low-income populations, as long as they followed federal regulations and guidelines. States were able to receive fully matched funds between 50%-80% from the federal government as long as they remained compliant with federal rules and regulations (<http://www.ahcccs.state.az.us/site>). While most states in the 70's welcomed the Medicaid program, Arizona was not as quick to join the cause. Arizona's argument by state officials was that "the benefit of federal dollars was outweighed by the burden of federal Medicaid requirements and the cost to the state treasury" (Sparer, 1999). According to Sparer (1999), state officials did not agree with Medicaid's enactment, so they decided "to maintain the county-operated and funded system of indigent care" on their own.

The enactment of AHCCCS brought a unique federal-state partnership. During the 1981 legislative session, Congress designated AHCCCS as the state's Medicaid program. AHCCCS operated under three premises: 1) AHCCCS "beneficiaries are required to enroll in a managed care system; 2) AHCCS did not cover long-term care services; and 3) AHCCCS did not cover behavioral health" service (<http://www.urban.org>). In 1982, Arizona's officials requested a waiver to operate AHCCCS as an approved Medicaid demonstration pilot. The state's new managed care Health Plans mainstreamed Medicaid recipients into physician's offices and gave AHCCCS members the freedom to choose their primary health care provider and health plan. The component that sets AHCCCS apart from the traditional fee-for-service reimbursement program is that AHCCCS was paid based on a capitation payment system. It permitted enrollees to be placed into a system that promoted preventative care and reduced fraud and abuse practices. Arizona became the first state in the nation to become a managed care system (<http://www.ahcccs.state.az.us/site>). Being paid on a capitation system was new for Medicaid in

1982. However, in years to come, states began mimicking the AHCCCS concept and became the way most consumers paid for their health insurance.

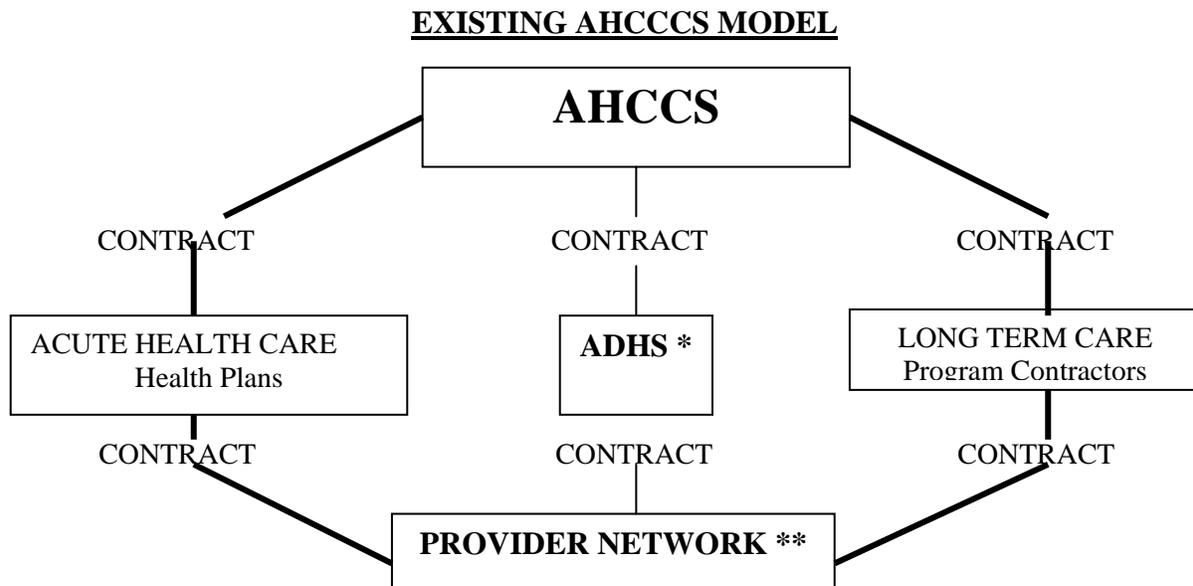
Arizona's synopsis from 1990-2000 timeline:

During the early nineties, AHCCCS had undergone massive reconstruction, which included the expansion of eligibility for its program. In 1991, the nation's first managed care computer system was brought on-line, and AHCCCS had begun its implementation of new programs and initiatives in the past seven years.

- In 1995, AHCCS completed a five-year phase-in of behavioral health care services for the Medicaid program, which the Arizona Department of Health Services contracts to deliver behavioral health services.
- In 1995, AHCCCS launched a major quality improvement initiative designed to test new ways to measure quality of care in a managed care environment.
- In 1998, the legislature added a new Premium Sharing Program, which is statedollars solely fund and which offers insurance coverage to low-income individuals.
- In 1998, AHCCCS implemented the States Children's Health Insurance Program (KidCare), with federal funding of 75 percent for uninsured children. Effective January 1, 2003, parents were added.
- In November 2000, Arizona voters approved Proposition 204, which expanded income limits to 100 percent of the FPL and added over 88,000 new people to the AHCCCS.

As of October 31, 2003, AHCCCS was providing health coverage to over 963,000 members, which is approximately 18 percent of Arizona's total population. According to Sparer (1999), the growth of this program was primarily due to recession and the expansion of eligibility to 100% of the federal poverty level for most of the covered population. Since its inception in

1982, “AHCCCS has evolved into a mature and well-respected health care system. It has become a pioneer in managed health care. Arizona is considered the “gold standard” for the nation as a model purchaser of health care services” (Sparer, 1999). Below is a diagram of the current AHCCCS model.



AHCCCS Managed Care System:

The Arizona Health Care Cost Containment System has three major programs. The programs include the Acute Care Program, the KidsCare program, and the Arizona Long-Term Care System. “AHCCCS acute care program is a statewide, managed care system that delivers acute care services through eight prepaid, capitated Health Plans. As of October 1, 2003, Health Plans were being delivered to 716,852 managed care Medicaid members”

<http://www.ahcccs.state.az.us/site>). The primary goal of AHCCCS since the program’s inception in 1982 has been access to care. In May 2003, AHCCCS awarded Geographic Service Area (GSA) contractors acute care contracts for a three-year period. GSA contractors were awarded contracts for the Acute Care Program with a majority of the GSAs covering two

counties each. All members have a choice of two health plans within a GSA, which they gain access to through their primary care physician's offices to become members.

Federal requirements determine eligibility for the AHCCCS acute care program. Some of the eligibility requirements for Medicaid groups as of October 1, 2003 consists of "families and children under Section 1931 of the Social Security Act, childless couples with income below 100 percent FPL, and individuals of families who incur sufficient medical expenses that when deducted from income will reduce to 40 percent of the FPL" (<http://www.ahcccs.state.az.us/site>). Other eligible groups consist of "persons eligible for the Medicare Cost Sharing Program (QMB, SLMB, OI 1's), women under age 65 diagnosed for treatment of breast and cervical cancer, parents of children eligible for Title XIX or XXI with income between 100% and 200% FPL, and working disabled persons over age 16 and under 65 with income below 250% FPL" (<http://www.ahcccs.state.az.us/site>).

Funding for AHCCCS comes from a combination of federal, state, and other funds such as fixed contributions from the tobacco industry. The state is paid a federal match from CMS based on Arizona's state FPL, which pays for all Medicaid members. During the federal fiscal year October 1, 2003, to March 31, 2003, the AHCCCS; federal match was 67.25 percent and 70.21 percent for fiscal year April 1, 2004, through September 30, 2003, for Medicaid dollars spent in the State. Arizona in return matched the federal program with 32.74 percent and 29.80 percent, which was paid through a combination of state and local funds.

Arizona Managed Long-Term Care System:

In 1982 when AHCCCS was established, long-term care services were excluded. This exclusion produced an enormous opposition from counties, nursing home owners, consumer advocates, and officials. In late 1987, the Arizona legislature provided long-term care to

AHCCCS beneficiaries through a government approved 1115 waiver request for Arizona's Long Term Care System (ALTCS). On December 19, 1988, ALTCS implemented the developmentally disabled (DD) population, and on January 1, 1989, the implementation of the elderly and/ or physically disabled (EPD) population became part of ALTCS. As of September 1998, 25,331 members were enrolled in ALTCS: 15, 970 EPD persons and 9, 361 DD persons. In October 2003, the ALTCS program served 38,092 persons; 23,134 were EPD persons, and 14, 958 DD persons (<http://www.ahcccs.state.az.us/site>).

