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policy
brief

The Future of Medicaid Long-term
Care Services in Pennsylvania:
A Wake-up Call

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INTRODUCTION

This policy paper establishes the urgent need to reshape how Pennsylvania provides long-term care for older residents through Medicaid. It explains how demographics, demand, cost shifting to the public sector, and management issues are combining to place rapidly growing financial strains on Medicaid’s ability to fund long-term care.

After providing general background on the Medicaid program, the paper discusses in detail each of the major factors contributing to this impending fiscal crisis.

Demographically, Pennsylvania is well ahead of the national curve in experiencing the economic pressure of an aging population. According to the 2010 U.S. Census, it has the fourth-largest percentage of residents age 65 and older (behind Florida, West Virginia, and Maine). According to the U.S. Census Bureau, Pennsylvania’s population as a whole grew by 3.4 percent between 2000 and 2010 whereas the number of Pennsylvanians age 85 and older grew by 28.7 percent during the same time period.

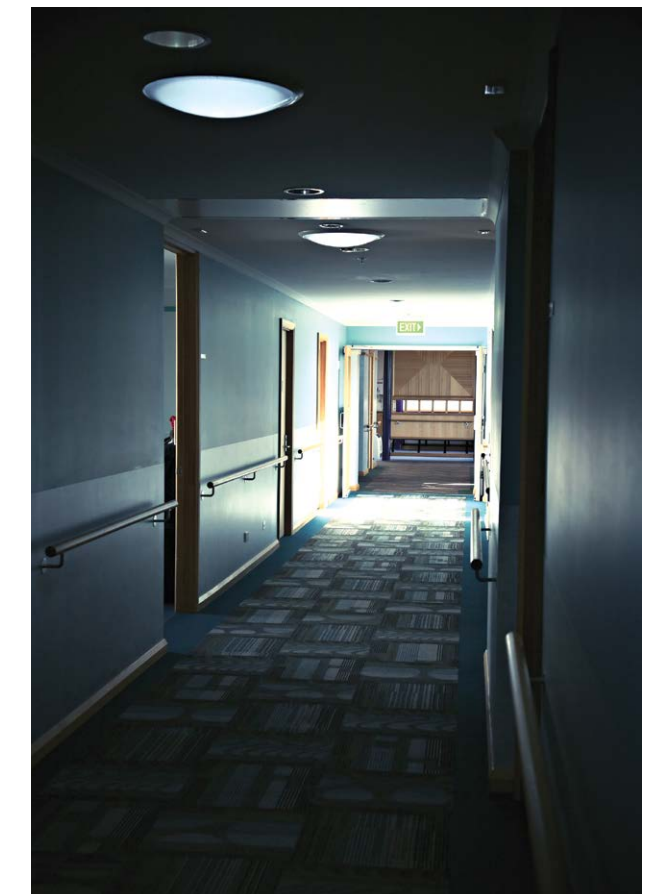
The **demand** for long-term care services is growing significantly as our aging population grows in number. Nearly 70 percent of people reaching age 65 in 2012 are expected to need long-term care services at some point—for an average of three years. The increase in the number of older Pennsylvanians alone would cause Medicaid long-term care costs to increase by 24 percent in the next 13 years even if no other factors were exacerbating the problem.

But there are other factors, of which the most significant is **cost shifting to the public sector**. Most older Pennsylvanians will exhaust their savings in less than a year if required to pay for a room in a nursing home (which in Pennsylvania currently costs an average of \$91,652 annually for a semiprivate room and \$99,280 annually for a private room)¹ and will have to depend on public funding. Already Medicaid shoulders 65 percent of the total cost of nursing home care in Pennsylvania. The economic recession is depleting older Pennsylvanians’ savings, further reducing the amount that they will be able to pay for long-term care, and only 40 out of 1,000 Pennsylvanians who are 40 or older own any kind of long-term care insurance.²

Patient management issues add to Pennsylvania’s Medicaid long-term care fiscal burden as well. Pennsylvania’s long-term care system is fragmented and poorly coordinated, causing many people to land in the most expensive and least desirable setting—a skilled nursing facility—unnecessarily. Even after adjusting for Pennsylvania’s aging demographics, the state spends 22 percent more than the national average on nursing

care and 8 percent less than the national average on home- and community-based services. Moreover, a Pennsylvania Department of Public Welfare (DPW) review of hospital admissions for people using long-term care services found that 30 percent of the hospitalizations were unnecessary. In short, we are spending public dollars in ways that do not improve patient outcomes.

Chapter 3 of this report discusses the improvements in access, quality of care, and cost control that have resulted from the implementation of Medicaid managed care in 28 Pennsylvania counties. It then introduces an opportunity for Pennsylvania to address systemic problems related to care for “dual eligibles”—that is, recipients who are eligible for coverage under both Medicare and Medicaid. The lack of coordination between



these two programs has created perverse incentives that do not enhance either cost savings or quality of care; however, the federal Centers for Medicare & Medicaid Services (CMS) have invited states to participate in a capitated demonstration project under which managed care organizations would receive combined Medicare/Medicaid payments to provide seamless service to dual eligibles. As of this writing, DPW has not decided whether to pursue this opportunity.

Chapter 4 of this report addresses areas in which Pennsylvania could improve the quality of its long-term services, often with little or no added expense (and, in some cases, probably reducing costs). Topics addressed in Chapter 4 include efforts to keep older persons living in their home settings rather than in nursing facilities, reducing unnecessary hospitalizations, hospice and palliative care, greater use of advance planning directives, reconsideration of staffing arrangements, improved communication between patients and providers and among providers, more appropriate medication use, infection control, and mental health issues.



Pennsylvania should redesign its publicly funded long-term care delivery system to (1) prepare for the demographic explosion of older Pennsylvanians needing long-term care; (2) improve and coordinate that care; and (3), whenever possible, serve people where they prefer to be served, generally in their homes, at a cost significantly less than nursing facility care. Chapter 5 presents a series of detailed recommendations that could help the state to achieve these goals. These recommendations are:

1. Establish an advisory committee, with direct access to top leadership in DPW and the governor's office, to guide the development, implementation, and operations of Medicaid long-term managed care and of the redesign of publicly funded long-term care in general.
2. Seek CMS approval to contract with managed care organizations for the management and delivery of Medicaid-funded long-term care in Pennsylvania.
3. Pursue participation in the capitated demonstration program for dual eligibles proposed by CMS.

4. In any requests for managed care proposals that DPW solicits in accordance with recommendations 2 and 3, require specific evidence-based quality-of-care measures and consumer protections as contract requirements.
5. Have Area Agencies on Aging target services to older Pennsylvanians not eligible for Medicaid who are at risk of nursing home placement and who might ultimately become dependent on Medicaid after depleting their own resources.
6. While working toward implementation of managed long-term care, expand the availability of home- and community-based services across Pennsylvania and expand programs to help long-term care recipients receive care in the community first, reserving nursing home placement for those who cannot be cared for in their communities.
7. Implement an expedited Medical Assistance eligibility and care planning process for people not already on Medicaid but who may be able to avoid placement in a nursing facility through the delivery of appropriate home- and community-based services.



8. Develop educational programs to support consumer choice of long-term care settings and, to promote the benefits of advance care planning, use of advance directives such as the Pennsylvania Orders for Life-sustaining Treatment form, hospice, and palliative care.
9. Maximize grant opportunities to improve the long-term care system. Relevant grant opportunities include the following:
 - The Medicaid health (medical) home state plan option
 - Money Follows the Person Rebalancing Demonstration Program grants, which include development and provision of adequate, affordable, accessible housing
 - The State Balancing Incentive Payments Program
 - Community transformation grants
10. Pursue potential quality and coordination improvements (described in detail in Chapter 4 of this report) throughout the long-term care system. No statutory or regulatory changes are required for care providers to undertake such improvements; in some cases, state policy could encourage their implementation through regulatory mandates, incentives, or a published rating system.

Finally, an approach for initial, voluntary pilot implementation of long-term Medicaid managed care is proposed.

The recommendations in this report have been endorsed by an advisory committee composed of a wide range of well-informed stakeholders engaged in health care policymaking. These stakeholders' ability to reach consensus in support of the recommendations reflects both their potential effectiveness and their political feasibility. The University of Pittsburgh Institute of Politics will communicate with state legislators and representatives of the executive branch and will hold educational forums to encourage prompt action on these recommendations so as to both save public funds and provide better, more appropriate care for older Pennsylvanians. ■

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CHAPTER 1: BACKGROUND ON MEDICAID

This opening chapter provides general background information on how Medicaid operates (nationally and in Pennsylvania) and how the program delivers long-term care services.

