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Forum Brief

Part 2 of a 2-part Brief

Kansas Health Policy Forums

2001



The Aging of Kansas: *Implications for the Future of Long-Term Care*

Thursday, September 13, 2001 • 9:00 am — 12:00 pm
212 SW Eighth Avenue, Topeka, KS • Lower Level Conference Room

A DISCUSSION FEATURING

Robyn Stone, *Executive Director,*
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Services for the Aging, Washington, D.C.

Connie Hubbell, *Secretary,*
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Kansas Health Policy Forums are a series of interactive sessions for policy-makers examining a broad array of health issues. Forums present a wide range of **expert views** on current health policy issues **followed by facilitated discussion** and dialogue in a non-partisan setting. **Forum Briefs** take an in-depth look at an issue, examine relevant data and information and are prepared in advance of each Forum.

The Aging of Kansas: Implications for the Future of Long-Term Care will examine key issues regarding the changing age demographics of the state and the development of a long-term care plan.

Part 1 of the Forum Brief describes the current system of long-term care for the elderly and highlights the demographic changes that will impact the system in the future. **Part 2 (attached)** presents key challenges and issues facing Kansas in addressing the future of long-term care for its aging citizens including:

- personal responsibility and informal supports;
- expanding home and community-based services;
- coordinating and integrating services;
- using public funds in strategic ways;
- concerns about quality; and
- public-private partnerships.

Speaker Bios

Robyn I. Stone, Dr.P.H., is a noted researcher and internationally recognized authority on health care and aging policy. In June 1999, she joined the Washington, D.C.-based American Association of Homes and Services for the Aging to establish and oversee the Institute for the Future of Aging Services. She is the Institute's executive director.

Dr. Stone has held senior research and policy positions in both the U.S. government and the private sector. She was an

appointee in the Clinton Administration, serving in the U.S. Department of Health and Human Services as Deputy Assistant Secretary for Disability, Aging and Long-Term Care Policy from 1993 through 1996 and as Assistant Secretary for Aging in 1997. In the 1980s and early 1990s, she was a senior researcher at the National Center for Health Services Research and at Project HOPE's Center for Health Affairs. Dr. Stone was on the staff of the 1989 Bipartisan Commission on Comprehensive Health Care (the Pepper Commission) and the 1993 Clinton Administration Task Force on Health Care Reform.

Dr. Stone is a distinguished speaker and has published widely in the areas of long-term care, chronic care for the disabled and family caregiving. Her doctorate in public health is from the University of California, Berkeley.

Connie Hubbell, was appointed Secretary on Aging on November 12, 1999. Prior to accepting this position, she served as the Assistant Secretary for Health Care Policy at the Kansas Department of Social and Rehabilitation Services (SRS).

Secretary Hubbell's previous professional experience includes: elementary and secondary educator; elected member of the Kansas State Board of Education, serving ten years, and as Chair for two years; Commissioner of Income Maintenance and Employment Preparation Services for SRS; Commissioner of Substance Abuse, Mental Health and Developmental Disabilities for SRS; President of the National Association of State Boards of Education; and Public Policy Monitor for

the YMCAs of Kansas.

Rosemary Chapin, Ph.D., Associate Professor, University of Kansas, School of Social Welfare, has extensive teaching, research, policy and program development experience in the long-term care arena. She directs the Office of Aging and Long-Term Care in the School of Social Welfare. For the past 12 years, Dr. Chapin has been involved in doing research and providing technical assistance to states to help craft more effective state long-term care policy. She has published widely in the area of long-term care policy and recently co-authored a handbook on strengths-based care management for older adults.

Brief Author and Forum Facilitator

Anthony Wellever is President of Delta Rural Health Consulting and Research, a firm specializing in providing technical assistance to rural health policy makers, providers, and communities. Mr. Wellever has written and spoken widely on the topics of rural health networks, managed care in rural areas, alternative model rural hospitals, and the meaning and consequences of local control of health care services. Previously he served as a Research Fellow and Deputy Director of the University of Minnesota Rural Health Research Center and as Senior Vice President of the Montana Hospital Association.

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Key Long-Term Care Challenges for Kansas

Building on the informal delivery system and personal responsibility

The informal delivery system allows elders to age in place and contributes to controlling the costs of formal long-term care (LTC). Public support for families and communities might encourage them to expand the provision and financing of services. Persons who accept the responsibility for financing their future LTC needs or who reduce their need for LTC services by adopting healthy life-styles contribute positively to restraining future public LTC expenditures. (Discussed on page 4)

Expanding home and community-based services

Home and community-based services aim to improve the lives of seniors by maintaining their involvement in social and family life. A unique provider in the spectrum of LTC services, home and community-based services fill the niche between informal and institutional care. (Discussed on page 6)