Unlike the other state Medicaid programs, the Arizona system is quite unusual. ALTCS requires beneficiaries to undergo a massive screening process. In order to receive long-term care services, the beneficiary must meet Medicaid financial eligibility criteria (300 % of the Federal Benefit Rate based on SSI) and must be sufficiently disabled. In addition, the beneficiary must be at risk for more than three months of services at a nursing home or an intermediate care facility for the mentally retarded. Even though ALTCS's criteria resembles most of the criteria used by other states' Medicaid home-and community based waivers, it is their strict eligibility requirement for functional disability that sets them apart from other states. Having a strict requirement allows the state to focus on people who really need the resources. This effort of ALTCS's has paid off tremendously.

According to the February 2004 issue of *Governing.com*, Arizona's nursing home population of 65+ was only 1.1 percent. This percentage was well below the U.S. average of 3.7 percent. The ATLCS system is unique in that all covered services are integrated into a single delivery package, which is coordinated and managed by one of the eight contracted Managed Care Organizations (MCO's). Program contractors provide services like the Health Plans acute care services. Only one contractor operated, enrolled, and managed all members in prospective

counties and provided services. Like many AHCCCS members, ALTCS also provided services such as inpatient and outpatient hospital services, laboratory x-ray medical imaging, physician services, and family planning services (<http://www.ahcccs.state.az.us/site>). Once the members are enrolled, they have the choice of providers for health care who serve as gatekeepers on their behalf.

Overview of Minnesota Managed Care System:

Medicaid is in the midst of fundamental change. Medicaid officials in most states including Minnesota, have been encouraged or have required Medicaid beneficiaries to enroll in managed care. This trend is a result of continuous increases of Medicaid expenses as well as an attempt to address the ongoing problems of access to care. Even though these problems remain, the federal/state insurance program accounts for much of the nation's progress over the past thirty years in improving access to health care for low-income populations (Gold, Sparer & Chu, 1996). By 1994, forty-three states, including the District of Columbia, had implemented a Medicaid managed care initiative, which represented thirty-two percent of all Medicaid beneficiaries enrolled in managed care (Roland & Hanson, 1996).

In late 1994 and early 1995, Minnesota had begun the mandatory expansion of its Medicaid program, MinnesotaCare. Minnesota had several initiatives on its table which ultimately resulted in their integration under the 1115 research and demonstration waiver. Under the waiver both Medicaid and MinnesotaCare would become integrated under managed care. In return, MinnesotaCare would be supported with federal Medicaid funds. In order for Minnesota to have a smooth transition from traditional Medicaid to managed care, the enrollment/ selection process is influenced by the design and funding of the program. Informing beneficiaries of the change and available choices, explaining the procedures for making choices and helping

beneficiaries understand the implications of these choices, and notifying plans and beneficiaries of their choices in a timely manner are functions of the administration (Gold, Sparer & Chu, 1996).

Additional administrative functions include determining who conducts the enrollment process (county, contractor, or health plan), deciding what enrollment is done in person or by mail, and how much, if any direct marketing individual health plans may do. Assurance of health plans and the access to health networks for new enrollees are also administrative functions. Providing educational sessions for beneficiaries has become part of Minnesota's success in transitioning to managed care. Eligibility turnover is a major concern for many states because it limits a plan's ability to pay high marketing costs and new enrollees' care costs over time. Under the 1115 waiver, Minnesota implemented strict guidelines that used a "one-month eligibility enrollment period" to address problems related to short-term eligibility turnovers (Holahan et al., 1995). In return, administrative requirements were fulfilled and eligibility shortfalls were eliminated.

Deliverance and coordination of managed care programs required the state of Minnesota to develop policies and procedures that select providers, prescribe required coverage, and establish rate processes and delivery systems. Risk adjustments are used to establish equitable rates by controlling disparities between enrolled populations. While some plans may serve higher cost enrollees (LTC), others serve relatively healthier low risk populations. The risk adjustments protect the states from losses and eliminate potential excessive gains. These rates are set based on geographical regions and the states' use to improve equity. Minnesota, however sets its rates based on a more costly case-mix in some of its safety-net plans.

Excluding benefits from capitation rates has been used in some states; however, Minnesota is less likely to eliminate benefits from enrollees. Since Minnesota provides care to individuals, any elimination of benefits could result in problems of coordination and burden-shifting (Gold, Sparer & Chu, 1996), yet, not all plans and their providers offer full range of benefits and services typical to Medicaid. States also vary in services such as translation, transportation, and outreach, as well as licensure of managed care plan as home maintenance organizations (HMOs). Minnesota contracts with plans stemming from new state or previous Medicaid managed care initiatives. New plans absorbed existing programs that serve low-income populations or were created to meet new demands (Gold, Sparer & Chu, 1996).

Minnesota's Managed Care Long-Term Care System:

According to Stone (2000), the dual need “to finance long-term care while maintaining or improving the quality of care” is becoming more recognizable to policymakers, practitioners, and consumers. These conflicting needs have contributed to several trends in the delivery of care. The demand for more services in long-term care has increased due to the aging baby boomers. Increased services by this population have led to numerous initiatives at the federal, state, and provider levels. These entities work expeditiously to manage acute and long-term care costs through the integration of services.

The growing numbers of the aged, blind, and disabled enrollees have motivated states like Minnesota to control escalating Medicaid budgets. As addressed previously, Minnesota has taken charge of controlling its Medicaid budget through integrated services. One of the major targeted populations for Minnesota and other states is the “dual eligibles.” Dual eligibles are individuals who qualify for both Medicare and Medicaid programs. According to Booth & et. al. (1997), dual eligibles account for “17 percent of the states’ Medicaid enrollees and 30 to 35

percent of the program's expenditures." Minnesota's dual eligibles account for 15 percent of the state's Medicaid enrollees and approximately 55 to 75 percent of the program's expenditures (<http://www.kff.org/medicaid/7024.cfm>).

Minnesota has had several options available in controlling its long-term care costs through managed care implementation of integrated services. Minnesota was the first state to receive Medicare and Medicaid waivers specifically for integrating acute and long-term care elder dual eligibles (Stone, 2000). The Minnesota Senior Health Options (MSHO) was developed from the waiver. It offers both services through "three managed care plans and voluntary enrollment. The first 180 days of nursing home costs are covered and reimbursed on a fee-for-service basis. MSHO also offers financial incentives for plans to use home and community-based care in lieu of institutional services" (Stone, 2000).

Minnesota, along with many other states such as New York, believes in maximizing its Medicare funds to cover long-term services. Medicare maximization is the process states [Medicaid home care programs] use when under budgetary pressure to assist their elder clients in becoming eligible for Medicare home health benefits. Becoming eligible for Medicare home health allows states to reduce their long-term care costs (Kenny et. al., 1998). Funding for long-term care has become a patchwork of public and private dollars from consumers purchasing private long-term care insurance to using federal funded services of Medicare and Medicaid. "More than one-third (37 percent) of the \$106.5 billion spent on long-term care is paid by the consumer" (Stone, 2000). Private insurance pays a small portion of long-term care, and it's highly unlikely for it to cover large portion in the future. Since its inception, Medicaid has always been the primary public payer of long-term care. With the expanding coverage of home and community-base services, Medicaid remains the primary public payer of LTC in lieu of

increasing efforts to pay more costs in home health and skilled nursing facility care (Balance Budget Act 1997) (Stone, 2000).

Minnesota's LTC Task Force:

In 2001, the Minnesota Legislature enacted a comprehensive set of historic long-term care reform provisions. A task force composed of Minnesota's Legislature and agency commissioners met together to discuss the status of Minnesota's long-term care. The task force addressed issues critical to long-term care, such as the life expectancy rate (second longest rate in the nation next to Hawaii) and the highest proportion of 85+ elders in the country (MDHHS, 2001). The biggest concern of the task force, however, was the expansion of the community-based care through home care and supportive housing options. This would deter residents from choosing nursing homes as their first and only option for long-term care. Since 67.7 percent of Minnesota's caregiver populations are working women, the increased demand for family caregivers has been considered. This coincides with Minnesota's vision of empowering its residents in managing their care (MDHHS, 2001).