Medicaid’s Structure and Scope

Medicaid is an entitlement program funded by federal and state governments. Created through a 1965 amendment to Title 19 of the Social Security Act of 1935, it is governed by Title 42 of the Code of Federal Regulations, under which the states are required to cover a set of mandatory services for qualified individuals. The federal government provides matching funds to complement state expenditures. Federal oversight comes through the Centers for Medicare & Medicaid Services (CMS). In Pennsylvania, the Medicaid program is generally referred to as Medical Assistance.

Medicaid is the nation’s largest public health insurance program, serving approximately 70 million individuals in 2011.³ At the young end of the life spectrum, Medicaid finances more than 40 percent of all births in the United States; at the opposite end, it is the primary payer for two-thirds of the nation’s nursing home residents.⁴

Those covered fall into five main categories: (1) children, (2) the elderly and people with disabilities, (3) adults in families with children, (4) pregnant women, and (5) women with breast or cervical cancer. Federal law has established minimum income requirements for eligibility governing each of these groups, as described below.⁵ States are allowed to set more generous limits.

Children in their first year of life must be covered by Medicaid if their families are below 185 percent of the federal poverty level (FPL). At ages 1–6, the maximum permissible income for Medicaid eligibility is 133 percent of FPL; at ages 6–19, it is 100 percent. Children who have been adopted or are receiving foster care are eligible regardless of income level. (Children without other health insurance can receive free coverage through the Children’s Health Insurance Program, or CHIP, if their family income is 200 percent of FPL or less.) Pennsylvania follows the minimum income requirements for children covered by Medical Assistance. Pennsylvania makes CHIP available for children in families with incomes of up to 300 percent of FPL.

The elderly and people with disabilities who are under age 65 may receive Medicaid if they are eligible for Supplemental Security Income. States must grant Medicaid coverage to people in these two groups if their income is less than 76 percent of FPL and if they have assets of less than \$2,000. Pennsylvania’s

income limits are more generous than the mandated minimum, covering the elderly and people with disabilities with incomes of up to 100 percent of FPL. Those persons age 60 and older who qualify for home- and community-based waiver services can have incomes up to 300 percent of FPL.

Adults in families with children must be covered if their family income is less than the income level governing eligibility for Aid to Families with Dependent Children in 1996. Pennsylvania covers adults with children in families with incomes of up to 36 percent of FPL, or the mandated minimum.

Pregnant women are covered if their incomes are less than 185 percent of FPL. Pennsylvania follows this standard.

Women with breast cancer or cervical cancer are eligible for Medicaid if their income is less than 250 percent of FPL. Pennsylvania follows this standard.

The Patient Protection and Affordable Care Act (PPACA) makes all persons under age 65, except certain immigrants, Medicaid eligible as of 2014 if their incomes are less than 133 percent of FPL (138 percent after allowable income deductions).⁶ This change is expected to increase the number of Medicaid participants in Pennsylvania from the current 2.3 million (18.1 percent of the population) to about 3 million.

The elderly and people with disabilities represent less than one-quarter of all Medicaid beneficiaries but account for 70 percent of Medicaid expenditures. On average, as of 2010, states paid \$138 per day for a Medicaid recipient who required long-term care.

Financially, Medicaid is a federal-state partnership: The federal government provides matching funds in proportion to state expenditures, contributing a percentage that can vary from state to state depending on per capita income and specific coverage factors. In 2010, the federal government covered 65.4 percent of Pennsylvania’s Medicaid spending, compared to an average of 67.7 percent of Medicaid spending nationwide.⁷ In 2014, the federal government will pay 100 percent of the costs for people newly eligible for Medicaid under PPACA; this payment will be gradually reduced to 90 percent after three years unless CMS deems Pennsylvania to be an “expansion state,” in which case the state will receive “equitable support.” Under the recent U.S. Supreme Court decision, states may decide if they want to expand their Medicaid programs or keep the present eligibility level.

State Administration and Discretion

Each state is responsible for administering the Medicaid program for its citizens and can establish rules for eligibility, benefits, and provider payments as long as these rules fall within federal guidelines. Following are some of the most significant areas of state discretion with regard to Medicaid and how Pennsylvania currently addresses them.

- **Whether to participate at all:** In theory, a state could decline to be part of the Medicaid program, but currently all 50 states participate.
- **Whether to provide optional services:** Medicaid includes 30 optional programs, such as personal care, prescription drugs, hospice, eye care, dental care, and prosthetic devices. States can choose whether to participate in any of these programs; participation leads to greater cost for the state but also to additional federal matching funds. Pennsylvania currently participates in 24 of the 30 optional programs.
- **Cost-sharing requirements:** Medicaid permits states to impose nominal cost-sharing requirements on beneficiaries in some cases. Pennsylvania has established copayments of \$3–21 per day for inpatient hospitalization and \$0.65–7.60 for office visits, outpatient services, and prescriptions.
- **Whether services will be provided on a managed care or fee-for-service basis:** Pennsylvania has applied three models in its Medicaid program. Most Medical Assistance beneficiaries in Pennsylvania receive services through a managed care organization as part of the state’s HealthChoices Program, while some receive care on a fee-for-service basis. Additionally, a separate managed care system provides services to Medicaid recipients with behavioral health needs. In those counties not covered by HealthChoices, Pennsylvania has implemented the ACCESS Plus program, through which most Medicaid recipients select or are assigned to a primary care provider who is paid a monthly premium to manage his or her patients’ care. Pennsylvania’s Department of Public Welfare (DPW) announced in April 2012 that most recipients in all 67 counties will be required to participate in HealthChoices.
- **Setting of payment rates to providers contracted on a fee-for-service basis:** Pennsylvania’s payments to physicians who treat Medicaid patients are below the national median except for obstetric care. While these rates apply directly only to fee-for-service contracts, managed care organizations use them as a guide when setting capitated grant levels for participating providers.

While states maintain some discretion as to how they will deliver the statutory benefits guaranteed under federal law, their delivery of services must meet the following criteria, except where a relevant waiver is granted:

- **Compatibility:** The provisions established for delivery of a Medicaid-funded service may not vary among individual beneficiaries; what is offered to one Medicaid enrollee must be offered to all enrollees. (Home- and community-based waiver services may offer additional coverage exclusively for enrollees in those waiver programs.)
- **Nondiscrimination:** States are precluded from limiting coverage for any particular service solely on the basis of diagnosis, type of illness, or condition. (Some waiver programs are directed specifically to people with certain conditions; in those cases, the condition becomes a requirement for eligibility.)
- **Statewide coverage:** States may not offer different mandatory or optional benefits to different geographic regions of the state. (Waiver programs may be offered to specified portions of a state.)

Medicaid and the State Budget

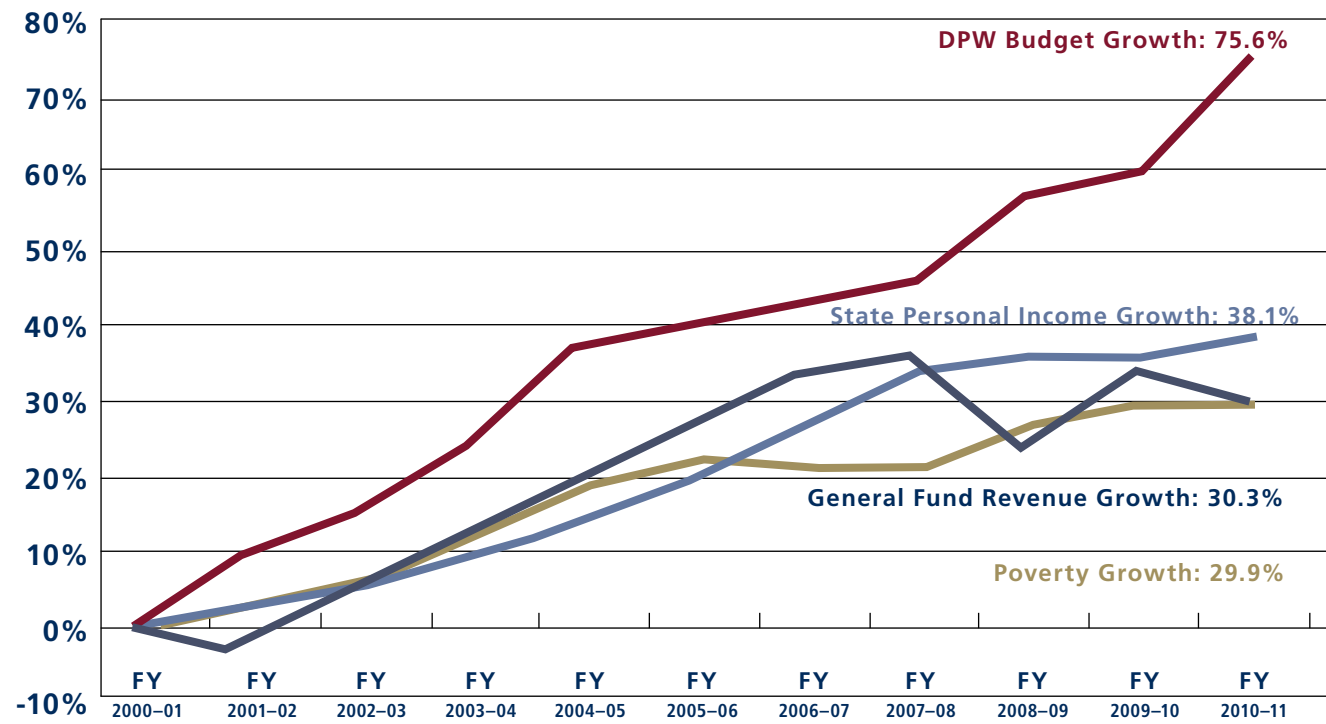
Medicaid’s impact on government finances has been increasing over the past several decades, and its costs are expected to continue to rise. Medicaid’s share of Pennsylvania’s general budget has risen from 24 percent in 1980 to more than 30 percent in fiscal year 2010–11 (see chart on page 8). According to Secretary of Public Welfare Gary Alexander, Medicaid makes up a larger portion of Pennsylvania’s budget than that of any other state except Missouri.⁸