Coordinating and integrating services

The LTC delivery system is composed of several different providers and various levels of service intensity and funding. Individuals navigate this complex, fragmented system according to their specific needs. Greater service coordination and integration of providers and payers might improve the efficiency and quality of the LTC system. (Discussed on page 7)

Using public funds in strategic ways

Future demand for LTC services will place great strains on the state budget (especially on Medicaid) unless creative steps are taken to control expenditures. The role that private LTC insurance will play in potentially offsetting public expenditures is not clear at the present time. (Discussed on page 9)

Addressing concerns about quality

Current LTC quality improvement systems tend to focus on places and services, rather than the impact of services on individuals as they navigate the LTC system. New quality measures and reporting systems are needed to help individuals, providers, and payers better assess the quality of services rendered. (Discussed on page 9)

Policy planning and public-private partnerships

Creation of a public policy for LTC in Kansas will require a coordinated effort by individuals, families, communities, employers, educators, LTC service providers, and state and local policy makers. The future demands on the LTC system of Kansas cannot be satisfied by the private sector alone, nor can they be satisfied by the public sector alone. Cooperation — a true public-private partnership with shared accountability — is needed to confront this emerging issue. (Discussed on page 11)

Introduction

The growing elderly population of Kansas will increase demand for long-term care (LTC) services in the coming decades. LTC is a general term for an array of supportive and medical services provided over an extended time to people who need assistance with a variety of activities. The ability of Kansas to meet this demand will depend in large part on the steps that are taken today to prepare for it. Consider the following:

■ The elderly are the primary users of LTC services.

■ State and federal governments are the primary payers for LTC services.

■ Increased life expectancy and the aging of the “Baby Boom” generation soon will produce a substantial increase in the number of elderly Kansans. The population of Kansans age 65 and over is expected to grow from 355,830 in 2000 to 507,000 in 2020, an increase of 42.5 percent. The population age 85 and over in Kansas — the largest consumers of LTC services — is projected to grow from 52,720 in 2000 to 63,760 in 2020, an increase of 21 percent. In contrast, the age 64 and under

population is expected to grow by only 10 percent during the same period.¹

The population of elders age 85 and older will increase dramatically as the Baby Boom generation continues to age. By 2040, the number of people over age 85 will grow to more than three times its current size.²

■ The Congressional Budget Office (CBO) estimates that expenditures for LTC services for the elderly (exclusive of medical, assisted living, and adult day care) will grow by 68 percent between 2000 and 2020, absent any inflationary increase in the cost of ser-

This brief is Part 2 of a two-part Forum Brief prepared for an upcoming Kansas Health Policy Forum entitled **The Aging of Kansas: Implications for the Future of Long-Term Care**, scheduled for September 13, 2001 in Topeka. Part 1 of the Forum Brief set the stage by describing current long-term care systems and presenting relevant demographic information about Kansas. Forum Brief, Part 2 builds on this information and discusses critical policy issues and challenges facing the state in dealing with the future of long-term care for the elderly.



vices.³ Including a modest inflation factor of 3 percent per year to the CBO estimate, the total cost of these LTC services to the Kansas Medicaid Program by the year 2020 will be approximately \$966 million, an increase of approximately 200 percent over the amount spent in 2000.⁴

As remarkable as these projections are, the impact of aging and LTC on the Medicaid budget is only one aspect of the issue. LTC is composed of a number of interrelated parts. Changes to one portion of the system may have unanticipated consequences for another. Certainly, the increase in demand for LTC in the coming decades will affect the LTC system in many ways, some of which may not even be contemplated today. One way to deal with the anticipated increased demand and its effects, is to establish a LTC public policy. A comprehensive LTC policy that sets goals and establishes delivery and financing priorities would help guide future decision-making.

What is a Long-Term Care Policy?

A LTC policy is a vision of the future for LTC service delivery and financing agreed to by public and private stakeholders. Some potential uses are —

- To establish a goal-oriented framework for future legislation, appropriations, and regulations;
- To identify the roles and responsibilities of various stakeholders;
- To define the need for LTC-related information for administration, coordination, quality improvement, and cost containment;
- To establish outcome measures for public and private programs and actions; and
- To agree on criteria for program evaluation and modification.

A comprehensive LTC policy would focus on current and future demand for services and would promote coordination, innovation, economy, and the pub-

Potential Components of a LTC Policy

- Personal and public values;
- Private, public, and individual roles and responsibilities;
- Public information and education about life-long health and aging;
- Provision of formal and informal care;
- Training and support for formal and informal caregivers;
- An infrastructure of LTC systems to provide social and health services;
- Income security and LTC financing;
- Current and future technology;
- Research, data collection, and strategic analysis; and
- Quality assurance designed to satisfy care recipients, caregivers, and payers.

Based on *Towards an International Consensus on Policy for Long-Term Care of the Aging*, World Health Organization and the Milbank Memorial Fund, 2000.

lic-private sharing of responsibility for meeting the needs of functionally impaired older Kansans. The formation of the Task Force on Long-Term Care Services last year by the Legislature could be a significant step toward developing a LTC policy for Kansas.