Another concern of the task force was the heavy reliance Minnesota had in the institutional model of long-term care (nursing homes). Reducing the reliance in the model resulted in voluntary nursing home closures. Minnesota has always depended on the institutional model of long-term care since 1960 (MDHHS, 2001). This rapid growth of nursing home care took a dramatic turn with all states including Minnesota. Nursing homes are considered to provide a more medical care model than most elderly have received, yet, it seems to be the only option available for those who require aid in multiple day-to-day activities. Even with the efforts to expand home and community-base care, Minnesota remains heavily reliant on nursing

homes (ranked 6th with highest number of bed per 1,000 persons 85+ in the U.S.) (MDHHS, 2001).

Minnesota's Project 2030:

In conjunction with Minnesota's task force, project 2030 was already in progress for the reshaping of the long-term care system. Project 2030 further explored the status of Minnesota's long-term care based on the policy direction and recommendations outlined by the task force. Implemented policies included assisting people in meeting their long-term care needs, improving consumer information, and promoting long-term care insurance (LTCI). Other issues addressed in the project included improving recruitment and retention strategies of direct support workers and aligning systems for support of high quality and goods outcome. Out of 48 recommendations, only 15 were considered a priority. Recommendations such as expanding the capacity of community long-term care previously addressed topped the task force list as well as assisted them in conducting surveys and implementing changes in the long-term care.

Project 2030 is an initiative coordinated by the Board of Aging under the direction of Minnesota's Department of Human Services. The purpose of project 2030 is to identify the impacts of Minnesota's aging population and prepare the state for the baby boom generation turning 85. The state will also respond to challenges created by changing age structure due to lifestyle characteristics, medical technology, family structure, and labor shortages (MDHHS, 2001).

A status report in 2002 showed Minnesota's government taking actions regarding project 2030. Based on the population projections, the state will rely on older adults to finance its long-term care and retirement expenses. Minnesota also promotes the use of federal programs to provide support, income, and health care for the elderly and those with limited resources. Lastly,

Minnesota relies on employers to assume increased responsibility for workforce accommodations for older workers and financing long-term care insurance (MDHHS, 2002).

Minnesota's LTC Financing Options:

In November 2004, Minnesota Department of Human Services conducted a feasibility study that reviewed several financing options for their long-care system. These options would be used in achieving the state's goals of limiting future Medicaid liabilities and expanding the use of private dollars to pay for long-term care (MDHHS, 2004). With the baby boomers aging, the need for long-term care will continue soaring, and the state's budget will become overwhelmed by demand for long-term care assistance. The study indicated eight options in which the MDHS could choose. Within the eight-month study, the options for the Minnesota Department of Health Human Services and the Minnesota Board on Aging were presented in a series. Some of these options included low-cost strategies for long-term care, private and public savings plans for Long-Term Care, and housing strategies.

"Reducing the Need and Cost for Long-Term Care" was one of the many policy briefings under the Lost-Cost Strategy section. Hal Freshley assumed three approaches in reducing the cost for long-term care from the perspectives of the individual, the provider, and the community. The focus of the individual dealt with preparing for the aging process through the maximization of healthy living and eating. Acquiring habits of eating and living healthy by exercising, this prevents or delays the need for long-term care. Another area of concern for individuals retirement planning, explore the options; of increasing personal savings, gathering information on Medicare and other insurance program options, and preparing for the nonfinancial aspects of retirement (housing, transportation, etc.). Freshley's last suggestion for individuals relates to

working longer. The continuance of working longer highlights the number of older persons who choose to stay in the workforce past retirement age (Freshley, 2004).

In addition to individuals working towards the reduction of long-term care costs, Freshley also centered on what family members can do in the reduction of long-term care costs. The suggestions to family members of older relatives entailed consulting with experts such as occupational or physical therapists. Getting advice from either expert will assist them in modifying the living environment to be more accessible. He also suggested to family members to get proper training and support to reduce the burden and personal costs of caregiving. Reducing the personal costs by purchasing services (cleaning, personal care services, transportation) as they are needed cuts down on the long-term costs.

Providers are also important in lowering the long-term costs. In order to lower costs, providers should begin redesigning their services such as streamline operations, expanding their scope, rethinking labor/personnel, and centering on more outcomes. Streamlining operations encompasses contracting specialty services, simplifying procedures, and adapting management information systems (<http://www.dhs.state.mn.us/main/groups/aging>). The expansion of scope encourages providers to enlarge their service area to include multiple target populations, which also spreads fixed costs (Freshley, 2004). Rethinking labor/personnel involves being more efficient with staff, using more technology like telemedicine, integrating more volunteers, and educating and supporting to caregivers. Finally, providers should place more emphasis on outcomes. According to Minnesota's Health Department, the use of evidence base practices results in lower costs and prevents crises (<http://www.dhs.state.mn.us/main/groups/aging>).

Freshley's last approach explores the community's role in reducing long-term care costs by developing aged-friendly communities. An aged-friendly community consists of physical

development of housing (accessibility), social development (faith communities and volunteer networks), and services (to accommodate older residents). These networks allow the elderly to remain in the community with assistance from family, friends, and neighbors, along with starter apartments for families. Starter apartments are components of the aged-friendly community's whole lifecycle housing option. This particular option maintains single-family homes, keeps in-laws close to family members and adds community improvements (ramps, railings, lighting) when needed (<http://www.gov.calgary.ab.ca/community/publications>). Ensuring a strong local economy through understanding the "seniors" market, developing strategies for youth retention, and expanding civic and community roles for older people (<http://www.van.umn.edu/advocate>) are the final steps for the community to reduce costs in long-term care.

The second series presented to the MDHHS and MBOA was "Private and Public Savings Plans" for financing LTC. This section viewed the public savings option that analyzed Hawaii's CarePlus program and the private option of long-term care annuity. However, the public option of Hawaii's CarePlus will be further explored.

The CarePlus program is a universal savings plan. It is considered the least expensive per person since it provides universal coverage across its population. Hawaii was the first state in 2003 to enact a long-term care financing programs (Seely, 2004). CarePlus is a compulsory social insurance program designed to supplement an individual's own long-term care funding. A payment of \$10 made by adults 25 and older paying state income taxes was going to be used to fund the program. In order to be eligible for claims, the beneficiary would need to have two deficiencies in the Activities of Daily Living (ADLs) or cognitive disabilities such as Alzheimer's (Moses, 2002). From this point, the program would make payments of \$70 per day

365 days after a 30 day deductible. The program is not implemented due to the Governor of Hawaii vetoing the proposal (Seely, 2004).

Currently, Minnesota does not have this option available to them. However, Minnesota has examined the advantages and disadvantages. The advantage in implementing a program like CarePlus would create a large risk pool and provide needy persons benefits (Seely, 2004). The program also spreads the risk of paying long-term care across Minnesota's adult population and makes it affordable. According to Seely (2004), the program also allows beneficiaries the flexibility to pay for services they need and from whomever they want. Like Hawaii, Minnesota's residents would have participated in a self-sufficient, self-perpetuating insurance program, which will benefit them for years to come (Byers, 2003). To accompany these benefits, Minnesota would have slowed the growth of Medicaid, protect current public Medicaid dollars, and stimulate the private LTCI industry to develop affordable plans (Seely, 2004).

Like advantages to a program, there are disadvantages. The program is an entitlement program (like Medicaid), and some feel it discourages the use of other products such as LTCI and weakens the goal of personal responsibility (Dunford & Bruce, 2002). All participants are charged the same premium regardless of level of risk or income, so the payments made into the system are somewhat regressive. If long-term care needs last more than one year, some participants may not have adequate provisions for additional services and may still need Medicaid. There was concern by some that the program was not actuarially sound, although independent actuaries assessed it as sound (Dunford & Bruce, 2002).

The objective in housing strategies is to explore options for using equity to fund long-term care. The options discussed about within this section are not only available nationwide, they are also available to Minnesotans. Options such as housing equity, reverse mortgages, and

home modification have helped seniors remain in their homes. However, reverse mortgages have been more widely accepted amongst Minnesotans, since most of its older population live in their homes and mortgages have been paid off. According to the National Council on Aging (2004), 80% of older households own their units, and 72% do not have mortgages. An estimated \$2 trillion are locked into equity among the 62+ households; 58% of Minnesota's housing meet Home and Urban Development (HUD) definition of low income; and 85% of the older homeowners want to continue living in their homes and never move.

