

# *Coordinating Services Across the Continuum of Health, Housing, and Supportive Services*

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This article describes trends in three areas of state long-term care policy for elderly low-income Medicaid beneficiaries—providing home care services to residents in subsidized housing and assisted living; offering nursing home residents opportunities to relocate to community settings; and integrating acute and long-term care services for beneficiaries who are dually eligible for Medicare and Medicaid. The information was obtained from reports and studies on state policy, site visits, and interviews with state officials. Multiple initiatives responding to consumer preferences and fragmentation of the delivery systems were identified. Key components were consumer demand; the availability of nursing facility alternatives; and state priorities for controlling expenditure growth. States use Medicaid to develop broad service menus that include in-home, community, residential, and institutional services. Several states are conducting demonstration programs that improve coordinating or integration of long-term care with the acute care system

**Keywords:** *elderly, managed care, dual eligibles, assisted living, state policy*

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## *State Goals, Trends, and Challenges*

Driven by demographic trends, consumer preferences, and the importance of addressing functional and health needs in a more comprehensive manner, state governments have undertaken multiple initiatives to reorganize delivery systems serving older people with functional limitations and chronic conditions. States have multiple and sometimes conflicting goals for changing long-term care policy: offer

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consumers more service options, reduce reliance on costly institutional care, improve coordination between health and supportive services, improve access to services, control expenditure growth, and assure quality of care. This article presents a descriptive overview of state initiatives for elderly, low-income Medicaid beneficiaries.

Medicaid is a significant payer for long-term care and, therefore, has a major influence on the service options available to low-income consumers. In 1998, Medicaid paid for 38% of all long-term care services and 46% of nursing home costs.<sup>1</sup> In Federal Fiscal Year (FFY) 2000, long-term care spending comprised 34.8% of all Medicaid spending.<sup>2</sup> Elderly beneficiaries account for 10% of all beneficiaries and 28% of total spending. The average spending for elderly Medicaid beneficiaries was \$11,235 in FFY 1998 compared to \$9,558 for disabled beneficiaries, \$1,892 for adults, and \$1,225 for children.

#### *TRENDS*

Long-term care spending includes personal care, Home and Community Based Services (HCBS) waiver spending, home health, and institutional services (Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded). Declining nursing home occupancy rates suggest that states may have achieved some success shifting funds from institutional to community settings. It could also indicate decline in total demand of age-specific disability or the increased use of assisted-living by private-pay consumers. The National Center for Health Statistics found that nursing home occupancy rates declined from 93% in 1985 to 87% in 1995 (Strahan, 1997). An analysis of occupancy trends from 1987 to 1996 by the Agency for Healthcare Research and Quality suggested that home and community-based services, including personal care and assisted living, provide alternatives to nursing homes for people with functional impairments.

Despite an increase from 1987 to 1996 in the number of nursing homes and nursing home beds, the supply of beds for the population 75 and over has declined. Nonetheless, nursing home occupancy rates have fallen. This suggests that the elderly's long-term care needs are increasingly being met outside of nursing homes. (Rhoades & Krauss, 1999, p. 24)

Ladd, Kane, and Kane (1999) found that states have increased spending on HCBS services. Spending for HCBS waiver services grew faster than other services at an annual rate of 29% over a 10-year period, whereas nursing home spending grew 8.6%, home health 14.1%, and personal care 9.6%. Medicaid spending for home- and community-based services rose over 1,000% between 1989 and 1999.<sup>3</sup> Despite dramatic growth of HCBS spending, nursing home spending remains considerably higher (see Table 1).

A number of states have shifted from incremental to comprehensive system changes. Coleman (1998) noted that more states are combining financing and reorganization of long-term care delivery systems to control the use of nursing homes. Coleman (1996) reported that states have limited the supply of nursing homes, expanded HCBS services, reorganized state agencies to centralize responsibilities, created single-entry-point delivery systems and covered services in residential settings.

#### *CHALLENGES*

Despite the progress, challenges remain. During good economic periods, service programs face competition from tax cuts, education, and other programs seeking additional funding. During periods of declining revenue, discretionary programs are more difficult to expand and may be curtailed. Competing needs for spending coupled with pressure to cut taxes or spending can lead to strategies that limit access. Studies of state HCBS waiver programs found significant numbers of states with waiting lists for services, whereas others had inadequate numbers of slots available to meet demand (Harrington, Carrillo, Welling, Miller, & LeBanc, 2000). The study found that the size of HCBS waiver programs was possibly associated with the population age 85 and older, high state personal income, and a high supply of residential (i.e., noninstitutional) facilities, including assisted living. The higher the supply of nursing home beds, the less states are able to expand HCBS programs because more funds are used to pay for nursing home care and are either not easily shifted or additional funds are difficult to obtain.

