Stay at Home,

Mom

States are searching for affordable ways to allow seniors in need of long-term care to remain in their homes.

By Dylan Scott

Photographs by Kristina Krug

After three years in a nursing home, Delores Powers moved in with her son and daughter-in-law. Her caregiver, Angie, helps her around the house five days a week.

For three years, Delores Powers languished in a nursing home. Already struggling with diabetes and early dementia, the 86-year-old Decherd, Tenn., resident landed in the hospital in 2008 after mismanaging the dozen or so medications she takes every day. Doctors told Delores' son David and his wife Dale that unless somebody could stay with her all day, she needed to live in a nursing home. Both David and Dale work full time, so staying home was not an option. Delores was moved to a nursing home, the default option for someone in her situation.

"She seemed to be going downhill, picking up speed," says Dale of how her mother-in-law handled the move. She recalls the conversations she and her husband had about what they could do. They talked about Dale quitting her job to stay home with Delores. "But we really couldn't afford that."

Then, a few years ago, Tennessee lawmakers approved a new program called CHOICES. Implemented in 2010, the program was conceived as a way to help seniors on Medicaid receive home- and community-based care instead of living in a nursing home. After an assessment of Delores' condition and finances, state officials approved her for the program.

This June, Delores came home. A caregiver named Angie, whose salary is paid by the state, comes from 7 to 5 every weekday. Angie gives her a bath, doles out her medications, checks her blood sugar, prepares lunch and takes Delores on walks outside. "You could say she does everything," Dale says. A physical therapist works with Delores at the house twice a week, and a registered nurse stops by once a week to check her vitals.

Today, Delores' life is getting back to normal. It's the little things: a shopping trip to Walmart, her first hair salon appointment in years, sitting on the porch in her small town of 2,200, waving as people walk by. In the afternoons, Angie hangs up a curtain in Delores' bedroom so she can watch movies late into the night, just as she likes.

The concept of managed care—the model that allows people like Delores to remain at home—has been around in health policy circles for years. But it's now gaining particular attention for seniors. The idea is that one company or organization oversees all of a patient's health-care needs. The company manages long-term aides and caseworker visits. If a patient ever needs more acute health care, such as a trip to her physician or specialist, the organization contracts with doctors, "managing" her care in a more holistic way than if she were left to navigate the system on her own.

Coordinating every aspect of one patient's health care is complicated enough. But when that care is paid for by the government, coordination can become next to impossible. Medicaid pays for almost all long-term care services for low-income patients. Medicare, the federal insurance program for individuals 65 and older, covers more acute care, such as emergency room visits and most prescriptions. Low-income seniors, such as Delores, are known as "dual eligibles." They qualify for both programs and are constantly bouncing back and forth between them—Medicare for an operation, Medicaid for long-term recovery. Sometimes, Medicaid pays part of a patient's out-of-pocket costs for Medicare premiums.

It's a maze.

As a result, reconciling the two programs can be a nightmare. Many primary care doctors who work under Medicare are not aware of their patients' options for long-term home- or community-based care under Medicaid. Everyone involved in health policy has heard horror stories of patients being stuck in a nursing home while the two programs bickered over which would pay for different services.

Under CHOICES, Angie's help allows Delores to remain as independent as she can. One recent afternoon, Angie took Delores to get her hair done for the first time since she came home.

It's a piecemeal system and one that's unacceptable, says Matt Salo, executive director of the National Association of Medicaid Directors. Speaking at a Washington, D.C., conference this July, Salo called it "a national shame that we're subjecting the poorest and sickest among us to this fragmented care."

Dual eligibles can also be a major expense for states. They make up 15 percent of the 62 million Medicaid enrollees nationwide, but they account for nearly 40 percent of the program's costs. And roughly 70 percent of those costs are tied up in long-term care. Better management of long-term care for dual eligibles means a lower burden on state resources.