Part 1 of this Forum Brief described the current LTC delivery and financing system in Kansas and highlighted the demographic changes that will affect the system in the coming decades. Part 2 of the brief will outline the critical challenges facing Kansas in addressing the future of LTC using a format suggested by the National Governors' Association.⁵ The challenges are: 1) building on the informal delivery system and personal responsibility, 2) expanding home and community-based services, 3) coordinating and integrating services, 4) using public funds in strategic ways, 5) addressing concerns about quality, and 6) policy planning and public-private partnerships.

Building on the Informal Delivery System and Personal Responsibility

The informal delivery system allows elders to age-in-place and contributes to controlling the costs of formal long-term care. Public support for families and communities might

encourage them to expand the provision and financing of services. Individuals who accept the responsibility for financing their future LTC needs or who reduce their need for LTC services by adopting healthy lifestyles contribute positively to restraining future public LTC expenditures.

Family and friends care for almost two-thirds of elderly individuals with functional impairments who live in their communities.⁶ This network of informal caregivers has declined somewhat in recent years due to economic and demographic changes in society. For example, the population today is highly mobile, with many adult children living and working in communities located at considerable distances from their parents.

Even when adult children and parents live in the same community, the informal LTC delivery system may be insufficient. The need for two incomes in many households means that daughters and daughters-in-law — the traditional informal caregivers — are no longer available to provide care to elderly relatives. The distance between elders and their family and friends in some rural areas also may present impediments to the timely provision of informal LTC services.

Informal caregiving for aging relatives has its financial and personal costs. Informal caregivers incur actual costs



(for medicines, supplies, lost time from work) and opportunity costs (for diminished time available for leisure, other family, and community activities). Caring for a parent or a spouse can be exhausting and stressful and may lead to depression and other behavioral and physical problems among caregivers. Medical advances have expanded longevity, increasing the amount of time required for some elders' care. Alzheimer's disease, for example, can span up to 20 years of a person's life.

The ability of families and friends to provide LTC services in the home may be prolonged by purchasing certain professional services from home health agencies, using respite care*, and modifying the home (for example, installing entry ramps and remodeling bathrooms for grab-bars and elevated toilet seats).

Extended life expectancy (a woman who has attained the age of 75 may expect to live 13.4 more years) has created new challenges for family caregivers. It is becoming more common to find adult children in their seventies providing care for parents in their nineties.

Personal responsibility

Former Surgeon General C. Everett Koop once observed that most of the nation's problems could be attributed to three factors, alone or in combination: racism, greed, and failure to accept personal responsibility.⁷ In LTC, as in many other areas of health, personal responsibility plays a key role. Toward the end of their lives, for example, most people will require assistance with various routine activities. In accepting personal responsibility, prudent individuals might take steps in advance to help finance the cost of the help they will need in the future. One option for financing future care might be to purchase long-term care insurance. Although LTC insurance may be prohibitively expensive when purchased later in

* Respite care (e.g., adult day care or short stays in nursing facilities) provides a temporary break from the responsibilities of caregiving.

life, it is less expensive when purchased early and allowed to grow over time. The cost of LTC insurance purchased at age 79 is approximately ten times greater than the cost if purchased at age 55.

Unless protected by a non-forfeiture clause, LTC insurance policies must be kept in force until claims are made against them. If premium payments lapse and the policy is cancelled, all benefits are forfeited, regardless of the amount of time subscribers held the policy or the amount of money they spent for it. People who select the option of purchasing LTC insurance, therefore, must be able to pay the premiums for the policies from the time they are first purchased until LTC is needed.

People are also personally responsible for their life-style choices. Poor life-styles (obesity, lack of exercise, and smoking, for example) will likely result in more rapid declines of functional ability. Wide-spread health promotion and disease prevention programs and adoption of more healthful life-styles may reduce the number and intensity of LTC services sought by elders in the future.

Options

Steps that might be taken to build upon the foundation of the informal LTC delivery system include:

- *Providing support (e.g., training, counseling, respite services) for family members and other informal caregivers to improve their effectiveness and to extend the amount of time they render care.* One federal effort is the Older Americans Act of 2000 that established the National Family Caregiver Support Program. This new program calls for states, working in partnership with Area Agencies on Aging and local community-service providers, to offer services to informal caregivers in five areas: information about services, assistance obtaining services, individual counseling, respite care, and supplemental services. Because funds have only recently been

released to states by the federal Administration on Aging, it is too soon to judge the impact of this program on family caregivers.