Pennsylvania’s Medicaid population has increased at an annual rate of 11 percent since the program’s inception, even while the state’s total population has remained stagnant. Pennsylvania currently has the country’s fourth-largest elderly population, and 85-year-olds are its fastest-growing cohort, suggesting that the program will continue to become more costly to operate in the future.⁹

Waivers

The U.S. secretary of health and human services may permit states to use federal Medicaid funds in a way that otherwise would not be allowed under federal law. The waivers can be comprehensive, allowing states to make significant alterations in eligibility, benefit, cost-sharing, or provider payment provisions; there also are more narrowly drawn waivers that focus on specific populations and services. Currently, all 50 states have at least one waiver program; Pennsylvania has 10 waivers in operation, two of which are closed to new entrants.¹⁰

Growth Rates of State Government Funds, State Personal Income, Poverty, and State Public Welfare Spending in Pennsylvania



Note: Percentages denote the total increase relative to fiscal year (FY) 2000–01 as of each year. Source: Pennsylvania Department of Public Welfare 2012–13 proposed budget, February 2012

Long-term Care

The phrase “long-term care” refers to a broad range of services and supports provided to people who need assistance for more than 90 days, including those with chronic illnesses or a variety of disabilities. People with the most serious ongoing medical conditions generally receive care in skilled nursing facilities, while those with lesser needs frequently reside in less costly intermediate care centers or may receive care in their own homes. Personal care homes and assisted living residences are not considered providers of long-term care.

The assessment process used to determine eligibility for long-term care begins with a physician’s recommendation as to whether the patient is nursing facility clinically eligible (NFCE). If a patient deemed to be NFCE meets financial guidelines for Medicaid, the local area agency on aging becomes involved in the assessment to determine the safest, most appropriate, and cost-effective location of long-term care—i.e., whether

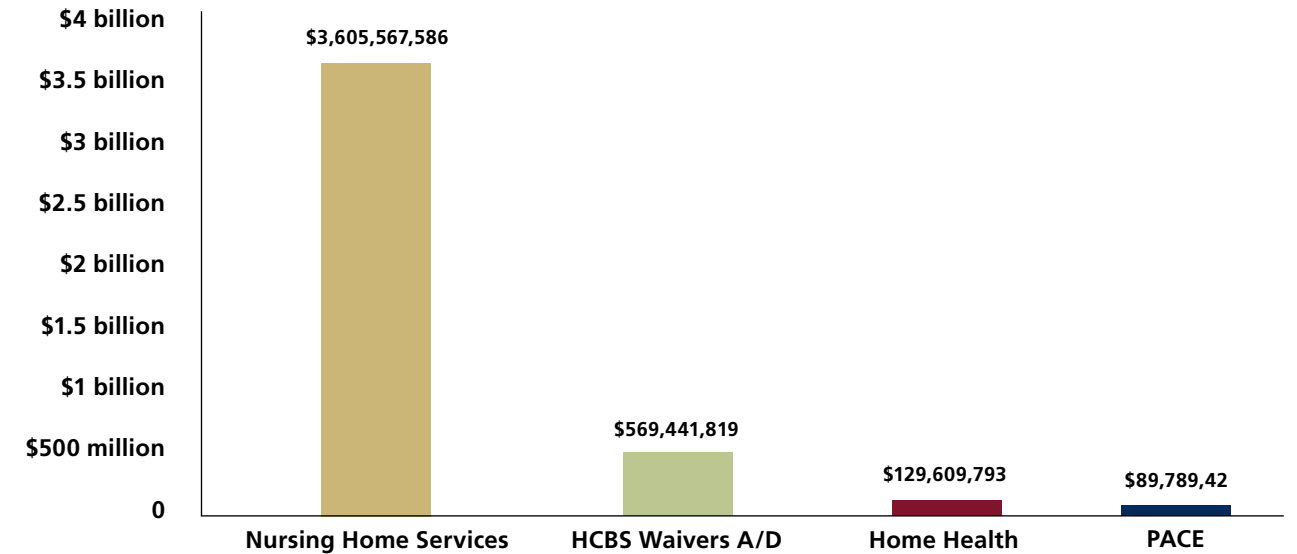
the patient should enter a nursing facility or receive home- and community-based services.¹

As of 2010, 82 percent of the paid long-term care provided in Pennsylvania was delivered by nursing homes, and two-thirds of all nursing home residents were covered by Medicaid. Because of the extremely high cost of nursing facility care and the fact that relatively few Americans purchase long-term care insurance, many people who enter nursing homes quickly spend down their assets and become dependent on Medicaid.¹¹ (See chart on top of page 9.)

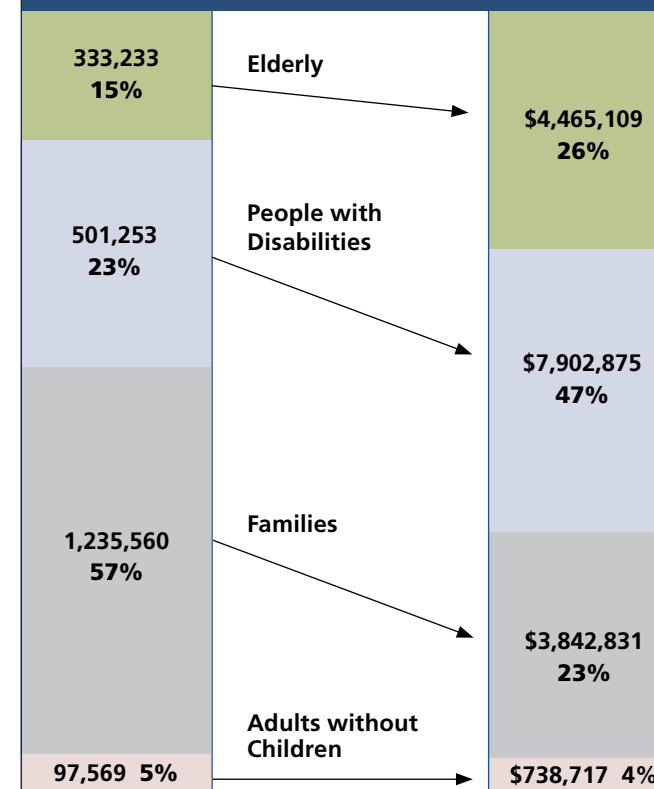
As can be seen from the chart at right (from DPW’s 2012–13 budget proposal), the elderly and people with disabilities consume a disproportionately large share of Medicaid costs.

¹ For Allegheny County’s description of the Level of Care Assessment, see www.alleghenycounty.us/WorkArea/DownloadAsset.aspx?id=35099.