Table 1  
*Medicaid Long-Term Care Spending (in dollars)*

<i>Service</i>	<i>Spending (in billions)</i>		
	<i>FFY 2000</i>	<i>FFY 1994</i>	<i>FFY 1989</i>
Personal care	3.8	3.0	1.7
HCBS waiver	12.0	3.8	0.9
Home health	2.3	1.6	0.7
Nursing homes	39.6	28.1	15.5
ICF-MR	9.9	9.2	6.6
Total	67.7	45.8	25.6

*Source.* Brian Burwell, The MedStat Group. Memorandum, July 6, 2001

*Note.* FFY = federal fiscal year; HCBS = home- and community-based services; ICF-MR = intermediate facilities for the mentally retarded.

Kassner and Shirley (2000) found that state Medicaid eligibility policies, such as establishing tighter income-eligibility levels for community residents than nursing home residents or setting low medically needy income levels, may limit access to home care services.

On the other hand, budget crises in Maine, Oregon, and Washington were cited by current and former state officials as providing impetus for changes that may not have occurred otherwise. In addition, states and consumers anticipate that progress will be made following the "Olmstead" decision by the Supreme Court in July 1999. The Court found that people with disabilities, including older persons, could not be limited to receiving care in an institution if community-based services were appropriate to their needs. It upheld the provisions of the Americans with Disabilities Act that require states to provide for the "most integrated setting appropriate to the needs of qualified individuals with disabilities" (28 CFR 35.130[d]).

However, the Court indicated that, although states were required to serve individuals with disabilities in the most integrated settings, the decision did not require an open checkbook. States could be required to serve people in integrated settings unless it required a fundamental alteration of their program. The Court "provided little guidance regarding what set of facts would justify a finding that the changes a state is being asked to make would constitute a 'fundamental alteration'" (Rosenbaum, 2000, p. 12). Rosenbaum (2000) concluded that the needs of people who are institutionalized or who are waiting for

services in the community must be balanced against those of others and the financial resources available to the state.

#### *EMERGING THEMES*

As public long-term care programs have expanded, several themes have emerged that shape public policy. First, older people prefer to receive services where they live rather than to move to a nursing home. When services are not available, or cannot be delivered efficiently in a person's home, consumers prefer residential settings to institutional environments. By expanding the menu of services available through Home and Community Based Services (HCBS) programs, states have supported aging in place and, when consumers must move, residential options such as assisted living and adult family care. Second, policy makers and practitioners have recognized the need for linkages between acute and chronic conditions and the importance of coordinating activities across settings, providers, and services. The Program for All-inclusive Care for the Elderly (PACE), a federal program option under Medicare and Medicaid, was among the first to develop an integrated model for meeting the health and functional needs of elders, and a number of states are designing and testing models that combine acute and long-term care services. Third, states are examining the structure of their delivery systems and creating comprehensive, or single, entry point systems to simplify access and coordination of care. Fourth, states are developing consumer-directed programs that give consumers control over the delivery of care. This article focuses on the first two themes:

1. The expansion of supportive services and residential options
2. The integration of services

#### *Aging in place and Residential Settings*

Aging in place, the ability to receive services in the same setting as a person's needs change, has become the mantra of consumers, advocates, and policy makers seeking support for expanding community-based long-term care services. It is based on a rather simple principle: No one, of any age, wants to move from his/her home because of

health or functional limitations. People often express their unwillingness to move to a nursing home. However, to remain at home, individuals need access to the supports either informally through family members or friends, or formally through paid caregivers, that enable them to perform the tasks of everyday life. The aging-in-place philosophy highlights the critical need for supportive services delivered to tenants in existing subsidized housing, affordable assisted living for older people who can no longer live alone and alternative affordable care arrangements for people now living in nursing homes.

States may pay for supportive services in noninstitutional settings through "state-only" programs or through Medicaid. States prefer to use Medicaid waivers in order to share costs with the federal government. Available since 1981, HCBS waivers afford states the flexibility to develop and implement creative alternatives to institutionalizing Medicaid-eligible individuals. States may request waivers of certain Federal rules that impede the development of Medicaid-financed community-based treatment alternatives. The program recognizes that many individuals at risk of institutionalization can be cared for in their homes and communities, preserving their independence and ties to family and friends, at a cost no higher than that of institutional care.

#### *PROGRAMS IN ELDERLY HOUSING*

For years managers of elderly housing sites have sought access to services to meet the needs of aging tenants. Buildings that opened in the 1970s and 1980s attracted active, functionally independent tenants. Twenty years later, the tenants had developed functional impairments and needed supportive services to continue to function independently (Pynoos, 1997).