At least 15 states developed state funded caregiver support programs in advance of the federal initiative.⁸ For example, the State of Pennsylvania provides assistance to more than 6,000 informal caregivers annually through its Family Caregiver Support Program. The program, administered by the state Department of Aging, provides up to \$200 per month in respite and chore services and a lifetime maximum of \$2,000 for home modifications. The program also provides caregiver training and counseling and provides assessments of both caregivers and care recipients.⁹

- *Offering tax credits for the costs of informal care delivery, including home modifications that encourage aging in place.*
- *Encouraging, requiring, or providing incentives to employers to recognize the contribution informal caregivers make to the community as a whole.* Care provided to the elderly by family and friends reduces Medicaid and Medicare expenditures. Reductions in Medicaid and Medicare not only help control the need for state and federal tax-based revenues, but by reducing the need to subsidize unprofitable payers (i.e., cost-shifting), they help control commercial health insurance premiums. Employers may support informal caregivers by giving them time off to take elderly people to doctors' appointments and to provide care for short periods of time for minor acute illnesses that may be treated in the home.
- *Standardizing LTC insurance benefits.* Approximately 40 insurance firms currently are licensed to sell LTC insurance in Kansas. Benefits offered and the prices charged vary widely. For example, some policies cover only



nursing facility care, while others cover nursing facility and home health agency services. Some require a prior hospitalization to trigger benefits and others do not. Some waive payment of premiums if an insured is admitted to a nursing facility and others continue to collect premiums. Elimination periods (the number of days following admission to a nursing facility before the policy starts paying) vary among plans. Finally, plans vary on whether they include inflation protection and non-forfeiture of benefits. Standardizing LTC insurance would make comparisons among plans somewhat easier for those purchasing these products.

- *Providing incentives for younger individuals and/or employers to purchase LTC insurance.* To encourage people to purchase LTC insurance, some states (California, Connecticut, Indiana, and New York) allow a person who has exhausted LTC insurance benefits to become eligible for Medicaid without requiring the person to deplete his or her assets. Approximately one-half of the states provide tax credits or tax deductions to stimulate purchase of LTC insurance policies — Kansas does not.¹⁰ A limited number of employers nationally offer long-term care insurance to their employees and retirees.¹¹
- *Allowing Kansans who own their homes to use reverse mortgages to fund their LTC needs.* Texas amended its constitution in 1999 to allow homeowners to borrow from the equity on their homes and arrange to receive fixed monthly installments. Reverse mortgages permit elder homeowners to remain in their homes when their only reason for giving them up would be the cost of community-based services.¹²
- *Encouraging public and private programs that provide medical and social support to the elderly poor* as a means of improving their health and functional ability. For example, providing prescription drugs and transportation

services may reduce acute and chronic illnesses requiring hospital or nursing facility care and increase functional independence, leading to smaller expenditures of health dollars.

Expanding Home and Community-Based Services

Home and community-based services aim to improve the lives of seniors by maintaining their involvement in social and family life. A unique provider in the spectrum of LTC services, home and community-based services fill the niche between informal and institutional care.

In the past ten years, the proportion of elderly persons admitted to nursing facilities has declined as the number of elderly persons consuming LTC community-based and home services has increased.

“Home and community-based services” is used in this Forum Brief to describe a variety of formal LTC services that are not provided in institutional settings. These include, but are not limited to, services provided under the Medicaid Home and Community-Based Services Waiver for the Frail Elderly (HCBS-FE). Examples of home and community-based services include adult day care, case management, Meals-on-Wheels, assisted living centers and boarding care homes.

Originally considered by many as a less costly alternative to nursing facility care, home and community-based services are now viewed widely as critical components in promoting improved quality of life for seniors. LTC and social service providers currently believe that the elderly should remain in the community as long as possible, maintaining their involvement in social and family life, and that care in institutional settings should be used as a last resort or as a temporary measure. The array of public and privately financed home and community-based services, therefore, is not aimed at keeping elderly persons out of nursing facilities, but at keeping them in the community.

Supportive housing arrangements, such as assisted living facilities, have sprouted up throughout the state. They provide an option for elders who can no longer live in their homes but whose conditions do not warrant admission to a nursing facility. Assisted living facilities and other forms of supportive housing offer moderate assistance with activities of daily living. To encourage the development of supportive housing options for elders, the Nebraska Department of Health and Human Services administers a state grant program that helps nursing homes convert some of their beds into assisted living facilities.¹³

Some policy makers are concerned that home and community-based services will not reduce current nursing facility use and that once payment for services is available, informal caregivers will stop providing care. This situation would increase the total LTC expenses of the state. This build-it-and-they-will-come school of thought may well be justified. However, policy makers in some states have controlled use of home and community-based services by improving program management, instituting, for example, assessment tools and case management programs, discussed more fully in the section below on case management.

Home and community-based services have become a distinct provider in the spectrum of LTC services, located between informal care and institutional care on a scale of intensity. With a broad range of LTC services of varying intensities available to seniors, a primary challenge in managing their care is to match their functional and medical needs to the appropriate level of care.

Rural elders' access to home and community-based services

Some home and community-based services are not available to rural seniors in certain areas of the state. Providers typically do not offer services in rural areas if the services are unprofitable and cannot be cross-subsidized by other, more profitable, lines of business.