According to Schindler (2004), reverse mortgages are receiving increasing attention as a choice for seniors who need additional home income, have equity, and want to stay in the home. A reverse mortgage is a mortgage that allows homeowners age 62 and older to use the equity in their home to receive cash while continuing to own and live in their home. It is used by older Americans to convert the equity in their homes into cash. They are different from conventional home equity loans because there are no income or credit qualifications, no monthly or immediate repayments, and the mortgage is paid off when the home is no longer the primary residence of the borrower (<http://www.medicare.gov>). The concept of reverse mortgages comes from the reverse payment stream. Instead of the borrower paying the lending company monthly, the lending company pays the borrower.

Although other types of home equity conversions include property tax deferral, deferred loans for repairs and improvements, and sale-leaseback or remainder interests plan, there are three types of reverse mortgages. The nonprofits or local governments provide funding towards the single purpose for repairs or property tax deferrals, Federal Housing Administration insured Housing Equity Conversion Mortgage ("HECM"), and Fannie Mae's proprietary program, Home Keeper ([http://www.seniorjournal.com/NEWS/reverse mortgages](http://www.seniorjournal.com/NEWS/reverse_mortgages)). The borrowers must qualify

through the HUD process as well as the Federal Housing Administration (FHA), which requires homeowners to seek assistance from a Housing and Urban Development (HUD) certified counseling agency before they apply for the loan. Once counseling is completed, lenders will be able to administer services (<http://www.ncoa.gov>).

After the type of mortgage is selected and counseling has been completed, then the borrower goes to the lending company to select a particular payment plan. There are five types of payment plans. The Term requires equal monthly advances for a fixed number of years; the Tenure involves Equal monthly advances for as long as the borrower remains in the home; and the Line of Credit, requires a cash dollar amount to be available on demand. The other two payment plans are the Modified Tenure, which sets aside part of the proceeds as a line of credit, in addition to monthly payments, and the Lump Sum Cash Advance that receives all money in a lump sum at the closing of the reverse mortgage

<http://www.seniorjournal.com/NEWS/ReverseMortgage/4-04-15LTC.htm>. Schindler emphasized the importance of borrowers searching for the right program that fits their needs. Features to look for in reverse mortgages plans are equity limits, the effect of household size payout, consideration of the credit line growth-how much and how often-and the costs and amount remaining in equity (Schindler, 2004).

During the policy briefing conference, reverse mortgages were ranked fourth, a positive reflection of what a program such as this can do for the state. If Minnesota were to accept this option, benefits to the state would include provision of financial resources accessed on relatively short notice and without regard for the health status of the borrower; funds can be used to purchase LTC insurance or to pay for LTC needs based on the loan amount (Patterson, 2004). Additional benefits to the state include equity in the home; underutilization could provide cash

flow for someone who is “house rich” and “cash poor”; heirs retaining homes upon death by repaying the reverse mortgage by selling the home and keeping the balance, if any, between the sale price and any loan amount due (Patterson, 2004). Even though reverse mortgages received a good response, there are critics who believe it is more of a disadvantage to the state than an advantage. These disadvantages include difficulties in the comparison of various costs of loans from different lenders, mismatch in the optimal time in purchasing LTCI and using reverse mortgages, insufficient funds generated for payment of long-term care needs, and non-adjustment of loan amounts for inflation (Patterson, 2004).

Minnesota began its process in controlling long-term care financing in 1994 with the mandatory expansion of its Medicaid program. Since then, Minnesota has analyzed and researched several financing options for the state. The University of Minnesota conducted the most significant study. This study identified several financing options that would encourage, support or perhaps subsidize to increase the proportion of elders who use their personal resources as a way to pay for long-term care. Having these various options available to finance individual long-term care allow residents to participate in the reduction of long-term care costs. It also allows residents to take responsibility of their future long-term care needs. In 2005, the state of Minnesota, as well as other states, began to participate in a 3-year national project in studying management approaches related to rebalancing Medicaid long-term care programs.

Overview of Florida Managed Care System:

Florida’s governor, like many other states’ governors in America, is dealing with Medicaid budget crises. Arizona faced its budget crises by implementing a fully operational managed care system in the eighties, while Minnesota used various piloted programs to manage Medicaid costs. During the 2005 legislative session, Florida’s legislature reviewed proposals for

implementing Medicaid reform for managing costs and controlling the Medicaid budget. Like Arizona and Minnesota, Florida will also be analyzed in its approach to managing its future Medicaid costs.

“Florida implemented the Medicaid program January 1, 1970, to provide medical services to indigent people. Over the years, the Florida Legislature has authorized Medicaid reimbursement for additional services. In 1989, a major expansion occurred with the United States Congress. Congress mandated that states provide all Medicaid services allowable under the Social Security Act to children under the age of 21” (<http://ahca.myflorida.com>). State individual Medicaid plans vary from state to state. However, all plans must be approved by the Center for Medicare and Medicaid Services. In Florida, the Legislature determines who is qualified, what services are covered, and how much is paid for services. Florida’s Medicaid plan addresses the areas of eligibility requirements, service coverage, and administration.

The Florida Department of Children and Families (DCF) and the Social Security Administration determine eligibility for Medicaid services. The Department of Children and Families determines eligibility requirements for low-income children and families, aged and disabled persons not currently receiving SSI, and persons seeking institutional care programs (<http://www.myflorida.com>). The target population that DCF provide services for are low-income families, children in low-income families, pregnant women, the disabled, and the elderly. The Social Security Administration determines eligibility for the Supplemental Security Income (SSI) programs, which provides assistance to poor, underserved populations. Recipients who receive SSI checks are automatically eligible for Medicaid. SSA provides services for SSI recipients, the aged, blind, and disabled persons, and individuals needing institutional care in Florida (October, 2004).

Services rendered through Medicaid can be mandatory or optional. Some mandatory services provided by Florida Medicaid include Advance Nurse Practitioner Services, Early & Periodic Screening of Children (EPSDT)/ Child Health Check-Up, Family Planning, Home Health Care, Skilled Nursing Facility, and Physician Services (March, 2004). Some optional services offered by Florida Medicaid are Adult Health Screening, Ambulatory Surgical Centers, Community Mental Health, Durable Medical Equipment, Home and Community Based Services, and Intermediate Care Facilities/ Developmentally Disabled (March, 2004).

The Agency for Health Care Administration (AHCA) administers Florida's Medicaid programs. AHCA develops and carries out policies related to the Florida Medicaid program and contracts with the fiscal agent (ACS State Healthcare) to enroll health care providers and process claims (October, 2004). AHCA has eleven area offices throughout the state that serve as local liaisons to providers and recipients. These area offices are responsible for exceptional claims processing, provider relations training, and consumer relations (October, 2004). The management of the Child Health Check-Up program, the transportation and school match programs on a local level, and the conducting of credentialing site visits to MediPass providers are the responsibilities of the area offices.

Florida Medicaid Managed Care Programs:

The vast majority of states, including Florida, already use managed care as a way to deliver services. Florida has 41 percent of its Medicaid population in fully capitated managed care, which is lower than the national average of 52 percent (<http://www.cms.gov>). Most Medicaid recipients are required to obtain services through managed care. Recipients who are not required to get managed care obtain care through the Medicaid providers of their choice on a fee-for-service basis. Medicaid contracts with a private company to help recipients enroll or

disenroll for Medicaid Managed Care programs. Under Florida law, Medicaid recipients must enroll with a managed care provider or a Medipass provider unless they have Medicare or are in a nursing facility. Eligible recipients are given 30 days from the date that Medicaid eligibility begins to select a managed care option. If recipients do not choose an option in 30 days, they are automatically assigned. Recipients can choose from five different Medicaid Options. MediPass (Medicaid Provider Access System) is a Medicaid primary care case management program that is available statewide. Its primary care providers are responsible for providing or arranging for the recipient's primary care and for referring the recipient for other necessary medical services. Recipients select the primary care provider of their choice from those participating in MediPass (October, 2004).

HMOs (Medicaid Health Maintenance Organizations) provide prepaid services to a defined population of enrolled Medicaid recipients. Approximately 750,000 Medicaid recipients are enrolled in 11 plans throughout the state. Many counties have at least 2-3 plans from which recipients can choose; however, some counties have no HMOs (<http://www.ahca.myflorida.com>). HMO services are negotiated under contract with a contractor. Contractors are required to provide services such as dialysis in a freestanding clinic, hearing services, hospital services, and x-ray services. In addition, HMO plans are required to provide quality and benefit enhancements such as smoking cessation, substance abuse, and programs for children and pregnancy prevention (October, 2004).