To meet growing service needs, operators of elderly housing sites may coordinate with existing HCBS programs or develop their own service package and market it to their residents. States with accessible Medicaid waiver and state-funded home care programs that serve residents in elderly housing buildings include Indiana, Illinois, Massachusetts, Oregon, Pennsylvania, Washington, and Wisconsin.

Service programs in elderly housing initially mirrored the services delivered in a person's single-family home. A case manager was assigned, services were authorized, and workers from a provider

agency traveled to the elderly housing site to provide care. As more residents received services, a single building had several case managers and workers, often from multiple agencies, entering the building to serve individual residents. To increase the efficiency of delivering care to elderly housing tenants, states such as Illinois and Massachusetts began to cluster case managers and home care workers. To improve services, one or more case managers were assigned to the building and, depending on the number of residents and their service needs, homemaker/personal care workers were identified and assigned to the building. When possible, office space was created in the building for case managers and workers to use. The clustering of workers reduces travel time and creates more stability for workers. Tasks are also clustered so that one worker, for example, may do the laundry for multiple tenants.

Reliance on state HCBS programs offers an attractive option for housing managers as they do not have to design, market, and operate their own programs. On the other hand, housing managers do not control HCBS funding, which may be limited. Programs may have waiting lists, and residents who need assistance with activities of daily living may not receive them in a timely way.

#### *ASSISTED-LIVING POLICY TRENDS*

Conventional elderly housing and service programs benefit residents with low to moderate services needs that can be met through scheduled visits. When older people need help meeting unscheduled needs or administration of medications and health oversight, more structured service capacity and oversight are needed. Assisted living is an option for low-income elders who might benefit from such a supportive, residential living environment. By June 2000, 29 states had issued regulations using the term *assisted living*. In addition, depending on state regulations, assisted-living facilities in other states may be licensed as residential care facilities, personal-care homes, boarding homes, or homes for the aged (Mollica, 2000).<sup>4</sup> State activity was brisk between 1998 to 2000, when 19 states revised their regulations and more than half the states were planning to make further revisions or issue new regulations in 2001.

Regulations in several states designated assisted living as a new model that is residential, home-like, and consumer centered. The primary components of this model are based on a philosophy that facilitates privacy, promotes independence, encourages aging in place, allows residents with greater needs to be admitted and retained by facilities, and negotiates service agreement through a negotiated-risk process.

In 2002, 28 states reported that they include a philosophy of assisted living in their regulations, up from 22 states in 1998 and 15 in 1996 (Mollica, 2002). Assisted living in many states now represents a more consumer-focused model that organizes the setting and the delivery of service around the resident rather than the facility. State rules that emphasize consumers use terms such as *independence*, *dignity*, *privacy*, *decision making*, and *autonomy* as a foundation for their policy.

Assisted living is primarily a private-pay market. The number of licensed facilities grew from 32,826 to 36,399 between 2000 and 2002. The new number of licensed units grew from 795,400 to 910,486 (Mollica, 2002). Only about 16% of the residents receive public support from SSI or Medicaid (National Investment Conference, 1998). However, the number of residents supported by Medicaid grew 70% between 2000 and 2002, from 60,000 to 102,000. By October 2002, 41 states had approval to cover services in assisted-living facilities under Medicaid, using either an HCBS waiver or the state plan.

#### *Relocation From Nursing Homes*

Driven by potential cost savings and consumer preferences, many states have worked with nursing home residents to explore opportunities to return to community settings. Older people sometimes enter nursing homes because they do not have a caregiver at night, or access to appropriate in-home services or residential settings. The expansion of home- and community-based programs and coverage of services in assisted-living settings has encouraged states to develop initiatives to help nursing home residents who have the interest and capacity to move to a community setting.



Nursing home relocation has been a priority for two federal agencies, the Center for Medicare and Medicaid Services (CMS) and the Office of the Assistant Secretary for Planning and Evaluation (ASPE). These agencies created a state Nursing Home Transition grant program to support the development of services and procedures for identifying and helping to relocate people in nursing homes who can move to the community. A total of 12 states received grants in the first three rounds of funding. In September 2001, CMS made additional awards to 12 states and 5 centers for independent living.