Home health care services provide an example of service delivery issues in rural areas. Prior to 1997, a network of home health agencies served rural Kansas. Medicare paid home health agencies on the basis of reasonable cost. Because Medicare provided 36 percent of all home health revenues, agencies were highly sensitive to changes in payment policy. The Balanced Budget Act of 1997 created a prospective payment system for home health agencies. A fixed-rate system intended to reward efficiency, the Medicare prospective payment system allows providers to keep the difference between fixed payments and their costs. However, if costs exceed fixed payments, the provider of services must absorb the difference. The fixed rates were established using national averages for economically and efficiently operated home health agencies. The costs of operating home health agencies in some rural areas are greater than those of urban areas or more populated rural areas. Travel among clients, bundling of services, intensity of services, and the lack of social supports contribute to the cost differential. In many rural areas, the fixed rate system transformed a service that had been essentially break-even into an unprofitable enterprise. Within months of the change in Medicare payments, rural home health agencies began to close and urban agencies that had served rural clients cut back their service areas, due largely to the lower payments. Access to home health care in some rural areas was compromised because of the unintended consequences of a change in Medicare payment methodology.

The lack of services in rural areas to transport elderly individuals from their homes to community-based LTC services may limit the effectiveness of existing services. Some community-based services, such as Meals-on-Wheels and home care, do not require senior citizens to leave their homes, but many community-based services are provided in congregate settings or require clients to visit centrally located offices.

Community-based services in rural areas also may be limited by the lack of

staff and expertise. In some rural communities, the staff of a particular community-based LTC service may consist of only one person. When the position is vacant, no one is available to provide the service. If the position is filled with a person who does not have adequate experience, the program suffers until sufficient expertise is gained.

Case management of home and community-based services

Many elders and their families need help to negotiate the LTC system. This support most typically would come from a trained case manager. Case managers help seniors arrange for and coordinate needed services. A critical link in the quality improvement process, they help ensure that needed services are provided in appropriate settings and that clients receive neither too many nor too few services. To be as effective as possible, community case managers must receive proper training and support.

The Kansas Department on Aging provides case management services under three different programs. Case management services paid by Medicaid under the Home and Community-Based Services Waiver for the Frail Elderly (HCBS/FE) are provided by Area Agencies on Aging. A much smaller program, State General Fund Case Management, targets services to clients with incomes of less than 150 percent of poverty. A smaller-still case management program is provided under the Older Americans Act, which requires no financial eligibility criteria. Whether these three programs have sufficient capacity to satisfy the needs of the growing elderly population is a question to be considered by policymakers.

Options

Improvements in the availability and management of home and community-based LTC services will likely contribute positively to the health and well-being of elderly Kansans. Possible programmatic expansions include:

- *Continuing to fund home and com-*

munity-based services through Medicaid as a recognized LTC service provider.

- *Encouraging private insurers to cover home and community-based services.*
- *Improving integration of home and community-based services through the use of local case management.* Public spending to increase the capacity of local case managers might pay dividends in terms of reduced nursing facility and acute-care costs.

Coordinating and Integrating Services

The LTC delivery system is composed of several different providers and various levels of service intensity and funding. Elderly individuals navigate this complex, fragmented system according to their specific needs. Greater service coordination and integration of providers and payers might improve the efficiency and quality of the LTC system.

In the previous section, the idea of improving the coordination of home and community-based services was introduced. In this section, the notion of improving coordination and integration is extended to the entire range of health and social services provided to elders. A goal of the LTC system is to provide required medical, social, and environmental support services that enable persons to maximize their functional independence. This broad goal cuts across organizational boundaries. LTC is not the exclusive responsibility of a hospital, a nursing home, or a senior center. It is their shared responsibility. Unfortunately, little communication about clients or patients that might affect their care is shared among the institutions and organizations that provide services to seniors.

Unlike the acute, hospital-based, system of care, which is short-term and episodic, people who use LTC services tend to use them continuously over longer periods of time. Because the elderly individual navigates the LTC system according to his or her specific needs, the individual should



be the focus of LTC coordination and integration efforts.

Once again, the responsibility for coordination may fall to a trained case manager. Success in coordination requires that certain institutional systems be integrated. For example, it is necessary that case managers be able to track the movements of clients through the system. The method of identifying where clients are in the system may be either manual or electronic, but it requires a degree of systematization and a willingness of all LTC providers to share information. It is key to the success of care that providers share information about diagnosis/assessments, treatment/intervention, and outcomes. The contribution (or failure) of one component of the system may affect the judgments and actions of another part.

The Program of All-Inclusive Care for the Elderly (PACE) provides one option for coordinating and integrating LTC services. The Kansas Medicaid Program will implement its first PACE site in fiscal year 2002.