Medicaid Expenditures: Institutional vs. Community-based Care



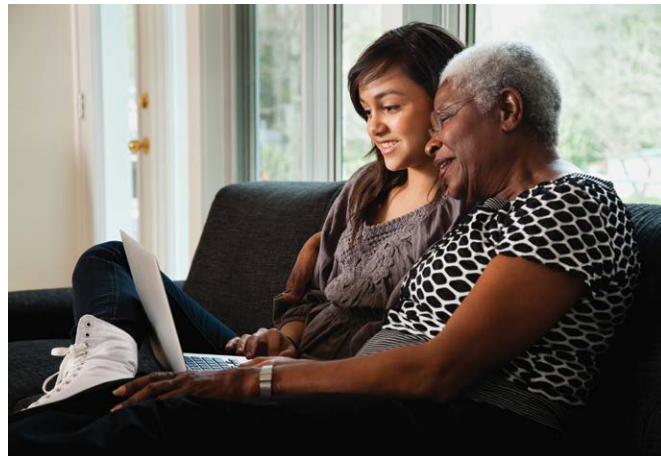
Categories of Pennsylvania Medicaid Recipients by Percentage of Population and Percentage of Expenditures (in Thousands of Dollars)



Most long-term care services are provided by immediate family members; nationally, more than 10 million Americans have family caregivers. As we will discuss further in the chapter on Medicaid financing, long-term care has shifted in the last decade toward increasing reliance on home- and community-based services. At the same time, however, the growing prevalence of two-income families has made it more difficult for many families to provide home-based care for elderly parents.

Medicaid also covers long-term care services provided outside an institutional setting. Three components of home health services are mandatory elements of the Medicaid program: (1) part-time nursing services; (2) home health aides; and (3) medical supplies, equipment, and appliances suitable for use in the home. In addition, Pennsylvania has elected to provide other services, such as respite care, home modifications, adult day care, and financial management, to further extend Medicaid coverage for noninstitutional delivery of long-term care. Moreover, personal care services enable individuals with long-term care needs to maintain their independence and remain in the community. Also, the Program of All-inclusive Care for the Elderly provides a wide range of additional supports to manage care for the frail elderly. (This program is referred to by the acronym PACE in most states but is called LIFE, or Living Independently for Elders, in Pennsylvania because the term PACE had previously been used for a state prescription drug program.) Under this program, services such as case management, adult day care, meals, nutritional counseling, and recreational opportunities can be provided to people who,

without these supports, would require nursing home care. The services are furnished through contractual arrangements, similar to managed care, under which the programs receive a set fee per patient and are responsible for covering the costs of care. As a result, LIFE programs have an incentive to help patients remain in their own homes as long as possible. These programs have proved to be a successful model, as only 7 percent of the enrollees in these programs are living in a medical facility.¹²



Both Medicare and Medicaid contribute funding to LIFE. Eighty-two such programs operate in 29 states; Pennsylvania leads the country with 17 programs.¹³ Though highly effective, LIFE by itself cannot be a primary statewide long-term care solution because of the relatively limited number of consumers able and willing to travel to LIFE centers for medical and social services. As of 2008, of the 20,531 older Pennsylvanians receiving home- and community-based services (HCBS), only 2,198 were enrolled in LIFE.

The Deficit Reduction Act of 2005 established a new option for states to offer HCBS under the Medicaid program.¹⁴ States can now offer through the regular Medicaid program some of the HCBS that were previously permitted only by waiver, and they do not have to demonstrate that the costs would be less than in an institution or that the recipients meet the eligibility criteria for admission to a nursing home. A state may limit the number of persons to be enrolled in this HCBS program. States also may allow consumers or their authorized representatives to direct or control the amount, duration, scope, provider, and location of services. While the program need not be offered everywhere in the state, all beneficiaries must be offered the same package of services. To date, Pennsylvania has not taken advantage of this option offered by the Deficit Reduction Act.

State-County Partnership in Aging Services

While DPW is Pennsylvania's designated state agency for Medicaid, the Office of Long-Term Living administers long-term care programs for adults age 60 and older. Responsibilities for program delivery are shared with the state's 52 Area Agencies on Aging, or AAAs, each of which serves one or more counties. AAAs assess eligibility for services, enroll consumers in HCBS programs, and offer counseling in cases in which residents of nursing facilities may be able to move back into home or community settings. As a result, AAAs are important stakeholders in any discussions regarding the restructuring of long-term care for the elderly.

The Special Challenges Posed by "Dual Eligibles"

Approximately 400,000 Pennsylvanians qualify for Medicare and also have incomes and assets low enough to make them eligible for Medicaid. These low-income seniors and younger persons with disabilities are the poorest, sickest, and most expensive groups covered by either Medicaid or Medicare. These beneficiaries have to navigate both programs, relying on Medicaid to pay for their Medicare premiums, cost sharing, long-term care, and other critical benefits that Medicare does not cover. Meanwhile, they must rely on Medicare to pay for physician care, hospitalization, prescription drugs, home health care, and other benefits.

These "dual eligibles" (i.e., persons receiving both Medicaid and Medicare) constitute only 18 percent of Pennsylvania's Medicaid enrollees, but they represent 43 percent of Pennsylvania's total Medicaid spending, mostly for long-term care. As of 2008, the Pennsylvania Medical Assistance program spent on average \$20,138 a year per dual eligible.

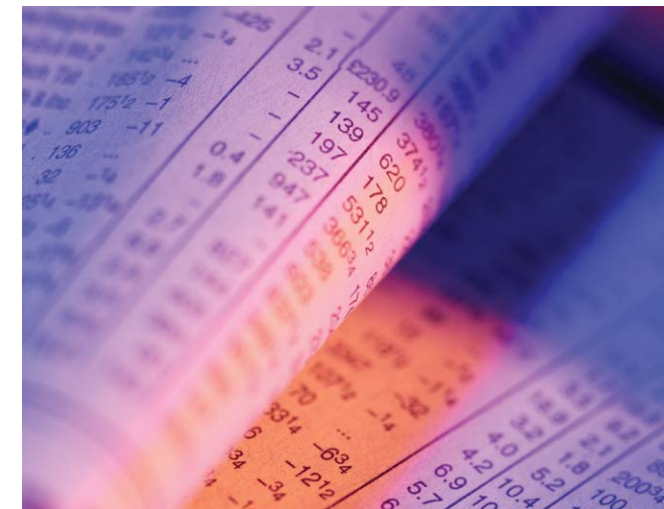
Nationally, 70 percent of Medicaid spending is for long-term care. Because the current design of Medicare and Medicaid leaves neither program fully responsible for dual eligibles, the care delivered often is fragmented and expensive. (The only exception has been the LIFE program, described above, in which payments are merged and care is managed by a single entity.) As dual eligibles represent such a large portion of total Pennsylvania Medicaid costs, it will be difficult to reduce overall expenditures significantly without addressing this problem of disjointed management of the care that dual eligibles receive. ■

CHAPTER 2: THE FISCAL CHALLENGES FACING MEDICAID LONG-TERM CARE SERVICES

From a financial perspective, Medicaid long-term care programs face a very uncertain future. Program expansions, inability to restrain increases in the cost of care, the sluggish economy, and the rapid growth in the U.S. elderly population have combined for continued ballooning of Medicaid expenditures.

Medicaid Generally

Nationally, on average, 57.7 million persons were enrolled in Medicaid during 2010. Total Medicaid expenditures for 2009 were \$373.9 billion, or more than \$6,000 per enrollee. This total cost represented a 9.9 percent increase from the previous year, driven substantially by the economic downturn, which contributed to a 6.5 percent increase in the number of Medicaid participants. From December 2007 to June 2010, Medicaid costs increased by almost 18 percent, or 7 percent per year—more than twice the overall rate of inflation.¹⁵



Counting federal contributions, Medicaid represented 20 percent of total state expenditures during 2010. State expenditures then grew by another 11.2 percent in 2011, leaving at least 31 states experiencing significant gaps between revenues and Medicaid spending.¹⁶ Thirty-one percent of the total state budget for Pennsylvania is currently spent on Medical Assistance, although more than half of that money comes from federal matching funds.¹⁷

States cannot change the federally established rules that determine who is eligible for Medicaid, so cost containment cannot be achieved by excluding recipients. States are currently

further limited by the maintenance-of-effort requirement in the Patient Protection and Affordable Care Act that prohibits states from changing their Medicaid eligibility or benefit rules until 2014. States can eliminate or reduce optional Medicaid benefits that they currently provide, but it is always hard for a state government to remove benefits that its citizens are accustomed to receiving. Moreover, the federal-state matching structure of Medicaid funding provides an incentive for states to participate as fully as possible, as, due to the additional federal money drawn down, the benefit to a state's residents of participating in an optional Medicaid program always exceeds the direct cost to the state.