That's why a program such as CHOICES is so attractive to policymakers. A decade-long study published in *Health Affairs* in 2009 found that states with established home- and community-based care programs had cut their overall Medicaid long-term care spending by nearly 8 percent. States that instead relied on institutions like nursing homes saw their long-term costs increase by almost 9 percent. According to a 2011 report from the Bowles-Simpson presidential commission on fiscal reform, placing dual eligibles in Medicaid managed-care programs like CHOICES could save up to $12 billion by 2020.

"As the population ages and more and more people need long-term care, if nursing homes are our default option, we're not going to be able to afford that," says Patti Killingsworth, chief of long-term services and supports at Tennessee's Medicaid office, which oversees CHOICES.

But improved coordination is not just about keeping costs down. It could also mean higher quality of care and a better patient experience. The federal Centers for Medicare & Medicaid Services (CMS) estimated in 2005 that 45 percent of hospitalizations for dual eligibles could have been avoided through better coordination between the two programs. Better coordination means greater independence for patients.

More than 80 percent of Americans over 50 say they want to remain in their home as they age, according to AARP. That includes Delores. "We didn't want her to leave before her time, and we felt like it was getting to that point. We had to do something. This is the best thing that ever happened," Dale says. "When they can come home, it changes everything. She's happy, she's going places, she's doing things."

Tennessee may seem an unlikely place to look for a national model of health-care reform. Before CHOICES passed in 2009, Tennessee had a poor record on long-term care. According to an AARP analysis, it had the nation's lowest percentage of low-income seniors who received home- or community-based care. In 1999, less than 1 percent of Tennessee seniors on Medicaid received that kind of care. In 2009, as planning for CHOICES was under way, the share was still below 10 percent. "We really had nowhere to go but up," says state Sen. Lowe Finney, who formed a study committee after taking office in 2006 to explore options for improving care for those individuals.

Tennessee's Medicaid program, TennCare, has one of the most expansive managed-care systems in the country. Health-care providers are paid on a per-patient basis, rather than per procedure, as was the case in more traditional fee-for-service models. TennCare has been in place since 1994, but seniors hadn't been integrated into the managed-care system. Instead, the default option for Medicaid-eligible seniors in need of long-term care was living in a nursing home.

In his 2008 State of the State address, then-Gov. Phil Bredesen made the CHOICES program the centerpiece of his plan for the state. "We need to make it easier to stay at home with more home- and community-based services. We need more residential alternatives to nursing homes," Bredesen said in his speech. "If you want to stay in your home, if it makes sense to do so, this is the year we're going to start making it easier."

With that, planning for CHOICES accelerated. Finney's study committee had found that 90 cents of every state dollar spent on long-term care went to nursing-home residency, the most expensive kind of care. So policymakers set dual goals: finding a more cost-effective solution and giving seniors a choice about what kind of care they would receive. Unsurprisingly, nursing homes were concerned that they would lose substantial amounts of revenue if more patients received at-home care. Lawmakers included provisions in the bill allowing nursing homes to provide additional services, such as adult day care, to make up for the reductions in permanent residents. The CHOICES Act passed the state General Assembly in May 2008 without a single "no" vote. A federal Medicaid waiver, which was required to modify the state's program, was granted in July 2009. "Everybody understood the goals we were trying to achieve," says Tennessee's Killingsworth, "and believed, based on everything we had studied and reviewed and analyzed, that this was the thing that was going to get us there."

Of course Tennessee is not alone in searching for new approaches for its long-term care population. Oregon's coordinated care organizations served as a model for Tennessee policymakers when they were designing CHOICES. Vermont had already implemented a tiered system similar to CHOICES, in which patients who didn't require nursing-home care could opt to stay at home. Arizona and Texas have had managed long-term care systems in place for more than 10 years. At the federal level, the Affordable Care Act created the Medicare-Medicaid Coordination Office within CMS. Twenty-six states—including Tennessee—have told the new office they will develop dual-eligibles demonstration projects over the next few years to improve coordination.