A 1998 pilot program in Colorado found that the average nursing home length of stay for people who relocated was 14 months, and 11% had stayed 3 years or longer.<sup>5</sup> Of the beneficiaries, 64% relocated to an assisted-living facility. Beneficiaries relocated represented a broad range in age and functional capacity. A total of 13% were under 49 years of age, 34% were 50 to 69, 33% were 70 to 84, and 20% were 85 or older. Of the residents, 3% had no activity of daily living (ADL) impairments and 13% had impairments in the eight ADLs assessed (bathing, dressing, eating, hygiene, mobility, transfers, bowel functioning, and bladder functioning). A total of 39% had four to five ADL impairments.

An expenditure analysis that included Medicaid nursing facility, home- and community-based services, and acute care costs, as well as the state-funded home care costs, found that Colorado saved \$750,000 over 2 years. Savings were calculated for the year in which a relocation was made and do not include "days avoided" in the following fiscal year. The program was expanded statewide in 1999.

*Common themes.* Transition programs face a number of common challenges. Lack of housing is the most significant barrier to returning to the community. Nursing home residents are often unable to maintain a home, or their functional capacity may have diminished and adaptations may be necessary to allow them to return home. Low-income nursing home residents may not have the funds to reestablish a community residence. Although active care coordination can help identify and access volunteers, donations, and other community resources, providing flexible funding for transitional needs may be necessary to give residents real choices. Help paying the first month's

rent, utility deposits, moving costs, and purchasing furniture or modifying bathrooms, kitchens, and stairways are some areas where help may be needed. In some instances, residents may need help paying their rent to maintain their apartment during in an intermediate nursing home stay (3 to 6 months). Such expenses can be covered through special needs allowances provided by the state. Both Oregon and Washington, for example, have used a combination of income exemptions and special needs grants to facilitate relocation from nursing home to community.

State officials report that care coordinators play an essential role helping beneficiaries and families during the transition. Care coordinators meet with residents, assess their interest in leaving the facility, determine their housing and care needs, and locate resources to assist in the relocation.

Care coordinators also help arrange visits to potential settings, arrange transportation on moving day, make sure the new location is appropriately furnished, and implement a plan of care so that services are available when the beneficiary moves.

### *Managed Care and Long-Term Care*

State policy makers seek to improve the delivery of services to beneficiaries who are dually eligible for Medicaid and Medicare. "Dual eligibles" have received attention because they have more chronic conditions and functional impairments than Medicare-only beneficiaries. Data collected by the CMS show that dual eligibles represent 16% of the Medicare population and 30% of spending. They comprise 17% of all Medicaid beneficiaries and 35% of total spending. Dual eligibles are more likely to be older, female, single, and living alone than Medicare-only beneficiaries. They are also more likely to live in an institution and have more impairments in ADLs and instrumental activities of daily living. Dual eligibles are more likely to have a diagnosis of stroke, chronic heart disease, diabetes, cancer, and other medical conditions. Utilization patterns also differ. Of dually eligible beneficiaries, 30% have no regular source of care, and 33.4% use emergency rooms when care is needed versus 20% and 18% respectively of Medicare-only beneficiaries.<sup>6</sup>

Beneficiaries with acute and chronic health conditions, functional and cognitive limitations, multiple funding sources, and multiple service providers pose challenges for the traditional health and long-term care systems. Coordination across settings and payers is needed to produce preferred outcomes, and integration of Medicare and Medicaid funding streams to facilitate integration of acute and long-term care services is thought by many to be a necessary condition for achieving such coordination.

Reports, materials from states, and interviews with state officials reveal a number of complex goals for programs that coordinate or integrate services for dual eligibles. They include the following:

- reorganize delivery systems;
- reduce fragmentation and simplify administration of multiple programs;
- create a seamless point of access for all services for clients and providers;
- improve coordination of services among payers, across settings and disciplines;
- improve outcomes for dually eligible beneficiaries such as morbidity and mortality, functional outcomes, and beneficiary satisfaction;
- develop effective interdisciplinary teams to coordinate services;
- create financial incentives to provide the most appropriate services in the least-restrictive setting;
- change utilization patterns; and
- reduce cost shifts between Medicare and Medicaid.

Wiener and Stevenson (1998) identified four specific goals for programs that integrate care: improve quality, lower costs, reduce the number of providers in order to set contract standards and monitor performance, and shift risk to providers through capitation.

Stone and Katz (1996) listed five features of integrated systems:

- a combination of acute and long-term care financing and service delivery for an elderly or disabled population or subpopulation;
- an organized continuum of services and providers;
- incentives for cost containment such as prepayment, full or partial capitation, case management fees, and utilization review;
- a case management function designed to assure continuity of care over time and across separate service delivery systems; and

- specialized training for providers so they are aware of the full array of services and providers and know how to help consumers access them.