Some states have taken other steps to control costs, such as freezing or even reducing payments to providers or implementing strategies to control prescription use. For example, Pennsylvania currently limits most adult Medicaid enrollees to six prescriptions per month and has placed limits on adult dental care. The State of Washington has indicated that, as of 2012, it will not pay for emergency room services in cases in which the needed care could have been delivered in a less expensive way.¹⁸

Pennsylvania is facing considerable budgetary strain resulting from the Medicaid cost spiral. Between July 2007 and November 2010, the Pennsylvania Medicaid rolls added more than 250,000 persons, jumping to a total of more than 2.1 million. Other than Blue Cross Blue Shield and its affiliates, Medicaid is Pennsylvania's largest insurer, with 68,000 providers participating in its system.

The percentage of residents enrolled in Medicaid varies widely across Pennsylvania's counties, from 31.5 percent in Philadelphia County to 6.4 percent in Chester County. It is particularly high in rural counties with relatively hard-to-reach populations.

Pennsylvania's federal medical assistance percentage for fiscal year 2012, or the portion of total Medicaid costs covered by the federal government, is 55.07 percent. For 2011–12, the state reduced its Medicaid budget by 1 percent from the previous year's expenditures and stopped dedicating tobacco settlement funds to Medicaid.¹⁹

Long-term Care

Long-term care has become an enormous and still-growing portion of Medicaid spending. Of the \$264 billion that the United States spent on long-term care in 2008, Medicaid paid about 42 percent and Medicare 25 percent. These percentages contradict the widespread assumption that Medicare, the nation's primary health care program for older Americans, also covers the lion's share of long-term care expenses. As of 2007, long-term care accounted for one-third of all Medicaid spending.



The burden on Medicaid would be even worse if not for the national shift from nursing facility care toward less expensive alternatives in the last decade. Since 1999, the number of Medicaid beneficiaries receiving home- and community-based services (HCBS) has grown by more than 1 million people nationally, while the number of nursing home residents has stayed roughly steady. In 1995, 19 percent of all Medicaid long-term care funds was spent on HCBS; by 2009, that figure had risen to 43 percent. During the eight-year period from 1999 to 2007, Medicaid HCBS spending increased by 95 percent to \$41.8 billion. Overall, Medicaid now finances 43 percent of the nation's spending on nursing homes and 34 percent of all home-based health care.²⁰ Approximately 11 million older Americans receive informal, unpaid home care from family members.

Unfortunately, Pennsylvania has lagged behind national trends in shifting from nursing home care to less expensive alternatives. As of 2011, more than 80,000 Pennsylvanians were residing

in the state's 710 nursing homes at an annual total cost of \$99,280 (for a private room); personal care homes had about 47,000 residents at an average cost of \$39,015 per year.²¹ Only about 21,700 older Pennsylvanians are HCBS recipients.²²

On a per capita basis, Pennsylvania ranks fourth in the country in state funding for home- and community-based care. However, that favorable ranking is largely due to the state's high total elderly population. A Medicaid scorecard, "Raising Expectations" (see www.longtermscorecard.org), produced by the SCAN Foundation, the Commonwealth Fund, and AARP, ranked Pennsylvania a dismal 46th with regard to the support it provides for family caregivers and 39th overall in providing quality Medicaid long-term care services.²³ The scorecard claimed that if Pennsylvania improved its performance to match that of the highest-ranking states, more than 15,000 Medicaid long-term care recipients would receive services in home- or community-based settings rather than in nursing homes.

In its 1999 *Olmstead v. L.C.* decision, the U.S. Supreme Court stated that the Americans with Disabilities Act requires public agencies to provide services to people with disabilities in the most integrated setting possible, appropriate to the needs of the individual. Because most Americans prefer to receive care at home rather than in a nursing home, Pennsylvania's current placement of recipients of long-term care appears to be quite inconsistent with this mandate.

Interestingly, some consumer advocates have viewed managed care as a means to aid implementation of this "most integrated setting" mandate and reduce unnecessary placements in nursing care. A 2003 settlement of a class-action suit (*Newberry et al v. Goetz et al*) in Tennessee, filed by Medicaid long-term care consumers whose only residential option had been nursing homes, committed that state to developing capitated long-term care services.²⁴

Waste and Fraud

In discussions of how to cut government spending, the two distinct but often paired issues of waste and fraud are everyone's favorite punching bags. In the case of federal health programs, waste and fraud are indeed a sizable part of the cost problem. Among the many entities striving to squeeze waste and fraud out of government-funded health care are Medicaid Integrity Contractors, who perform both review and audit functions, and Recovery Audit Contractors, who seek to recover identified overpayments.

Of course, if knocking waste out of such a complex system was easy, it would have happened long ago. The Centers for Medicare & Medicaid Services (CMS) estimated that Medicare and Medicaid combined to make \$70 billion in improper payments—representing 8 percent of total program



expenditures—in fiscal year 2010. Donald Berwick, who served as CMS administrator for 17 months in 2010–11, estimated that 20–30 percent of health care spending is wasteful and provides no benefit to patients.²⁵

The U.S. Government Accountability Office has identified controlling Medicare and Medicaid fraud as a top priority, dividing the task of preventing and detecting improper payments into five categories: provider enrollment, prepayment claims review, postpayment claims review, contractor oversight, and addressing identified vulnerabilities.

Congress offered a financial incentive to pursue Medicaid fraud when, as part of the Deficit Reduction Act of 2005, it allowed states to keep up to 10 percent of any federal expenditures recovered as a result of their Medicaid enforcement activity. Federal funding also is available for state fraud control units, which exist in 47 states.

Pennsylvania created its Medicaid fraud unit way back in 1978, but the challenge of spotting fraud or correcting processing errors remains. A U.S. Department of Health and Human Services study found a 4.07 percent error rate in Pennsylvania's processing of Medicaid claims, less than half the national average of 8.98 percent.²⁶ State Auditor General Jack Wagner has asserted, based on his own office's audit, that Pennsylvania's error rate in assessing Medicaid eligibility is at least 10 percent, but the Department of Public Welfare has disputed this figure.

Tracking down fraud is always difficult, and this report makes no attempt to evaluate the quality of Pennsylvania's investigative efforts. However, as the next two chapters seek to document, one does not need a skilled investigator to identify inefficient uses of Medicaid resources. The most substantial misuse of taxpayer money in Medicaid long-term care results when people unnecessarily end up in a nursing facility at public expense or are unnecessarily hospitalized due to the fragmented, inconsistently managed nature of our health care system. ■

CHAPTER 3: SHOULD MEDICAID LONG-TERM CARE MOVE TO A MANAGED CARE MODEL?

One way to sustain both quality and affordability in Pennsylvania's Medicaid long-term care services would be to move more fully toward a managed care model. There is a precedent within the Pennsylvania Medicaid system in that other medical and behavioral health services have shifted from fee for service to managed care over the last 15 years. This option could impact Medicaid's effectiveness generally, and its potential usefulness for one important set of recipients—the dual eligibles, who receive coverage from both Medicaid and Medicare—has been highlighted by a recently established federal demonstration project.

The Precedent

It is commonly assumed that fee-for-service health care gives recipients the widest choice of health care providers and the greatest access to quality care. But this assumption is not always true. In the early 1990s, the fee-for-service nature of Pennsylvania's Medicaid program was actually creating barriers to the availability of quality care:

- **Access:** Because the fees paid by the Pennsylvania Department of Public Welfare (DPW) for Medicaid services were substantially below those paid by any other insurer, health care providers were declining to serve Medicaid patients, making it difficult for recipients to find someone to treat them.
- **Quality of care:** No medical provider had a duty to treat any specific Medicaid patient, and no one was responsible for coordinating care for recipients. As a result, no one was directly accountable for ensuring quality health outcomes.
- **High cost:** Despite the low reimbursement rate for physician services, Medical Assistance costs were high due to recipients' frequent use of emergency rooms and repeated readmissions to hospitals.

In 1997, DPW began to address this issue by moving toward implementation of mandatory managed care for both physical and behavioral health. The goals of the new managed care program, called HealthChoices, were to improve access to and quality of health care services available to Medical Assistance recipients while stabilizing Pennsylvania's Medicaid spending. In 2013, after several phases of program expansion over the intervening 15 years, HealthChoices will cover most recipients in all 67 Pennsylvania counties for the first time.