But Tennessee did something those other states hadn't. It integrated CHOICES into its overall managed-care program, rather than creating a separate entity for long-term care recipients. The idea was that it would be more efficient if that population could draw on the resources of the larger program. Since its implementation, Killingsworth says her office has fielded calls from more than 20 states about CHOICES. Other states' officials involved with developing long-term care strategies have visited to see the program at work firsthand, as have officials from CMS.

Since Tennessee's program took effect, the number of long-term care recipients who stayed in their homes or their community doubled from 17 percent in 2010 to 34 percent in 2012. The

state is seeing a financial benefit as well: Its Medicaid program's costs are projected to increase by half the national average in 2013.

Other states are now developing managed-care systems modeled on Tennessee's. When Kansas officials decided in 2010 to implement a managed-care program, including for long-term services, they spoke to Killingsworth and her office. "They've been there, done that, and they've been successful," says Susan Mosier, director of the Kansas Medicaid office, which is set to implement KanCare in January.

Similarly, New Jersey officials determined that they should adopt a managed long-term care system. (Like Tennessee prior to CHOICES, New Jersey has ranked near the bottom in terms of home- and community-care services.) Before filing a waiver application with CMS last September, New Jersey officials sent potential health-care providers on site visits to meet with their counterparts in Tennessee.

Valerie Harr, director of the New Jersey Medicaid office, says she regularly exchanges emails with Killingsworth about how Tennessee's experience could be translated to her state. "They're a model. You have to look to states that have been in the same situation," Harr says. "They've already asked all the questions that we're trying to answer."

Managed long-term care is the first step toward a coordinated approach on dual eligibles. Of the 26 states set to initiate dual-eligibles demonstration projects, 15 say they plan to move forward next year; the other 11 say they will to start theirs in 2014. Tennessee was one of 15 states to receive a $1 million federal grant to plan its demonstration. The state plans to integrate Medicare benefits into its managed-care system. Patients would have a single insurance card and a single care management office to oversee their needs. Savings are expected for both Medicare and Medicaid within three years if the demonstration is successful.

That's just one of the myriad ways that states are proposing to improve coordination for dual eligibles. Generally, the plans fall into one of two categories: blended rate, which sets a single rate for health-care providers to offer both Medicare and Medicaid services; and state coordination, in which the state takes responsibility for integrating care and could qualify for financial bonuses if certain savings targets are met.

There's widespread agreement that dual eligibles and managed long-term care offer an important opportunity for policymakers. But there are challenges, to be sure. Dual eligibles are, almost by definition, a high-needs population. There are many questions about whether state-run managed-care systems are prepared to handle those needs. And there's uncertainty about proper oversight and how to measure and maintain quality when health-care services are increasingly being delivered in individual patients' homes. Some patient advocates have already warned against rushing into Medicare-Medicaid coordination. "Part of our concern is that there is a lot of vagueness, a lot of unknowns," Patricia Nemore, senior policy attorney at the Center for Medicare Advocacy, told *Governing*'s Health newsletter in July. "You can't talk about duals uniformly. You can't even talk about a state uniformly: The infrastructure is different in city versus rural, one part of a state versus another part."

Since 2010, CHOICES has doubled the number of seniors like Delores who receive home-based long-term care. A regular exercise routine, overseen by Angie, ensures Delores is as healthy as possible.

But federal officials say the best option available is to let states experiment with different approaches. "There's not one model that would work in every case," says Alper Ozinal, a CMS spokesman. "We need to be flexible enough to recognize that states have different strengths and delivery systems to build around."

Now is the time to act, say advocates of dual-eligible reform. With a rapidly aging population, they say, states must be as proactive as possible. "You have two options," says Killingsworth. "You can either plan now or you can wait till it gets here. The only way we're going to be ready is if the planning occurs now and these kind of decisions are made now rather than later." **G**

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