Booth, Fralich, Saucier, Mollica, and Riley (1997) described a continuum of integration and discussed six components of an integrated system: scope and flexibility of benefits, delivery system, care coordination, program administration, quality management and accountability, and financing and payment. Feder (1997) examined the access implications of Medicaid's cost-sharing liability for Medicare services under fee-for-service and managed care arrangements. The paper traces the complicated financial, access, and policy issues related to state policy and managed care and highlights the need to build effective coordination mechanisms to ensure that beneficiaries have access to appropriate services.

Developing programs and obtaining the necessary authority to integrate services for dual eligibles poses many challenges to state officials. The difficulties faced by state policy makers in designing and implementing programs to integrate services were described by Parker (1998) in testimony before the Medicare Commission:

*Fragmented clinical system.* Each nursing home, hospital and home care agency conducts its own independent case management. Communication links between long-term care providers and hospitals, clinics and physicians responsible for management of acute care services, are often lacking. There is often little coordination between the acute care and long-term care systems and seniors' real needs may fall through the cracks.

*Poor clinical incentives.* Under fee-for-service, Medicare pays physicians more if they treat seniors in the hospital or clinic instead of the nursing home. Medicare does not pay physicians and other health care professionals for working with families and community services to keep seniors in their own homes and out of institutions. In addition, Medicare risk plans are paid more for seniors in nursing homes and those payments are reduced substantially when the individual is discharged to the community.

*Duplicative administration.* Providers submit bills to Medicare and Medicaid for the same service. Dually eligible seniors receive confusing paperwork from Medicare, even though Medicaid is paying for their Medicare coinsurance and deductibles.

*Cost shifting between providers and programs.* Hospitals have incentives to admit seniors frequently for short stays to obtain the Medicare payment. Nursing homes have incentives to send people to the hospital for short stays rather than treat the person because Medicaid does not directly reimburse for the extra care required. Health plans have no incentive to keep seniors in their own home rather than a nursing home.

*Lack of accountability.* Responsibility for care outcomes is passed from one provider to another. No one can track how much services really cost because payments are fragmented between programs and payers.

#### STATE INITIATIVES

Managed care for dual eligibles appeals to state policy makers and health plans for several reasons. It creates financial incentives to use the most appropriate services without regard to coverage under Medicare or Medicaid. As such, it avoids shifting costs between programs. Savings to Medicare through reduced in-patient utilization can be invested in residential and community care services not traditionally covered by Medicare. Integration also offers opportunities to combine overlapping requirements for administering contracts, enrollment procedures, grievance and appeal procedures, and quality assurance requirements.

In 1997, 24 states enrolled elderly Medicaid beneficiaries in managed care plans (Mollica & Riley 1997). Additional states were planning or considering developing programs to integrate acute and long-term care services for dual eligibles. By the end of 1998, implementation activity was slower than expected due in part to the complexities of developing programs, gaining CMS approval to implement programs, and contracting with health plans to serve beneficiaries. Existing programs have given policy makers further insights into the nature and workings of these efforts.

Two technical assistance papers prepared for the Medicare/Medicaid Integration Program (Booth et al., 1997; Mollica, Saucier, Riley, & Booth, 1997) described state integration initiatives as a continuum: Multiple variables of the same program may be placed at points along the continuum. The papers identified four arrangements for financing and delivering services to dual eligibles:

- Medicaid managed care and Medicare managed care,
- Medicaid fee-for-service and Medicare managed care,
- Medicaid managed care and Medicare fee-for-service, and
- Medicaid fee-for-service and Medicare fee-for-service.

States can be grouped among the above arrangements and multiple arrangements may be found in a state depending on the scope of their program. Arrangements through which dual eligibles are enrolled in managed care plans for both Medicare and Medicaid operate in a small number of states. By design, programs in Minnesota (MSHO), Wisconsin, and PACE programs involve capitation of both Medicaid and Medicare. Programs in Florida and New York provide Medicaid capitation whereas Medicare services remain fee-for-service. Medicare may be fee-for-service or capitated in Arizona, Oregon, and Texas depending on whether the health plan also has a Medicare contract and whether the beneficiary chooses to enroll in the plan for Medicare benefits. Of all the challenges facing programs serving dual eligibles, among the most interesting is the manner in which services are coordinated across funding sources, providers, and settings. Each of the arrangements described above affect the way providers work together to ensure continuity and effective care. Coordination is challenging but easier when all services are delivered through one organization such as PACE programs and initiatives in Minnesota and Wisconsin.