Prepaid Mental Health Plans are only offered to recipients in AHCA's Areas 1 and 6 that are enrolled with MediPass or in an HMO, which provides medical and mental health care services. Medicaid contracts with Access Behavioral Health, Inc., (ABH) in Area 1 and Florida Health Partners, Inc., (FHP) in Area 6 for mental health services provided to recipients in

MediPass. The MediPass primary care provider and the prepaid mental health plan contractor coordinate the recipients' health care needs to ensure medical and psychiatric services are provided. Medicaid HMO recipients in Areas 1 and 6 receive both physical health care and mental health care services from HMO providers. The provider (the prepaid mental health contractor of the Medicaid HMO) approves services provided by all plans (October, 2004).

Prepaid Dental Health Plan (PDHP) is a Medicaid managed dental care option available to Medicaid recipients in Dade County under the age 21 who are not enrolled in an HMO that provides dental services. Recipients who reside in an intermediate care facility for the developmentally disabled or state hospital cannot receive PDHP. Recipients who are determined medically needy and members of a Medicaid-funded HMO who provides dental services are not available to receive PDHP. Services such as sealants, dentures, orthodontic treatment, and diagnostic examinations are provided under the PDHP (October, 2004).

A Provider Service Networks (PSNs) is an integrated healthcare delivery system owned and operated by Florida hospitals and physician groups. The PSN is a Medicaid managed care option for Medicaid recipients in Miami-Dade and Broward counties. The South Florida Community Care Network (SFCCN) is composed of three health care systems. Enrollees in the SFCCN receive the majority of their health care through provider service networks. To receive network care provided to PSN (for PSN-managed services), enrollees must be authorized by the PSN in order for claims to be paid by the Medicaid fiscal agent. Claims for non-PSN managed services are submitted directly to the Medicaid fiscal agent for processing (October, 2004).

Snapshot of Florida Medicaid:

Medicaid serves approximately 2.3 million people in Florida, with over half of Medicaid recipients being children and adolescents under the age of 21; and with 44% of pregnant women

receiving their prenatal care through Medicaid (<http://ahca.myflorida.com>). Medicaid has also become a critical source of coverage for elderly and disabled-covering two-thirds of all nursing home days (February, 2005). In addition to serving the above populations, Florida's Medicaid program has become a vital funding source for Florida's healthcare infrastructure. Medicaid gives major support to hospitals, nursing homes, and urban and rural community clinics. In conjunction with Medicaid's current position, it has become the largest source of federal funding coming into the state (Form-CMS 37). The federal match program will provide an estimated \$8.1 billion dollars for 2005 fiscal year.

According to statistics reported by the Kaiser Family Foundation (KFF), 38 % of Florida's population is below the federal poverty level of 199% from 2002-2003 fiscal year (<http://www.statehealthfacts.org>). Twenty-two percent of the children 18 years and under are uninsured with Florida slightly higher than the national average, and 78% of the adults 65 and under are uninsured for 2002-2003 (<http://www.statehealthfacts.org>).

Based on a March 2004 report published by Florida Medicaid, the 2003-2004 FY eligibility coverage was estimated as \$2,141, 613 dollars. TANF (Temporary Assistance for Needy Families) generated the most funds of \$655,219. TANF represented 23.2% of Florida's budget for a family of three-income poverty level. SSI was the second highest generated funds at \$479,839 dollars and represented 72% of Florida's budget for a family of two-income poverty level. The age groups one-six represent the third largest generated funds in Florida budget at \$205,573 and a 133% of the income poverty level (February, 2004).

In addition to the 2003-2004 eligibility coverage, the report also highlighted projected Medicaid expenditures based on categories. An estimated Medicaid spending was also featured along with the average Medicaid growth by caseload and growth in Medicaid service

expenditures. The four categories that represented most of the project Medicaid expenditures were prescription drugs 19.03%; nursing home care 17.76%, hospital inpatient services 12.84%; and prepaid health plans/ HMOs 9.66% (March, 2004). The estimated Medicaid spending totaled \$13+ billion, with prescribed medicine, nursing home care, hospital inpatient services, and prepaid health plans/HMOs as the top four highest budgetary items (February, 2004).

According to the Medicaid Service Eligibility Subsystem Report, the average Medicaid caseload increased from 2.071 million in fiscal year 2002-2003 to 2.142 million 2003-2004FY and 2.29 million in 2004-2005FY (February, 2004). Based on the Medicaid service budget forecasting reports, Medicaid service expenditures increased from \$11.44 billion in 2002-2003 FY to \$14.27 billion for 2004-2005FY, resulting in a 2.83 billion dollar increased of Medicaid service expenditures.

Medicaid Reform SB 838:

After reviewing the various report findings, it is obvious that Florida is encountering a budget crisis. As a response to this crisis, the state has tried numerous cost-containment measures to control costs. In its efforts to control costs, the state has cut Medicaid funding from various programs and capped SCHIP (State Child Health Insurance Program) enrollment to finding sources to replace non-recurring funds. However, the most contentious proposal came from Governor Jeb Bush when he presented the proposal to reform Florida's Medicaid to the 2005 state Legislature. Like most states, Florida's state budget has faced fiscal pressures due to declining revenue and increasing Medicaid costs.

On January 11, 2005, Governor Bush released his plan to restructure the Florida Medicaid program. The \$2.1 billion proposal, if approved by CMS, will allow Medicaid recipients to buy their own health care coverage from managed care organizations and other

private medical networks. The restructuring of Florida Medicaid will bring budget predictability to the state's \$14 billion spending on the Medicaid program (<http://www.empoweredcare.com>).

The premise of the Governor's proposal is centered on two essential elements; the first element entails the empowerment of patients, and the second element involves the creation of a Medicaid marketplace.

Patient-Centered Vision, also known as empowering the patient, is in the beginning phase of Medicaid Reform. It places Medicaid participants in the center of their own healthcare. This allows them to make informed decisions regarding their healthcare and communicate with provider networks. The healthcare provider networks in return will create benefit packages that cater to the unique needs of patients. With the help of counselors, participants will choose the plan that best meets their needs (<http://ahca.myflorida.com>).

Furthermore, Medicaid participants will be able to build a "bridge to independence" by "opting out" of Medicaid plans and using their state-paid premium to purchase insurance in the private market. Participants will also earn enhanced benefits in flexible spending accounts by participating in healthy practices and responsible lifestyle choices (<http://www.empoweredcare.com>). Having enhanced benefits will allow participants to purchase additional healthcare coverage and services not covered by their plan. Additionally, provider networks will be paid a monthly, risk-adjusted premium for patients, based on the three funding components: comprehensive care, catastrophic care, and enhanced benefits.

The creation of a Medicaid marketplace consists of competitive forces, choices, and participants. Competitive markets are the most efficient means for achieving optimal allocation of resources (Holohan & Ghosh, 2005). The current Florida Medicaid program does not have the option of market forces available to them. The inability to choose alternative health plans

places participants at a disadvantage in having an incentive to use resources wisely (Bush, 2005). Providers lack incentives to control costs, and participating plans lack incentives or even the freedom to modify benefits to lure participants. Competitive forces and choices are going to be the determining factors in transforming Florida Medicaid.

Implementing highly competitive markets creates multiple options for the participants, providers, and vendors. It gives Medicaid participants a variety of options to choose, including MCOs, insurance plans, and provider service for example. Participants may be able to qualify for additional benefits and enhance flexible spending accounts. As mentioned before, flexible accounts will allow participants to expand the amount of coverage or purchase special services (Bush, 2005). Having several options to choose from empowers participants to take control of their healthcare within a competitive marketplace.

Competition within the Medicaid program will permit a new level of flexibility. This flexibility will provide the platform for competition based on coverage and the delivery of services. MCOs, insurers, and providers will be encouraged to specialize and diversify in ways that effectively manage how participants access and use services (Bush, 2005). In addition to the increased competition and flexibility, providers are allowed to define the amount and scope of benefits offered; they can freely compete for membership of participants by offering innovative care, convenient networks, and optional care (Bush, 2005). These features are intended by the state to be added bonuses to the basic catastrophic and enhanced benefit services. Furthermore, participants will not be limited to the traditional HMO; instead, they will have options available to them such as Provider Service Networks, insurance plans, and innovative community-based systems, which will meet the unique medical needs of participants (<http://www.ahca.myflorida.com>). It should be noted that many advocacy groups are concerned

that only large HMOs will be interested in participating and the results may not be as expansive as envisioned by Gov. Bush.