Limited initially to Sedgwick County, PACE is a form of managed care in which the provider of services accepts a fixed per-enrollee-per-month payment and accepts the risk of providing all covered services to an enrolled population. For example, PACE providers are responsible for providing care and for assuming the costs of care whether the care is provided in a hospital, a nursing facility, or at home. To manage their risk, PACE providers try to keep elderly enrollees as healthy and mobile as possible to reduce expenditures for expensive acute and sub-acute services.

Whether PACE will prove to be a model that can be successfully implemented across Kansas remains to be seen. PACE requires a network of providers ranging from community services through nursing facilities, hospitals, and doctors. Because services are provided on a negotiated pre-paid rate, PACE providers must also be able to manage and accept risk. The infrastructure for facilitating the introduction of PACE may not exist in some areas of the state. Many sparsely populated rural

areas of Kansas will be unable to implement PACE using solely local resources. It also is possible that urban PACE providers will not reach out to rural areas, because the infrastructure needed to develop managed long-term care (e.g., establishing a provider network, enrolling seniors, marketing) is more costly in rural areas than in urban areas. Because of these additional costs, managed long-term care companies and the Medicaid program may be reluctant to spread PACE to rural areas.

Although greater collaboration and information integration among LTC providers are crucial to improving the quality and reducing the cost of LTC services, exactly what data is to be integrated and who will do it are far from certain. Among the questions to be considered are:

- Whose responsibility is it to monitor the client as he or she navigates the LTC system? —The state? The primary care provider? A local case manager? A case manager employed by a managed long-term care company?
- What types of information are needed and how should they be collected?
- How can medical information and non-medical information about clients be integrated and how can confidentiality be preserved?
- Should long-term care be subject to guidelines and protocols or is each case unique?

Program of All-Inclusive Care for the Elderly (PACE)

Nationally, PACE became a permanent provider of comprehensive medical and LTC services to the elderly under Medicare and a state option under Medicaid with the passage of the Balanced Budget Act of 1997.

Under PACE, medical and LTC services are provided according to a managed care model. PACE providers enroll elderly persons who are certified as eligible for nursing home care.

PACE providers offer all items and services covered by Medicare and Medicaid and all additional items (such as community-based services) specified in the federal regulations. These services may be offered by the PACE provider organization itself using its own interdisciplinary team, or services may be provided under contract with other entities, such as hospitals and home health agencies.

PACE providers will receive fixed per-enrollee-per-month payments (or capitation) from Medicare and Medicaid to provide covered services to enrollees. Capitation levels are required to be less than those which would have been paid for a comparable population not enrolled in PACE. Services are provided to enrollees without any limitations or conditions concerning their amount or duration. Deductibles, co-payments, coinsurance, or other cost-sharing that might otherwise apply under Medicare or Medicaid rules are waived for enrollees.

State-level coordination of LTC services

Kansas is among a small number of states that have attempted to consolidate aging and LTC services for the elderly at the state level. In 1997, the Legislature transferred the Medicaid nursing facility and home and community-based programs for the elderly from the Department of Social and Rehabilitation Services to the Department on Aging. However, until recently, state payment systems for services provided to LTC clients did not “talk” to one another and it was difficult to make client-specific queries or to make



summary reports across systems. Introduction of the Kansas Aging Management Information System (KAMIS) at the Department on Aging in 2000 should improve data coordination.

Despite state-level improvements to coordinate LTC services, other improvements still can be made. For example, state agencies involved with aging and LTC issues do not have established routines for discussing topics of mutual interest. Several state departments and agencies are involved with LTC issues. They include, among others, the Department on Aging, the Department of Health and Environment, the Department of Social and Rehabilitation Services, the Department of Insurance, the Department of Administration, the Department of Commerce and Housing, the State Long-Term Care Ombudsman, and the Office of the Governor. Better communication among state-level departments, agencies, and offices might reduce duplication of effort, resolve conflicts, and improve efficiency of state programs for the elderly. Because the Task Force on Long-Term Care Services is a focal point for those with an interest in LTC issues, it, or a sub-set of its members, might constitute the basis for a future interagency LTC policy group.

Using Public Funds in Strategic Ways

Future demand for LTC services will place great strains on the state budget (especially on Medicaid) unless creative steps are taken to control expenditures. The role that options like private LTC insurance will play in potentially offsetting public expenditures is not clear at the present time.

Under any scenario of the future, it is likely that the public costs for LTC will continue to swell due to the increase in the number of elderly. A major public policy concern will be how to control public expenditures for LTC services at the same time that the well-being and functional abilities of elder Kansans are maximized. Using public funds in strategic ways requires an understanding of the inter-

relationship of the various parts of the LTC continuum and the trade-offs that exist among them. For example:

- Greater public spending on home and community-based services may reduce the number of future expenditures for more expensive acute and nursing home expenditures.
- Total public and private expenditures for LTC services may increase when LTC insurance is more widely purchased, because lowering the price for LTC users may encourage greater use of services.
- Establishing tax credits for purchasing LTC insurance may reduce revenues in the short term but may reduce public expenditures for LTC in the long term.
- Improving access to needed drugs and therapies in the home may help reduce the use of medical and social services overall.
- Increasing nursing facility admission criteria for Medicaid may place greater burdens on home and community-based services, requiring them to become more resource-intensive (and therefore, more expensive), or it may increase the need for and intensity of acute services.