Among the managed care arrangements, coordination is most complex when beneficiaries enrolled in a health plan for Medicaid services use the fee-for-service system for Medicare services. "MaineNET" was designed to coordinate dual delivery systems by assigning case managers to work with primary care physicians. The first program of its kind, primary care physicians receive \$5 per member per month (pmpm) to manage primary and acute services with a focus on prescription drugs. For beneficiaries using long-term care services, physicians receive \$20 pmpm and work in partnership with a registered nurse employed by the state's care coordination organization or single-entry system. The registered nurse functions as a "care partner" and is located in the physicians' group-practice office and coordinates the long-term care services plan and the physician's treatment plan (see Table 2). This program has subsequently been redesigned to work with primary care physicians on medication use.

Table 2  
*Summary of Selected Programs Serving Dually Eligible Beneficiaries*

	<i>Target Population</i>	<i>Scope of Service</i>	<i>Enrollment</i>	<i>Medicare Approach</i>	<i>Statewide</i>
Arizona long-term care system	Nursing facility eligible elderly, physical or developmentally disabled	Primary, acute, and long-term care	Mandatory	Usually coordinated on FFS basis	Yes
Florida long-term care community diversion project	Nursing home eligible	Medicaid acute and long-term care services	Voluntary	Coordinated FFS	No
MaineNET	Elderly and disabled	Primary, acute, and long-term care	Voluntary	Primary care case management	No
Minnesota senior health options	Elderly and disabled, including dually eligible	Primary, acute, and long-term care	Voluntary	Capitated through Medicare waiver	No
New York—VNSNY “Choice”	Elderly nursing home eligible and living in community on enrollment	Primary, acute, and long-term care	Voluntary	Coordinated FFS	No
Oregon health plan	All Medicaid, including dually eligible	Primary and acute	Mandatory for Medicaid	Capitated through Medicare health management organization, or FFS	Yes
PACE	55+ years, nursing facility eligible	Primary, acute, and long-term care	Voluntary	Capitated through Medicare waiver	No
Texas Star+Plus	Elderly and disabled, including dually eligible	Primary, acute, and long-term care	Mandatory for Medicaid	FFS	No

*Source.* Chart based on Booth, Fralich, Saucier, Mollica, and Riley (1997).  
*Note.* FFS = fee for service. MaineNET has since been redesigned.

*MODELS FOR COORDINATING MEDICAL  
AND SUPPORTIVE SERVICES*

Other models were identified by Rosenbach and Young (1999) in a study of Medicaid managed care programs in Colorado, Delaware, New Mexico, Oregon, and Washington. They found that case management programs relying on a medical model focused on health concerns, whereas care coordination models based on a broader social service model extended their focus beyond health care to social issues such as housing, income, and social supports. The study found that managed care organizations used three models for care coordination: centralized teams, regional teams, and provider-based models. The latter two models used registered nurse/social worker teams more often than medical case management models and focused on problem solving and advocacy for their beneficiaries.

A 1997 case study by Mollica of Medicaid managed care programs in four states (Arizona, California, Oregon, and Tennessee) concluded that case management can be a significant asset in coordinating services between Medicare and Medicaid. The review found the following:

- Dually eligible beneficiaries are more likely to require coordination and case management services than Medicare only beneficiaries because they have a greater incidence of acute and chronic conditions.
- Case management systems that build strong links with the long-term care system perform better for dually eligible beneficiaries who are more likely to use a range of medical and nonmedical services.
- Coordination and case management is more difficult when beneficiaries receive care from different systems (e.g., Medicaid managed care and Medicare fee-for-service) except in Oregon when all services are provided within the same plan.
- Disease management programs have also been effective for managing health conditions of some dually eligible beneficiaries because they are more likely to have conditions that lend themselves to management protocols—heart conditions, diabetes, and cancer. However, linkages are also needed between the health system and other services outside the health network in order to address the full range of beneficiary needs.
- Medicare Health Management Organizations (HMOs) have evolved their case-management functions in response to the needs of dually eligible beneficiaries.



- Because of the complexity of coordinating services from multiple providers and payers, consumers should be partners in the process.

Coordination models have been built around the role of case managers, use of geriatric nurse practitioners, and interdisciplinary care coordination teams. In Oregon, Exceptional Needs Care Coordinator (ENCC) positions have been created by health plans to identify members who have disabilities or complex medical needs, provide assistance to ensure timely access to providers and capitated services, coordinate services with providers to ensure consideration is given to the unique needs in treatment planning, assist providers with coordination and discharge planning and coordinate community supportive and social service systems linkages.