How HealthChoices Has Met the Goals

Implementation of HealthChoices has enabled DPW to play a stronger role in ensuring improved **access** to health care services. The HealthChoices managed care organizations (MCOs), like all health management organizations in Pennsylvania, are jointly licensed by the state Department of Health and the state Department of Insurance. To obtain a license, MCOs must submit their network provider panels (i.e., their lists of participating physicians) demonstrating adequate access by provider type for the number of enrollees in the plan to the Department of Health. In some cases, Medical Assistance MCOs have had to pay providers higher fees than the prior fee-for-service reimbursement levels in order to assemble a sufficient network. Under fee for service, those providers would simply not have participated in Medical Assistance; in the managed



care system, MCOs are held responsible for ensuring adequate access to physicians throughout the geographic area they serve. Enrollees with disabilities or chronic conditions who are having problems with access to care can contact special needs units in the physical health MCO for assistance.

Quality of care has been improved through a certification process that applies nationally recognized quality measures under the oversight of the National Committee for Quality

Assurance (NCQA). All Medicaid MCOs operating in Pennsylvania have obtained NCQA certification except one that is still completing the process as of this writing. Four Pennsylvania MCOs have been ranked by NCQA among the nation's top 25 Medicaid managed care providers.

Finally, the implementation of managed care appears to have helped to **control Medical Assistance spending**, as documented through two studies funded by participating MCOs and conducted by the Lewin Group. A study conducted in 2005 found a total savings of \$2.7 billion (including \$1.4 billion in reduced cost to Pennsylvania) for the preceding five years. A more recent study on the impact of mandatory managed care in 25 Pennsylvania counties found a savings of \$2.9–3.3 billion in state funds over 11 years in comparison to the cost of providing that care through a fee-for-service system.ⁱⁱ

The Federal Demonstration Project: A Specific Opportunity to Apply MCOs to Dual Eligibles

Where it has required mandatory managed care of Medical Assistance recipients through HealthChoices, DPW has successfully increased access to care, improved the quality of care, and stabilized Medical Assistance spending for non-long-term care services. In many ways, Pennsylvania Medicaid long-term care services today are where general medical and behavioral health services were in 1997 before the advent of managed care. Could a similar shift to managed care achieve similarly positive results in the long-term care sector? Believing that the answer is yes, the federal government has invited states to participate in a demonstration project covering one portion of the long-term care population.

In April 2011, the Centers for Medicare & Medicaid Services (CMS) awarded grants of \$1 million each to 15 states to help them to develop service, delivery, and payment models that would integrate care for dual eligibles. Pennsylvania was not one of those 15 states. However, CMS subsequently invited all states to apply for entry into a demonstration program that would implement capitated arrangements for dual eligibles, with the same three goals of improving access to and quality of long-term care while stabilizing costs.

According to the program announcement, under this capitated approach, CMS, the state Medicaid agency, and the state's MCOs would enter into a three-way contract, the terms of which would grant MCOs a combined Medicare/Medicaid prospective payment to provide comprehensive, seamless coverage for dual eligibles, including long-term care. CMS

ⁱⁱ See www.panco.org/publication_files/an-evaluation-of-medicaid-savings.pdf for the second study, released in May 2011.



and the state Medicaid agency would enter into such a contract with an MCO only if the terms of the contract realized up-front savings. States were invited to submit a demonstration project proposal by April 2, 2012, with the expectation that they would effectuate enrollment of dual eligibles in managed care by January 2013.

The Corbett administration initially advised CMS of its interest in pursuing this option, as did all but 12 states, and the HealthChoices MCOs in Pennsylvania all signed a letter of support for this concept.ⁱⁱⁱ However, DPW was not among the 26 states that submitted an application for the demonstration by the April 2 deadline. The requirement that states be ready to enroll dual eligibles in the program as of January 2013 was widely viewed as a very aggressive timetable. Several states have asked CMS to extend the starting date to 2014, which CMS has agreed to, and some members of Congress have expressed concern about the large number of Medicare beneficiaries in the demonstration, asking that it initially be piloted with a smaller number of beneficiaries. CMS officials have stated that Pennsylvania will have another chance to pursue coordination of care for dual eligibles, although the timing is uncertain at this time.

Many states are adopting managed care approaches to long-term services because of the unsustainability of present long-term care expenditures and because almost all evaluations of existing long-term managed care programs have shown an improvement in quality of care. The three most populous states—California, Texas, and New York—have announced that they will expand managed care to cover all Medicaid beneficiaries. Kentucky, Louisiana, and New Hampshire, all of which previously had negligible participation in managed care, also have decided to turn to Medicaid managed care on a statewide basis. Overall, 19 states have mandatory or voluntary managed long-term care programs in place, and 11 more states are in the process of migrating Medicaid recipients needing long-term care into managed care plans. Pennsylvania thus appears to be lagging behind this emerging policy trend. ■

ⁱⁱⁱ See dualsdemoadvocacy.org for more information on this initiative.

CHAPTER 4: WAYS TO IMPROVE LONG-TERM CARE QUALITY—WITHOUT SPENDING MORE

It is often assumed that reductions in health care spending will inevitably lead to a decline in the quality of health care. But a review of the health care quality literature suggests many areas where we are not getting much for our investment or even where more costly interventions have inferior outcomes. This chapter will present evidence from medical research as to ways in which long-term care could be improved without spending more money—and, in some cases, while saving money.

Use of Home Settings

Nursing homes are not the setting of choice for most Americans. In fact, 30 percent of Americans with chronic illnesses have indicated that they would rather die than enter a nursing home.²⁷ The widespread preference for living at home as long as possible opens up a pathway for serving patient preferences and saving public money at the same time.

As noted in Chapter 2, increased use of home- and community-based services (HCBS) has great promise for reducing costs. In 2011, Pennsylvania ranked 39th in the country with regard to the portion of Medicaid long-term care expenditures going to HCBS. Only 21.9 percent of Pennsylvania’s spending fell into this category, compared to nearly 64 percent in New Mexico, which, out of all the states, has the largest portion of Medicaid long-term care expenditures going to HCBS. Moreover, only 31 percent of new recipients of Medicaid long-term care in Pennsylvania received their first services in the community rather than from an institution, placing Pennsylvania 40th in the national rankings.²⁸ Pennsylvania spends nearly \$12 on institutional care for the elderly for every dollar it spends on HCBS.²⁹

Some fear that increased use of HCBS would result in spending public dollars on families who would have cared for their elderly family member at home even without the public aid (a possible consequence commonly referred to as the woodwork effect). This concern may be true, but many such cases would be needed to outweigh the savings achieved by reducing nursing facility admissions. The average cost of a Pennsylvania Department of Aging HCBS waiver is less than one-quarter of the cost of a year in a nursing home.³⁰

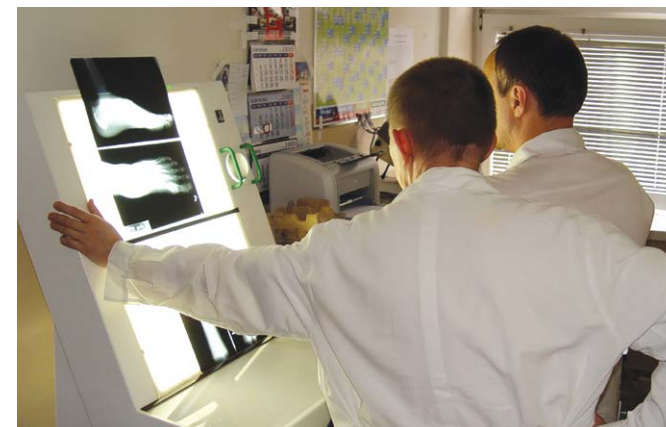
Research suggests that health care providers, patients, and families often lack the training and information necessary to make long-term care placement decisions. Patients and caregivers often indicate little or no knowledge of HCBS and assume that nursing care is their only option.³¹ In Pennsylvania,

Area Agencies on Aging (AAAs) assist older first-day Medicaid recipients (i.e., those immediately eligible for Medicaid) in finding the best care setting, and they often help consumers of long-term care to avoid nursing homes. However, non-first-day Medicaid recipients often do not receive similar consultation assistance when hospitalized, thereby increasing the likelihood that they will end up being placed in nursing homes. Increasing resources available at hospitals to direct Medicaid recipients who require long-term care services to the most appropriate care setting can help to reduce nursing home placements.