The LTC system will continue to change as new techniques and philosophies of care and new funding mechanisms are employed. Any LTC strategy using public funds will need to be flexible enough to adapt to these changes. Periodically, future policy makers will need to assess whether the payment systems in use fairly compensate providers and create the proper system incentives. These assessments may use anecdotes to illustrate certain points, but decision-making should rely heavily on data-driven research findings.

Options

Obviously, the Legislature will revisit public funding of LTC services every year. The decisions of how much and where to spend will likely change over time. Among the currently visible LTC

financing options are:

- *Developing incentives to increase private purchases of long-term care insurance.*
- *Providing consumer education on LTC financing choices, including LTC insurance and personal savings.*
- *Providing public information on the importance of health promotion and disease prevention as a strategy to reduce future health problems and disability.*
- *Encouraging client assessment and case management to help reduce duplication and unnecessary use of services and to promote the efficiency of the LTC system.*
- *Providing incentives, possibly through payment systems, that encourage LTC providers to improve efficiency and/or quality.*
- *Designing delivery and financing options, such as PACE, which limit the expenditure of public money and encourage third-party managers to improve the functional ability of enrolled seniors as a condition of their profitability.* PACE is one managed care model; Arizona has created another, a Medicaid-only mandatory managed care system targeted at Medicaid-eligible seniors. Called the Arizona Long-Term Care System (ALTCS), the program integrates LTC and acute services paid by Medicaid. ALTCS differs from PACE in two ways. First, enrolled seniors do not have to be dually eligible for Medicare and Medicaid to receive benefits. The program only requires Medicaid eligibility. Second, enrollment in the PACE program is voluntary; ALTCS enrollment is mandatory.¹⁴

Addressing Concerns about Quality
Current LTC quality improvement systems tend to focus on location and services rather than the impact of services on individuals as they navigate the LTC system. New quality measures and reporting systems are needed to help individuals, providers, and



What is Quality?

- Quality is the safe delivery of appropriate health care services in which the benefits to the patient equal or outweigh the risks of treatment.

Source: Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services, *Rural Health Dictionary of Terms, Acronyms and Organizations*, 1997, p.55.

- Quality of care is a measure of the degree to which delivered health services meet established professional standards and judgments of value to the consumer. Quality is frequently described as having three dimensions: quality of input resources (certification and/or training of providers); quality of the process of service delivery (the use of appropriate procedures for a given condition); and quality of outcome of service use (actual improvement in condition or reduction of harmful effects).

Source: The Alpha Center, *Glossary of Terms Commonly used in Health Care*, 1994, p. 22-23.

payers better assess the quality of services rendered.

Throughout this Forum Brief, concerns about quality of services have not been far from the surface.

To the extent possible, vulnerable elders using the LTC system should be protected from errors and abuse. The quality of LTC services rendered not only affects the health of elders, but it is also a financial issue. Poor quality increases costs for providers and payers when it leads to a higher level of care than otherwise would have been necessary or when the consumption of additional resources at the same level of care is necessary to correct a problem caused by poor quality. More serious lapses in quality of care may result in fines or lawsuits.

Quality improvement begins with quality measurement. Unfortunately, few methods are available for system-wide quality measurement in LTC. Most quality measures in LTC are highly specific to place and service, for example, nursing facilities or home health agencies. Generally, quality is measured in these organizations by

the absence of adverse events, such as decubitus ulcers (bedsores) or patient falls. Quality of care is considered only within the context of the services they provide. For example, neither a hospital nor a nursing facility would assess outcomes for patients discharged from their facilities to the care of a home health agency.

Few quality measurement systems have client/patient-focused measures that follow the person through the LTC system and measure the impact of services on well-being, quality of life, func-

tional independence, and satisfaction of individuals receiving services. These are the true hallmarks of quality among the community of people needing LTC services. New measures of quality and reporting systems must be designed to help providers and those who pay for the services make better assessments of the quality of care rendered.¹⁵

Complying with quality assurance regulations can be costly. A balance between LTC rules and the burdens placed upon providers should be sought. The potential outcome of regulations should be weighed against the costs to providers of achieving the outcome: small potential benefits should not have large costs. One method of improving quality assurance systems may be to include providers in their development to the extent possible.

One measure of quality is that people receive services when and where they are needed. As mentioned previously in this Forum Brief, elders living in some rural areas do not have access to some LTC services. The lack of access is a fundamental quality issue. The fairness

of a system may be questioned when quality is distributed unequally throughout a state, whether by geography or by the personal characteristics of potential consumers.