Implementation of Medicaid Reform:

The implementation of Medicaid reform in the state of Florida is scheduled for a four-year phase-in of Medicaid managed care, which will include a two-year pilot project in Broward County and five counties surrounding Jacksonville (Gomez, 2005). Under the implementation in SB838, the Senate requires a comprehensive study of the program reported to the governor and both legislative chambers (Gomez, 2005). It also enables state officials to set the contracting parameters for Medicaid managed care, as well as monitor and evaluate the program for the first two years. The Senate also requires HMOs to contract with qualified nursing homes, and if there is no agreement on the rate, the HMO will have to pay the existing Medicaid rate (Nohlgren & Ulfrets, 2005). However, nursing home associations have been advised that these nursing homes will not be brought into managed care until the third year. Under both the House and Senate plans, the state would pay a set amount per patient to a health maintenance organization or other provider network; based on the patient's risk factors and needs, the amount will be determined (Hollis, 2005).

Proponents of Medicaid reform say Bush's plan will curtail the rate of Medicaid growth and give state control over the program, especially in the areas of prescription drugs, long-term care, and the working population without access to affordable health insurance (<http://www.news-journalonline.com>). Advocates of Bush's plan also support the incentives given to patients choosing their dental care and eyeglasses, maintaining their healthcare, and avoiding costly emergency room treatments (Hollis, 2005). Opponents of Medicaid reform fear the poor will lose access to health care, and managed care organizations will not provide

adequate healthcare at a savings to taxpayers (Hollis, 2005). Nevertheless, both supporters and non-supporters will have to accept the decision the legislature passes and has implemented.

One of the primary targets of Medicaid reform is long-term care. The initial reform placed managed care along the I-4 corridor by including Pinellas, Hillsborough, Orange, Osceola, and Seminole counties as the beginning of the integration of services for the elderly (Nohlgren & Ulferts, 2005). All Medicaid services, including nursing homes, assisted living homes, adult day care and home-delivered meals, would be coordinated by managed care organizations. In addition to the House and Senate requirements, HMOs would also pay for drug management, home health therapies, transportation, and other needed services to keep people in their homes or in assisted living facilities. The change from government and local nonprofit agencies to private insurance companies is going to be a dramatic experiment in how Florida provides long-term care to its elderly. However, the initial plan for the I-4 corridor will have to wait until the pilot is completed.

The concerns and opinions in long-term care do not vary much from the overall perception of Medicaid reform. Bob Wychulis, president of the Florida Health Care Association of Health Plans, feels the plan will be advantageous for everyone. The plan aims to keep the elderly at home and independent and out of the nursing homes and lower health care costs (Nohlgren & Ulferts, 2005). Erwin Bodo, spokesperson for the Florida Association for the Aging, disapproves Bush's plan. He stated, "Basically, they got shafted, probably 92 to 93 percent of nursing homes are not getting a rate sufficient to provide care to their Medicaid residents, and many of the contracts to managed care providers are going to be lower than the current rate (Nohlgren & Ulferts, 2005). Ed Towey, spokesperson of the Florida Health Care Association, Florida's largest nursing home trade group, said in a deal like this, HMOs still have

the advantage. The objective is to reach an agreement. If an agreement is not reached under the Senate terms, no Florida nursing home will be able to survive without Medicaid residents (Nohlgren & Ulferts, 2005,) for 67% of resident days are paid for by Medicaid. Even though the focus of the program aims to keep seniors at home and save the state money, it is also to concentrate on the consumers having options to choose the right setting for their family members during any part of their care.

Florida's Managed Long-Term Care:

Florida's seniors compromise 20 percent of the state's population. There are approximately 17 million elders over age 60 residing in the state of Florida (<http://www.census.gov>). There are already 70,000 people in the nursing homes across the state, with roughly 46,000 covered by Medicaid (Fitzgerald, 2005). Currently, the state's share in caring for the elderly in nursing homes is an estimated \$2.5 billion annually and growing by 10 percent per year (Fitzgerald, 2005). In addition to the mounting expense, in 1998, the state began a pilot program in Orlando to help elderly people remain in their homes as long as possible. The Nursing Home Diversion Program (NHDP), run by Evercare a unit of Minnetonka, Minn.-based United Healthcare, was awarded a budget of \$128.5 million by the 2004 legislature. Due to the 2004 mandate, the Florida legislature created a plan for an "integrated, long-term, fixed payment, delivery system for Medicaid beneficiaries age 65 and older" (<http://www.elderaffairs.state.fl.us>).

Senior Health Choices (SHC) is an extension of the NHDP that will be expanding to other counties in Florida. SHC is a comprehensive health and long-term care system, it's a piloted program with the intentions to create a care management model designed to serve consumers in their community (December, 2004). The managed care program is for all

individuals age 65 or older enrolled in Medicaid in the designated pilot areas. In order to be accepted into the program, the following must be met: individuals eligible under the “medically needy” program that qualifying for Medicaid based on the monthly expenditure on medical expenses, individuals under a penalty for disposal of assets, or individuals certified for a retroactive eligibility period (December, 2004). Individuals currently participating in home and community based waivers such as the NHDP will continue receiving waiver services based on DCF financial determination, and medical eligibility for long-term care services will be determined by Department of Elder Affairs’ CARES (Comprehensive Assessment Review and Evaluation Services) Unit.

Medicaid’s current long-term care system is a collection of distinct services, with varied eligibility criteria. Services are considered either institutional or home and community based (<http://www.ahca.myflorida.com>). Institutional services are mandatory for the Medicaid program and must be available to any Medicaid eligible that meets the criteria. There are two types of mandatory institutional long-term care services: Nursing Facility and the Intermediate Care Facility for the Developmentally Disabled (ICF/DD). Nursing facility services include skilled (mandatory) and intermediate (optional) care services, special care for AIDS patients and medically fragile children, swing bed services provide by a rural acute care hospital, and skilled nursing services provided in hospital-based, skilled nursing unit (<http://www.ahca.myflorida.com>). ICF/DD services are provided by licensed intermediate care facilities and developmentally disabled, which provides coverage for room and board, therapies, nursing services, and training with daily living skills. ICF/DD services also cover rehabilitative care to individuals with developmental disabilities (<http://www.ahca.myflorida.com>).

Home and community based long-term care services are optional for Medicaid; the state may choose to provide the service. These services are aimed at keeping the frail elderly and disabled individuals living at home or in a community setting such as an assisted living facility or an apartment with provided services (December, 2004). Home and Community-Based Service Waivers (HCBS) and AssistedCare Services are the two optional home and community based long-term care services reimbursed under Medicaid. Under Medicaid section 1915(c) of the Social Security Act, HCBS waivers are permitted to provide services for individuals who normally qualify for institutionalization without community supports. Florida has twelve approved HCBS waivers, each containing its own specific eligibility criteria such as age, type and level of disability, and service area covered. Services vary by waiver; however, typical waiver services include personal care, homemaker, companion, chore, respite care, and adult day health care. Furthermore, all waivers provide case management services to assess individual needs and work with individuals to develop their health plans (December, 2004).

AssistiveCare Services provide assistive care to residents of congregate living facilities, such as assisted living facilities or adult facility care homes. Individuals within these settings have functional deterioration that makes it medically necessary for them to live in the facility and receive services on a 24-hour scheduled and unscheduled basis. Assisted care services may include health support and assistance with activities of daily living instrumental activities and medication (December, 2004).

Long-term care in the state of Florida has been a major expense. In fiscal year 2002-2003, long-term care providers were reimbursed \$3.2 billion by Medicaid (<http://www.kff.org>). This reimbursement represented 28% of the Medicaid budget, which was the largest single expenditure compared with the pharmacy category. As indicated in Table 1, nursing facility

costs are the most expensive, primarily due to the cost of delivery care to 70,000 frail individuals having multiple health conditions (December, 2004). Long-term care costs are expected to increase due to demographic trends of the aging population, particularly Florida, since it has the highest proportion of individuals age 65 and older than any other state in the nation (<http://www.census.gov>). In lieu of the trends of rising costs and population growth, it is vital for Florida to improve its long-term care delivery of services to control costs. In response, Florida has shifted resources from institutional to HCBS services, which is less expensive than institutional services. A gradual shift of resources over time to help the greater percentage of individuals needing long-term care services could help level rising costs for the state.