Programs that aim to place recipients in settings that provide less acute and less costly care have shown significant success. For example, the Arkansas Community Connector Program uses specially trained community health workers to identify people with unmet long-term care needs who may be at risk of needing nursing care and to connect these people to HCBS. Over a three-year period, Arkansas realized a \$2.6 million savings in three counties through this program.³² An analysis of state HCBS program expansions found that they generally have involved a short-term spending increase but achieve long-term cost savings.³³

Potentially Avoidable Hospitalizations

Because of their complex medical needs, elderly long-term care patients are frequently transferred to acute care hospitals. Obviously some hospital admissions are medically necessary, but many are not. These hospitalizations are not only costly but can increase the risk for a variety of complications, including delirium, polypharmacy (use of multiple medications, which can be risky), disorientation, stress, and pressure ulcers.³⁴



A review of medical records from eight nursing homes found that 40 percent of the hospital admissions were inappropriate, meaning that the resident could have been cared for safely at the skilled nursing facility. Reviewers believed that 21 percent of the inappropriate transfers were attributable to poor quality of care at the skilled nursing facility where the resident had been living.³⁵

Another study concluded that 67 percent of hospitalizations from nursing homes in Georgia were potentially avoidable.³⁶ Among the quality problems at nursing homes leading to these unnecessary hospital admissions are lack of on-site availability of primary care clinicians, inability to obtain timely laboratory tests and intravenous fluids, and difficulty in assessing changes in patient status.³⁷

Interventions to improve monitoring of patients and reduce potentially avoidable hospitalizations are available. For example, a model called Interventions to Reduce Acute Care Transfers (INTERACT II) offers tools and strategies designed to assist nursing homes in early identification, assessment, communications, and documentation of changes in resident status. Implementation of this model in 25 nursing homes resulted in a 17 percent reduction in hospital admissions and an estimated cost savings of \$125,000 per year for a 100-bed nursing home.³⁸ In addition, managed long-term care plans would be likely to provide additional clinical care in nursing homes under contract with them to prevent potentially avoidable hospitalizations.

Similarly, the research literature contains numerous models of primary care delivery improvements. Some of these have been examined through randomized controlled trials that documented substantial improvements in care quality and cost savings through reduction of hospitalizations and nursing home admissions. These patient-centered models focus on coordinating care and integrating treatments for patients and on improving communication between patients and providers.³⁹

Hospice and Palliative Care

The U.S. health care system tends to use extraordinary lifesaving measures even for patients on the brink of death or whose likelihood of survival is very low. Many families have found that hospice services, in which curative treatments are halted while pain and symptoms are managed, provide a more caring and sensitive environment for a terminally ill patient. Studies have found that hospice patients live longer and have much greater quality of life.⁴⁰

The availability of hospice services has been shown to decrease the frequency of hospitalization of nursing home residents. A recent controlled study found that providing a hospice informational visit resulted in higher enrollment in hospice care and fewer hospitalizations.⁴¹ In another study, patients enrolled in hospice were significantly less likely than residents not enrolled in hospice to be hospitalized in the last 30 days of life.⁴² Current payment policy creates an unfortunate disincentive for state Medicaid programs to promote hospice for nursing home residents who are covered by Medicare because Medicare policy does not pay hospice costs for these dual-eligible patients, forcing Medicaid to pick up the tab.⁴³

Palliative care, which focuses on relieving the suffering of patients with advanced illness without stopping curative treatment, also can contribute to both higher quality of life and reduced costs simultaneously. By controlling symptoms, palliative care, whether provided in primary care or through hospital-based programs, can reduce overuse of more expensive but ineffective services and decrease the likelihood of hospital admission.⁴⁴ A 2011 study estimated that the State of New York could reduce its Medicaid hospital spending by \$84–252 million annually if the state’s hospitals made palliative care consultations available to their patients.⁴⁵ In Pennsylvania, only half of the hospitals that are the sole health care provider for their communities have palliative care programs.⁴⁶ Expanding availability of and access to information about palliative care could result in substantial cost savings for Pennsylvania while improving family and patient satisfaction.

Advance Care Planning

A large portion of health care spending occurs fruitlessly at the very end of life, often in ways that the patients themselves would not have wanted. Advance directives, such as the Pennsylvania Orders for Life-sustaining Treatment and do not hospitalize or do not resuscitate orders, provide a legal expression of patient preferences before a medical crisis arises.

The use of advance directives varies across long-term care populations; 65 percent of nursing home residents have expressed their preferences in this way, but only 28 percent of home health care patients have given directives.⁴⁷ When patients and physicians have discussions about the patient’s end-of-life preferences, health care costs during the last week of life are reduced by 35.7 percent; in one study, the savings connected with use of advance directives was estimated at \$5,585 per patient.⁴⁸ Clearly, further promotion of advance care planning could result in significant cost savings without negative impact on quality of care.

Patient-Provider Communication

The quality of communication between patients and health care providers often is deficient in numerous respects. For example, many older adults with multiple chronic health conditions report receiving duplicate tests and procedures, conflicting diagnoses, and contradictory information as well as failure to receive adequate information about potential drug interactions.⁴⁹ Long-term care patients often are taken to hospital emergency rooms with inadequate documentation or even no documentation at all; according to one study, emergency department staff members were aware of a patient’s cognitive impairment issues in only 38 percent of cases.⁵⁰

According to a 2006 study on nursing homes' decisions to hospitalize patients, families' lack of information about end-of-life care and physicians' unfamiliarity with patients (primarily a problem among physicians providing off-hours coverage) were identified as the most significant causes of overhospitalization.⁵¹

Poor communication also can be a problem at the back end of hospital stays. In most cases, a discharge summary from the hospital is not available to the first provider who sees a long-term care patient after his or her discharge. Moreover, hospital discharge summaries often lack important information such as test results, treatments initiated at the hospital, or medications administered.⁵²

Electronic health records (EHRs) can assist health care providers in reducing errors, improving patient safety and quality, and decreasing costs.⁵³ Long-term care facilities have been slower to adopt EHRs compared to hospitals and medical groups, perhaps due to the lack of government financial incentives. However, in a recent study of long-term care facilities that became early EHR adopters, administrators indicated their belief that these systems improved quality of care, were cost-effective, and constituted a positive return on investment.⁵⁴

The main barrier to EHR adoption in long-term care facilities is cost. Long-term care facilities may need partnerships or financial assistance to acquire and implement EHRs.

Staffing

The relationship between nursing home staffing and hospitalization of patients is complex and not always clear. It might seem that nursing facilities with more physicians on staff would need to hospitalize patients less often, but some physicians have indicated that treating patients in the hospital can be more convenient for them (and can provide higher reimbursement rates than if the patient is treated in the nursing home).⁵⁵

On the other hand, there is stronger evidence that the presence of nurse practitioners, physician assistants, or greater nursing staff coverage in nursing facilities is associated with less frequent hospitalization, making these staff members a good investment in both quality of care and cost reduction.⁵⁶

Financial Incentives to Nursing Homes

In some cases, the structure of Medicaid payments to nursing homes provides a perverse incentive for hospitalization. Medicaid has a "bed hold" policy that continues payment to a nursing home when a patient is hospitalized so that a bed is still available for the resident upon his or her return from the hospital. However, if the profit from the bed hold payment is greater than the profit from Medicaid's payment for providing care to the patient, then a perverse incentive is created for

hospitalizing nursing home residents. Another incentive to hospitalize nursing facility residents is that, upon patients' discharge, the nursing facility may be temporarily eligible for Medicare reimbursement, which is greater than Medicaid's payment. Moreover, there is no incentive for state Medicaid systems to help nursing homes to manage patients more effectively and keep them out of the hospital because the savings achieved through reduced hospitalization are credited to the federal Medicare program, not the state Medicaid program.

Participation in the CMS demonstration program for dual eligibles described in Chapter 3 would be one way to remove the perverse financial incentives that promote hospitalization of these patients, as the cost savings achieved could benefit both Medicare and Medicaid.

Infection

Health care-associated infections, or HAIs, are a major problem in the U.S. health care system, accounting for approximately 99,000 deaths each year.⁵⁷ Elderly patients are particularly susceptible to HAIs; in Pennsylvania, the rate of infection for patients 65–84 years old is 15.6 per thousand, or 38 percent more than in the general population.