Quality-workforce connection

A key determinant of quality of care is the character of the LTC workforce: are there sufficient numbers of workers to provide services and are they adequately trained? The increased demand in the future for LTC services also will result in an increased demand for LTC workers. Whether that demand for workers can be satisfied will rely on several economic, social, educational, and demographic factors. The current shortage of certified nurse assistants (CNAs) in Kansas — the most frequently employed LTC occupation — is approximately 11 percent. In other words, more than one in ten budgeted CNA positions is vacant. In comparison, the vacancy rate for staff nurses in hospitals in 2000 was 6.1 percent.¹⁶

There is also a cost dimension to the connection between workforce and quality. LTC providers dedicate a good deal of time to educating and training new employees. If the rate of turnover among LTC workers could be reduced, the productivity of the system would improve. The current turnover rate among CNAs in Kansas is over 100 percent annually. As a result, countless “unproductive” hours are spent training and retraining employees.

Options

The State of Kansas ensures quality of LTC services through professional and facility licensure, unannounced inspections of nursing facilities and supportive housing options it licenses, and the investigation of complaints. Because the settings and service vary, quality assurance and improvement in home and community-based care is more difficult than in nursing facilities. To improve the quality of LTC services provided, policy makers might consider:

- *Supporting the development of home and community-based quality assur-*



ance/quality improvement techniques in the private sector.

- Encouraging the Kansas research community to investigate methods of measuring client-specific outcomes across sites of care.
- Including LTC providers and other stakeholders in the determination of quality assurance regulations before the public comment period.

Policy Planning and Public-Private Partnerships

Creation of a public policy for LTC in Kansas will require a coordinated effort by individuals, families, communities, employers, educators, LTC service providers, and state and local policy makers. All have a stake in the problem, and all can contribute to the solution. The future demands on the long-term care system of Kansas can-

not be satisfied by the private sector alone, nor can they be satisfied by the public sector alone. Cooperation — a true public-private partnership with shared accountability — is needed to confront this emerging issue.

The future cannot be foretold with absolute certainty, but we do know that the demand for services will increase over the next 50 years, with large spikes in demand occurring as soon as 2015.¹⁷ What we do not know is how many and what configuration of LTC services will be needed; what constellation of services will be available to offer high-quality, cost-effective care; and whether adequate public resources will be available to fund LTC services for those who cannot afford to pay.

In anticipation of the growth in demand for LTC services, it would be prudent to

engage in an open discussion of the goals of the LTC system, how the goals might be achieved (given what is known today), and how responsibility and accountability should be shared among the stakeholders.

As our vision of the future becomes clearer and as we learn from our experiences and the experiences of others, we can begin to implement plans based upon our shared LTC policy goals and monitor progress to make certain that goals are met. Public discussion of LTC issues should be revisited periodically to ensure that policies do not have unintended consequences and verify that the underlying assumptions upon which the LTC policy is based have not changed.

The contents of this brief are solely the responsibility of the authors and do not necessarily represent the views of the funding organizations.

Endnotes

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² Congressional Budget Office. *CBO Memorandum: Projections of Expenditures for Long-Term Care Services for the Elderly*. Washington, D.C., 1999.

³ Congressional Budget Office.

⁴ The estimate of future Medicaid expenses in Kansas was calculated as follows. Actual Medicaid nursing facility and Home and Community-Based Waiver expenses for FY 2000 (\$318.5 million) were multiplied by CBO's population-based estimate of increases in expense plus 1 (i.e., 1.68). The resulting product of this calculation was multiplied by the future value of \$1 at a three percent rate of growth compounded over 20 years (i.e., 1.8061). The product of this calculation includes both population growth and increases in the unit cost of services due to inflation.

⁵ National Governors' Association, Center for Best Practices, Health Policy Division. *Challenges and Opportunities for states in providing Long-Term Care for the Elderly*. Washington, D.C.: National Governors' Association, 2000.

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⁸ Family Caregiver Alliance, *Survey of Fifteen States' Caregiver Support Programs: Final Report*, San Francisco, CA: Family Caregiver Alliance, 1999

⁹ National Conference of State Legislatures, Forum for State Health Policy Leadership. *Frequently Asked Questions... Long-Term Care*. Washington, D.C.: National Conference of State Legislatures, 2000.

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¹³ National Governors' Association.

¹⁴ National Governors' Association.

¹⁵ Kane, R.A. and R.L. Kane. Long-Term Care: Variations on a Quality Assurance Theme. *Inquiry* 25:132-146, 1988.

¹⁶ Kansas Hospital Association.

¹⁷ While the population of the United States is aging, the health status of older Americans also has steadily improved. The Congressional Budget Office (1999) estimates that disability prevalence among the U.S. population age 65 and older declined by 1.5 percent per year from 1989 to 1994.