Table 1: Medicaid Long Term Care Expenditures in State Fiscal Year 2002-2003

Long Term Care Service	Expenditures in SFY 2002-03	Percentage of Total Medicaid Expenditures in SFY 2002-03
Nursing Facility	\$2,091,099,715	18%
Intermediate Care Facility for the Developmentally Disabled	\$316,540,833	3%
Home & Community Based Services Waivers	\$760,205,124	7%
Assistive Care Service	\$ 35,457,223	<1%
Total Medicaid Long-Term Care	\$ 3,203,302,895	28%

As mentioned previously, the current Medicaid system is a collection of distinct services. The Senior Health Choices (SHC) pilot will differ dramatically from the current Medicaid long-term care system. The administration of SHC will be conducted by AHCA and AHCA will have lead responsibility of the program. AHCA, along with the DOEA, will develop maintenance and accountability provisions for the Medicaid waivers and develop capitated payments. Procurements and contracts with managed care organizations will be handled by AHCA. Additionally, AHCA will serve as the primary contact with the Centers for Medicare and Medicaid Services (CMS) and the Medicaid fiscal agent.

The Department of Children and Family Services will continue establishing eligibility requirements for Medicaid recipients under AHCA's agreement, while DOEA will collaborate on waiver and procurement development and consult the project's design with AHCA. DOEA will perform CARES nursing facility level of care assessments, coordinate outreach, handle information and referral, and also perform ombudsman activities for older adults through Florida's network of Area Agencies on Aging and the planned Aging Resources Center (AHCA, 2004). The Office of Insurance Regulation (OIR) will determine whether managed care organizations seeking to be SHC providers meet financial solvency standards. OIR will also review quarterly reports from managed care organizations to ensure that solvency standards are maintained (AHCA, 2004).

The financing goals of the program is to achieve more budget predictability, transfer financial risk through fixed prospective payments, and reduce the rate of growth in expenditures in the Medicaid program (AHCA, 2004). Funding for the SHC program will come from individual Medicaid services line items in the budget, as appropriated by the Florida Legislature. Additionally, the funds will be taken in proportion to the 65 and older population served in the designated pilot areas. Service funds will be pooled in order to make fixed monthly payments to SHC plans for each person enrolled (AHCA, 2004). Capitated payments will be developed based on the current costs to Medicaid, which will be used to provide services for the elderly population. Extra funds that are over \$600,000 per year will be used for program administration, including staff, an enrollment broker, and program evaluation (AHCA, 2004).

Recipients already enrolled in Medicaid will be able to keep their current services while being enrolled as a SHC enrollee (AHCA, 2004). In addition to their current Medicaid state plan services, SHC enrollees will also receive primary, acute, and long-term care, as well as

prescription medication. Each enrollee will have a care manager that will assist him in planning and coordinating his care and navigating the SHC program. Since 87% of the SHC enrollees qualify for Medicare (dual eligibles) and Medicaid, Medicare (AHCA, 2004) will cover many of the primary and acute care services. SHC case managers are still required to plan and coordinate enrollees' care based on Medicare services, which are only eligible for Medicaid.

Senior Health Choices provides numerous opportunities for Florida and its participants. SHC promotes the state expansion of its current managed long-term care program; it presents the benefit to coordinate care for the elderly population prior to their encountering a crisis or seeking long-term care services and permits unlimited flexibility to MCOs. Including the entire elderly population instead of a selected few will allow managed care organizations to spread their risk by incorporating more healthy individuals into their plan by having a greater number of enrollees. Furthermore, Senior Health Choices will bring budget predictability to the State Medicaid program.

Trends in Medicaid Long-Term Care Spending

Medicaid Spending in the 1990s:

Several factors drive Medicaid expenditures, especially the economic cycle, demographic trends, and healthcare inflation. Medicaid spending for older adults specifically is rising due to the increased population of older adults. Demographics in state populations are important factors in understating growth trends in Medicaid spending. In the nineties factors such as increased eligibility criteria among Medicaid beneficiaries (women, children, and elderly) contributed to Medicaid's growth. According to the 1996 Census, Medicaid spent \$54 billion on the long-term care population, which represented 34 percent of Medicaid expenditures (U.S. Dept. of Commerce and Census Bureau, 1996). Experts in long-term care have predicted that Medicaid

long-term care expenditures for the elderly will double in inflation-adjusted dollars between 1993-2018 due to the aging population and increased prices for excess general inflation (Wierner, Illston & Hanley, 1994).

Based on the findings of Wierner, Sullivan and Skaggs (1996), an estimated one-third of discharged nursing home residents paid out of private funds when admitted, and they eventually spent down their assets to become Medicaid eligible. Sixty-eight percent of nursing home residents depended on Medicaid to finance their care in 1997. In addition to increased nursing home spending during 1990-1996, the distribution of services by states also increased based on supply and demand. In 1995, \$30 billion dollars was spent on long-term care elder beneficiaries, which contributed to states funding more diverse services for their disabled and elder populations (Wierner & Stevenson, 1998).

Medicaid Spending 2000-2003:

The Medicaid spending increases have fluctuated significantly since the 3.6 percent low growth rate between 1995 and 1998 to the high growth rate of 12 percent between 2000 and 2002. Even though the increase in rates happened during different periods, according to Holahan and Ghosh (2005), the 3.6 percent growth between 1995 and 1998 was an aberration due to welfare reform and the strong economy and an actual decline in Medicaid enrollment. At the same time, health care inflation was low throughout the entire health care sector.

In the late 1990s (1998-2000), Medicaid spending growth increased to 7.8 percent per year due to increased Medicaid enrollment (Holahan & Ghosh, 2005). States' adoption of the SCHIP program (Children's Health Insurance Program) played a significant role in increased Medicaid spending, as well as the expansion of home and community based waiver programs and the expansion of prescriptive drug programs for the elderly. Furthermore, the prescription

drug growth contributed to health care inflation, which was growing in double digits per year (Holahan & Ghosh, 2005) as a result of the increasing age and disabled populations across the states. Other components fueling costs in the late-1990s were the rapid growth in hospital costs for inpatient and outpatient care and the accelerated use of the upper payment limit (UPL), which contributed to rising Medicaid spending (Bruen & Holahan, 1998). States aggressively pursued the upper payment limit option to bring more federal Medicaid funds without increasing their state revenue match requirements. The upper payment limit option allows states to use provider taxes and provider generated revenue in lieu of the states' general revenues to earn the federal match.

Between 2000 and 2002, Medicaid spending growth increased for several reasons. Medicaid enrollment increased because of the economic downturn and a continuing increase in the uninsured, which made more people eligible for the program. The aging of the population is continuing to increase the institutional Medicaid budgets attributed to nursing homes and facilities for the developmentally disabled as well as the mentally ill. Rapid growth in health care costs also influenced the increasing costs primarily caused by prescription drug costs and hospital costs. Lastly, Medicaid managed care organizations were not providing states with the same savings as they did in mid-1990s (Bruen & Holahan, 2003).

Comparison & Analysis of State Medicaid Programs

Budget predictability is a vehicle used by many states like Arizona, Minnesota, and Florida. Budget predictability allows states to make financial forecasts into their Medicaid program. It establishes predictability through practices such as “cost-sharing, program flexibility and controls, and enrollment caps on expansion populations” (<http://www.cms.gov>). Budget predictability used to control costs is due to an increasing number of Medicaid enrollees,

increased prices of medical care and long-term care, and increased shortfalls in States budget, which all result in growth in Medicaid expenditures (Sanders, 2005).

Under state law, “the Medicaid program cannot spend funds beyond the amount appropriated and collected from other sources during a fiscal period” (<http://www.cms.gov>). Budget forecasting (under the current entitlement rules) is considered uncertain and has a significant effect on annual expected outcomes due to multiple changing variables. Uncertainty within the healthcare market cannot be predicted, even though many feel differently about the subject matter. In order for lawmakers to establish an effective budget predictability, they must evaluate “the budget needs of their Medicaid program against the needs of other important state programs. If an over-appropriation to Medicaid occurs, then fewer dollars are available for other programs. Consequentially, an under-appropriation of Medicaid can result in the need for mid-year supplemental appropriations” (Sanders, 2005).