Case managers play a similar role in Arizona's ALTCS program, which capitates all Medicaid acute and long-term care services. The case manager develops a service plan for institutional services, home- and community-based services, behavioral health, durable medical equipment, medically necessary transportation, therapies, and individual/group and/or family therapies. Primary care physicians are contacted to discuss changes in the client's condition and to determine whether any changes are needed in the physician's order concerning the level of care, care plan, medical services, behavioral health services, prescription drugs or medical equipment. Two models of care management have emerged in the Minnesota Senior Health Options Program (MSHO). For nursing home residents, care management is generally done by geriatric nurse practitioners (GNPs). GNPs work with primary care physicians, nursing home staff, and others as needed to coordinate care. For members living in the community, registered nurses and Master's level social workers are generally used to coordinate long-term care services.

The Wisconsin Partnership Program (WPP) sites use interdisciplinary teams to assess, authorize, and coordinate care. Each team consists of a nurse practitioner, registered nurse, social worker, or independent-living coordinator (as appropriate), a primary care physician, and the beneficiary. Other professionals (personal care workers, therapists, pharmacists, dieticians, durable medical equipment (DME) specialists) are included as needed.

*PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY*

Perhaps the first comprehensive program for integrating acute and long-term care is PACE. PACE began as a demonstration program but was granted program status by the Balanced Budget Act of 1997 (BBA). PACE offers dually eligible beneficiaries a comprehensive service delivery system that allows providers to integrate Medicare and Medicaid benefits. Members of the PACE team include primary care physicians and nurses, physical and occupational therapists, social workers, recreation therapists, home health aides, dietitians, and drivers. Other services and providers—medical specialists, laboratory and other diagnostic tests, and hospital and nursing home care—are used when needed. States interested in developing a program can add PACE as an optional service to their state Medicaid plan. Though granted program status, the BBA limited the number of new programs to 60 in the first year and 20 each year thereafter. PACE participants must meet the state's criteria for admission to a nursing facility and be at least 55 years old. PACE providers receive capitation payments each month from Medicaid and Medicare for eligible enrollees. Providers are at full risk for delivering covered services for participants.

PACE programs have been approved in California, Colorado, Massachusetts, Maryland, Michigan, Missouri, New York, Ohio, Oregon, South Carolina, Tennessee, Texas, Washington, and Wisconsin.

States have been reluctant to limit their initiatives solely to the PACE model because of its reliance on adult day health centers and the requirement that beneficiaries must be nursing home certifiable in order to enroll. Because it operates as group practice model, beneficiaries seeking to enroll may have to change their primary care physician to participate.

*CHALLENGES*

The experience among states programs serving dual eligibles is limited geographically and by enrollment. Only Arizona operates statewide and offers over a decade of experience. Other initiatives plan to expand as their programs mature and the risks and benefits become known and their experience providing long-term care evolves.

Implementation and expansion has been hindered by changes in the Medicare managed care market and the reluctance of HMOs, which, for the most part, have little experience serving frail elders or coordinating long-term care, to assume new challenges.

Despite the number of demonstrations, only Arizona Long-Term Care System (ALTCS) has been evaluated. McCall et al. (1993) found that ALTCS was cost effective and improved health outcomes in selected areas. An evaluation of the Minnesota Senior Health Options program and the WPP are underway. Further studies are needed to determine the impact of integration for dual eligibles.

To expand, state initiatives must overcome barriers to enrollment. Dually eligible beneficiaries would seem to have little incentive to enroll in a managed care program. They have access to all Medicare fee-for-service providers, face no out-of-pocket expenses, and can receive home- and community-based long-term care services. However, many states have waiting lists for home- and community-based waiver services and enrolling in an integrated program may give them immediate access to care. Although the fee-for-service system allows freedom to choose among providers, many fee-for-service providers do not accept or limit the number of Medicaid beneficiaries they will serve. Dually eligible beneficiaries often use hospital emergency rooms as their source of primary care. Managed care programs, although they may have difficulty recruiting and maintaining a network, often have increased opportunities for beneficiaries to access providers.

Coordination among a host of confusing benefits and providers is also a potential benefit to enrollment. All programs offer some form care coordination, usually through an interdisciplinary care team, to facilitate access, monitor care, and adjust service when necessary. Programs face the challenge of explaining the process and benefits of care coordination to potential members.

State initiatives share several common themes but they reflect a variety of compromises based on the availability and willingness of health plans to serve older and frailer beneficiaries, and difficulties negotiating acceptable parameters with CMS over budget neutrality and reimbursement.