The demands for managed long-term care have been exhibited among these states. While their individually targeted populations and functional needs of the programs may vary, the method of managed long-term care has been widely accepted among their individual respected state governments and administrations. Arizona’s (ALTCS) and Florida’s long-term care system focused on the highly functional needs of individuals who qualified for the traditional home and community-based waivers, while Minnesota’s (MSHO) program covered an array of needs, including those without existing long-term needs. Geographically, Arizona has the only program that covers its entire state. In terms of funding, Minnesota’s program includes a fully capitated Medicare benefits package in addition to its Medicaid benefits. This program was designed to include comprehensive care coordination for dually eligible members, which typically is comprised of 90% of elderly Medicaid beneficiaries and 50% of disabled young people (Saucier,

Burwell, & Gerst, 2005). Minnesota relies heavily on participating plans' interaction with managed care providers within their networks.

Membership enrollment strategies have been highly critiqued. Most programs throughout the US are voluntary; however, large majorities of the programs' members are mandatory. Members have the option to enroll or not enroll. Adequate enrollment levels are essential to states' long-term care programs. Arizona has the largest enrollment population of 23,000, excluding persons with developmental disabilities. In addition to adequate enrollment levels, having a program of sufficient size to warrant investments for the state's infrastructure must be designed appropriately. Arizona has also exhibited this feature well. The implementation of a monitoring system is highly recommended for these programs. A monitoring system ensures the program will be monitored for performance and minimize problems.

Involuntary or voluntary enrollment depends on the state's structuring of its program. Unlike Arizona, Minnesota designed its program with Medicare as a key component. By integrating its long-term care services with their acute care services, MSHO made Medicare's inclusion paramount. Consequentially, the freedom of choice with Medicare may not be waived, so programs including Medicare must be voluntary (MSHO, 2002). Protecting the traditional long-term care infrastructure comes with consequences. ALTCS gave counties the authority to oversee the funding and operation of long-term care programs at the local level, while Florida will permit certain long-term care providers the opportunity to compete with HMOs and other managed care entities. Providers input regarding the long-term care infrastructure is also considered. Their influences play an intricate role in the design of the managed long-term care

programs. In Florida, certain long-term care providers are statutorily eligible to become contractors of the states diversion programs (Saucier, Burwell, & Gerst, 2005).

While states show a growing interest in managed care models to purchase benefits for Medicaid LTC populations, the future success of market growth relies on the development of organizations that can provide services. The development of LTC managed care programs requires the business relationship of managed care entities to connect with expertise in clinical and social management of LTC populations. Traditional health plans do not possess the LTC operational knowledge, yet organizations with skills in providing services do not have experience in managed care. A successfully developed market encompasses the emergence of managed care expertise along with the experience in management of LTC populations (Saucier, Burwell, & Gerst, 2005). The marketplace consists of two kinds of managed LTC entities: the managed care companies that are expanding into the long-term business and long-term care companies that are expanding into the managed care business, which currently dominate the industry.

The two major for-profit companies participating in the managed long-term care market are EverCare and Amerigroup. EverCare is an affiliate of UnitedHealth Group. It dominates in the managed long-term care arena; it focuses exclusively on products related to the management of the frail elderly and persons of all ages with physical disabilities. EverCare's business strategy reflects the firm belief of government purchasers such as CMS and state's Medicaid programs. EverCare's presence is recognized across the country throughout state and federal governments. Currently, EverCare holds managed long-term care contracts or subcontracts in Arizona, Minnesota, and Florida (Saucier, Burwell, & Gerst, 2005).

High consumer approval levels of states' managed care programs are considered when state administrators conduct surveys. Quality-the essential factor- ranks high; the number one indicator for quality is measured through the states' nursing home systems. ALTCS and MSHO did not fare too well due to the oversight of nursing home administrators; however, the overall satisfaction approval rating for ALTCS and MSHO was ranked high among their consumers. Florida's data for consumer satisfaction was not available because its Senior Health Choice program will be implemented in January 2006.

Table 2: Characteristic of Arizona, Minnesota, and Florida’s Managed Long Term Care Programs

	Arizona Long Term Care System (ALTCS)	Minnesota Senior Health Options (MSHO)	Florida Senior Health Choices (SHC)
Implementation Date	1989	1997	January 2006
Population Eligible	Aged and Disabled; NF- level LTC Needs	All aged	Aged and Disabled
Voluntary/Mandatory for Medicaid	Mandatory	Voluntary	Mandatory
Geographical Coverage	Statewide (urban and rural)	7 urban and 3 rural counties	1 urban and 4 rural counties
Medicaid Payments	Capitated primary, acute and LTC; single blended rate	Capitated primary, acute and LTC (NF limited to 6 mos.); multiple rate cells	Capitated primary and LTC; multiple rate cells
Medicare Payments	FFS	Capitated	Capitated
Political Feasibility	Arizona’s legislature agreed on the implementation of AHCCCS program.	Minnesota’s legislature was open to the implementation of MSHO program.	FL House & Senate members had different views on the program. On 12/08/05, an agreement was met regarding the programs expansion.
Administrative Feasibility	Arizona’s budget has been able to keep up with its growing Medicaid population.	Minnesota budget has been able to keep up with its growing Medicaid population.	Not yet determined until pilot begins in January 2006.

Conclusion:

Currently, the nation's long-term care system is a fragmented delivery system with much variation across the 50 states. Reimbursement is rarely connected to quality outcomes and is budget driven. In anticipation of the growth of the aging population, state Medicaid programs are looking closely at the innovations of state waivers and initiatives to assist elders and the disabled to age with dignity (home and community). Arizona, Minnesota, and Florida have experimented with consumer driven pilot projects, nursing home diversion models, Cash Counseling programs, and managed care. These programs have allowed these states and others to meet the challenges of managing large arrays of home-based services while meeting the needs of long-term care.

The move from a traditional fee-for-service system to a managed care system allows consumers to take control over their healthcare according to states' policymakers. The option to choose the kind of service, physician, and healthcare plan, gives consumers great satisfaction in knowing they have contributed to their invested care. The most important element in reforming healthcare is defining the quality of long-term care delivery system. The development of an integrated long-term care model consists of defragmentation, incorporates positive dialogue among the states and providers, evolves consumer-direction in the delivery of personal care services, and includes transparency and choice. Participants have the freedom of choice to make decisions on their healthcare have influenced Arizona, Minnesota, and Florida Medicaid reforms.

With respect to Medicaid reform, there are several recommendations: (1) Invest in an effective enrollment process that anticipates confusion and questions. (2) Place emphasis on educating consumers about the program, providers, and enrollment process. (3) Establish a monitoring system of the program to minimize problems and monitor performance. (4)

Implement a managed care program that is sensitive and understand the current Medicaid environment and the providers. (5) Allow sufficient time for the implementation of the program. (6) Invest in a secure administrative structure that will be able to absorb growing costs of the program. (7) Set reasonable rates that represent current Medicaid managed care populations and set realistic objectives. These additional factors play an intricate role in these states' LTC infrastructure. Both Florida and Minnesota exhibit these factors in their Medicaid reform implementation. Although these factors may be thought of as antiquated, they are the foundation and backbone of an effective managed long-term care system.

There is no definitive approach to controlling Medicaid costs, as illustrated by these states; their approach to Medicaid's escalating costs varied tremendously. Arizona, Minnesota, and Florida have their own distinctive demographics, Medicaid populations, and the aligned long-term care infrastructures. The underlying fact that has driven these states to try a different approaches to controlling their Medicaid budgets is due to their programs' rising costs and expenses. Arizona has had the most extensive experience with managed care for many years, while Minnesota and Florida have supported pilot projects and various cost-containment methods. The debate over controlling Medicaid LTC costs through fee-for-service or managed care has plagued each state's public policy, Medicaid administrations, and budgets. Challenges, such as ensuring the limited resources are available for people who truly need it, offering incentives to state partners who can offer LTC insurance to be purchased, and developing a Medicaid program that will be able to absorb the growing cost of care, keeps these states' Medicaid directors and administration busy. The idea of change in the current Medicaid programs gives great hope for these states.

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