*Summary and Conclusions*

Beneficiaries, government policy makers, providers, family members, and advocates face a myriad of challenges trying to achieve a shared goal: to deliver the most appropriate service to people in the least restrictive environment. This seemingly simple goal is complicated by the different interests of the parties and the boundaries of the systems and perspective they represent. Payers typically play a prominent role in determining which benefits will be provided and in what setting. Providers are limited to decisions about the services or settings they are paid to deliver. Policy makers have a major role in shaping the delivery systems that serve beneficiaries but they may be limited by the scope of financing. On their face, programs that integrate acute and long-term care services under Medicare and Medicaid have tremendous appeal and perhaps their appeal explains why state policy makers have committed extensive resources to design policies and programs, develop provider networks, and negotiate complicated federal approval procedures to implement programs whose enrollment may remain relatively small. Broad replication and statewide expansion of these efforts has been difficult, yet the lessons learned may spawn additional policy changes.

As each stakeholder has a slightly different perspective and interest, housing managers have a huge stake in the decisions made by the health system and the long-term care system. Often left without access to services needed by residents, the housing system has entered the fray seeking scarce resources to allow tenants to age in place and remain independent. All service decisions begin with housing although its importance is often only vaguely described. Lacking direct control of funding to provide long-term care services, housing managers may hire service coordinators to broker the needs of tenants with community resources.

This review has highlighted a number of programs and state initiatives in which health care and long-term care services are being integrated and a few in which the housing component is a key focus. Over time, service providers are likely to seek opportunities to locate staff or establish a clinic in an elderly housing site in order to reach residents more directly. Elderly housing sites have become a logical point to deliver services to large numbers of residents who have chronic

health conditions and functional limitations. But developing effective programs adds another stakeholder to the process further complicates the arrangements. Collaboration, though more complex, is important if we are to meet the preferences of beneficiaries to remain where they are and to prevent the need to develop additional settings to serve people.

The review also shows the rising prominence of assisted living and the limitations of current programs to make it affordable for low-income beneficiaries. Until assisted living is more accessible, options for low-income elders who can no longer live at home will be limited to nursing homes. Several trends suggest a potential convergence of nursing homes and assisted living. The supply of assisted living is growing significantly, resulting in a decline in nursing home occupancy rates. State regulations allow assisted living facilities to provide a higher level of care and the overlap with nursing homes is considerable. On the other hand, the characteristics of nursing home and assisted-living residents are different. Nursing homes, generally speaking, care for a more medically involved, short-term stay population than they did 10 years ago. Although the impairment level of assisted-living residents is greater than it was before state regulations became more flexible, it is still much lower than in nursing homes. Over time, aging in place and competition among assisted-living providers may lead to higher, more nursing home–like acuity levels, lessening the differences between assisted living and nursing home residents. Faced with dropping occupancy rates and aging stock, nursing homes may replace their existing buildings with new structures that look more residential and similar to the design of assisted-living facilities. Although this course is quite speculative, it reflects one potential outcome based on trends in each industry in recent years.

However the housing and assisted-living sectors develop, linkages with the health care system will be stronger over time. Although the number of initiatives integrating acute care, long-term care, and housing may be limited, the attention and interest at all levels—policy, financing and provider—is sufficient to build on their experience and to develop new initiatives shaped by very local environments. Ongoing research, case studies, and sharing of the results will be important in determining the pace and direction of their expansion and stimulation of new projects. Given the complicated needs of older people and

the multiple interventions that are needed, care coordination, regardless of the organization base of its participants, will remain a critical part of the response to meeting those needs.

In all areas, few evaluations have been conducted to determine the impact of state initiatives. Evaluations should examine issues beyond the marginal cost or the so-called woodwork effect. The essential questions are the extent to which public policy has achieved its goals to deliver services that meet consumer preferences in the most cost effective and efficient manner. The focus should be on the total long-term care system, rather than the incremental effect of covering additional services or serving more people. States and the nation need to determine the extent to which public funds will be used to meet the needs of low-income, frail elders, and the philosophical basis for structuring delivery systems and covering services. Linkages between the acute care and long-term care systems are also important. Although the implications for Medicare were not addressed in this article, successful integration will require either some fundamental changes that increase compatibility between Medicare and Medicaid or investments in demonstrations that improve coordination between single-entry/managed care style Medicaid long-term care programs and the fee-for-service health system.

## NOTES

1. Medicaid Facts, Kaiser Commission on Medicaid and the Uninsured, March 2001.
2. Data provided by Brian Burwell, The MedStat Group. Memorandum, April 25, 2000.
3. Data provided by Brian Burwell, The MedStat Group. Memorandum, April 25, 2000.
4. In a few states, buildings marketed as assisted living may not be required to seek a license if the services are provided by an outside agency rather than the owner/operator of the building.
5. Barbara Prehmus, presentation at the National Academy for State Health Policy Annual Conference, August, 2000.
6. "A Profile of Dually Eligible Beneficiaries," Health Care Financing Administration, March 1997.

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