In Pennsylvania, HAIs are associated with a 15.3-day increase in the average length of a hospital stay and a fivefold increase in mortality. Pennsylvania's Medicaid program pays, on average, \$27,289 more for hospitalization of patients with HAIs.⁵⁸ Given the enormous costs resulting from infections, it is readily apparent that successful infection prevention and control programs can have a substantial return on investment. The Centers for Disease Control and Prevention have estimated that the \$45 billion annual direct cost of HAIs could be reduced by as much as \$31.5 billion through effective prevention and control programs.⁵⁹

Such programs have been implemented successfully in some Pennsylvania nursing homes. Nursing facilities within the state that introduced a lower respiratory tract infection prevention and control program had a 21.5 percent lower rate of infection and a 42 percent lower mortality rate than facilities without such a program.⁶⁰

The Patient Protection and Affordable Care Act (PPACA) now prohibits federal payments to states for Medicaid services related to certain hospital-acquired infections. Another provision of PPACA will reduce Medicare payments for hospital-acquired conditions by 1 percent beginning in 2014. These provisions give hospitals additional incentives for a stronger emphasis on infection control, but nursing facilities also should treat this issue as a high priority.

Medication Issues

Medication usage is a major cost driver in long-term care. The use of medications by elderly patients is enormous if not mind-boggling; approximately 40 percent of all nursing home residents take nine or more medications concurrently.⁶¹

Some of this drug use is unquestionably inappropriate. The increasing use of antipsychotic medications provides a good example. According to one study, about 28 percent of Medicare beneficiaries in nursing homes have a prescription for antipsychotic drugs; of these, less than 42 percent received antipsychotic therapy in accordance with the facility's own prescribing guidelines, 23.4 percent had no indication of the need for antipsychotics, and 17.2 percent had daily doses exceeding the recommended levels.⁶² Another study found that 40 percent of nursing home residents taking antipsychotic medication had no appropriate indication calling for its use.⁶³

Federal regulations require states to conduct drug utilization review activities regarding the Medicaid patient population along with monthly drug regimen reviews for each resident of a long-term care facility. However, in 2006, a provision of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) shifted the burden of drug costs incurred by elderly Medicaid residents from the state/federal Medicaid partnership to the federal government, thereby removing the state's incentive to reduce drug expenditures on its Medicaid patients.⁶⁴

Prior to the existence of the MMA outpatient drug benefit, North Carolina introduced a program that incorporated pharmacist recommendations into drug therapy decisions. Physicians concurred with nearly 60 percent of the pharmacists' recommendations, resulting in an average cost reduction of \$19 per patient per month.⁶⁵

Another review of interventions regarding drug prescription in nursing homes concluded that in "interventions using educational outreach, on-site education given alone or as part of an intervention package and pharmacist medication review under certain circumstances may reduce inappropriate drug use in nursing homes."

Mental Health

Mental health issues are extremely common among the long-term care population; in fact, estimates of the percentage of nursing home residents with a significant mental disorder range from 65 to 91 percent.⁶⁶ While dementia is often the primary cause of an elderly person's admission to a skilled nursing facility, depression is by far the most frequently occurring mental disorder, affecting up to 48 percent of nursing home residents.⁶⁷

Despite the high prevalence of mental illness in this population, most nursing homes have minimal access to trained mental health professionals. One study found that only 20 percent of residents with mental illness received visits from a psychiatrist, clinical psychologist, or licensed clinical social worker.⁶⁸

Where the facility has a special care unit for dementia patients, the probability of hospitalization is decreased. Higher Medicaid payment rates also have been associated with reduced hospitalization, whereas application of a bed-hold policy leads to greater likelihood of hospitalization (largely for the financial incentive reasons discussed earlier).⁶⁹



Federal legislation passed in 1987 requires that nursing homes use a Preadmission Screening Resident Review (PASRR) to identify applicants and residents with mental illness, but this review process has not been implemented effectively. A report by the U.S. Department of Health and Human Services' Office of Inspector General found that less than half of nursing home residents with serious mental illness receive appropriate preadmission screening,⁷⁰ and a 2006 study determined that the PASRR process does not ensure that residents receive proper mental health services.⁷¹

Seizing the Possibilities

This chapter has described numerous changes in health care delivery that could reduce Medicaid long-term care costs without sacrificing quality. Some could be implemented programmatically, while others would require changes in eligibility or reimbursement rules or in allocation of funds (such as for state HCBS waivers). Taken together, however, this collection of options leaves an unmistakable sense that Pennsylvania could do better in delivering Medicaid long-term care than it is doing today. The final chapter of this study presents the top-priority recommendations supported by an advisory committee of leading Pennsylvania health care stakeholders. ■

CHAPTER 5: CONSENSUS RECOMMENDATIONS

Often, changes in public policy are stymied by partisan conflict, but in this case, partisanship is not the problem. Democrats and Republicans may differ as to the amount they are willing to spend, but both parties recognize that health care costs for our growing elderly population cannot increase indefinitely, and everyone wants to control Medicaid long-term care costs while maintaining quality.

Pennsylvania Secretary of Public Welfare Gary Alexander recently proposed the following five priorities for reforming Medicaid long-term care:

1. Improve care integration and care coordination among long-term care facilities, home- and community-based services (HCBS), hospitals, and other settings.
2. Increase transparency of cost and quality data to empower consumer choice. According to the recent “Raising Expectations” report, Pennsylvania ranks high (12th in the nation) on “choice of setting and provider” for long-term care. However, Pennsylvanians have little access to cost and quality information.
3. Streamline the bureaucracy of Medicaid long-term care at the county and state level.
4. Consolidate or reduce the number of waivers. Each waiver has its own criteria for eligibility, and this situation is confusing for consumers.
5. Decrease the number of Medicaid long-term care recipients in nursing homes. Pennsylvania has increased the number of people receiving HCBS, but this has not resulted in decreased nursing home use.

The Institute of Politics Health and Human Services Medicaid Subcommittee agrees with all five of these priorities, and the following recommendations will address all of them to varying degrees.

Because of the attention recently attracted by the federal demonstration program for dual eligibles, the subcommittee also considered two alternative approaches to reducing the fragmentation and lack of coordination of long-term care for this population. These alternatives were as follows:

- Relying exclusively on expansion of the Living Independently for Elders (LIFE) program. As previously noted, one major advantage of LIFE (known as Program of All-inclusive Care for the Elderly [PACE] in other states) is that it combines Medicare and Medicaid funding, making LIFE responsible and financially at risk for all management of care for

dual-eligible patients. It is thus in LIFE’s financial interest to keep patients in their homes as long as possible and to avoid expensive nursing facility care. Although Pennsylvania has more such programs than any other state, they have been slow to evolve and have limited capacity. Some people do not want to have to go to a LIFE center for their meals, bathing, and medical care and would prefer to receive personal care services at home. LIFE centers are not conveniently located for all state residents and have only about 2,200 enrollees statewide. Under mandatory managed care, managed care organizations (MCOs) could contract with LIFE programs for patients who want to receive their care at a LIFE center, usually because of the socialization opportunities available there. An MCO also could contract with LIFE for individual services to enrollees, given LIFE’s excellent record in providing such forms of assistance as weekend care, transportation, and meals. This arrangement could provide a great boost to the use of LIFE programs in Pennsylvania without asking LIFE to shoulder an enormous expansion of its role.

- Pursuing a global waiver. Another possible option would be to ask the federal government for a global, or all-encompassing, waiver to redesign Medicaid in Pennsylvania. However, the terms of such a global waiver might not combine Medicare and Medicaid financing for dual eligibles or result in improved coordination of the care covered by these two programs. For example, a global Medicaid waiver granted to Rhode Island in 2009 eliminated the state’s existing waivers and covered the full continuum of Medicaid-funded services, including long-term and end-of-life care, but did not address the lack of coordination of care or separate funding for the dual eligibles. Thus, it is not certain that a global waiver would address the problems with inefficiency, fragmentation, and inadequate quality of care described in this report. Neither is there a guarantee of up-front savings like that offered by the Centers for Medicare & Medicaid Services (CMS) dual eligible capitated demonstration project. It also would take years to design a global waiver, obtain CMS approval, and implement the new program, whereas the CMS demonstration could start much sooner.

Recommendations

1. **Establish an advisory committee, with high-level access to top Department of Public Welfare (DPW) leadership and the governor’s office, to guide the development, implementation, and operations of Medicaid long-term managed care and of the redesign of publicly funded long-term care in general.** This committee could draw on expertise from all stakeholder groups to ensure prudent program development as well as to proactively prevent fraud and abuse and contribute to ongoing quality improvement.

2. **Seek CMS approval to contract with MCOs for the management and delivery of Medicaid-funded long-term care in Pennsylvania.** Overall, contracting with MCOs to provide all physical, behavioral, and long-term care for Medicaid recipients would offer numerous advantages:

- **Quality and efficiency improvement:** Managed care can improve quality of care and can eliminate inefficiencies and waste by providing:
 - financial incentives for development of electronic health records to allow better coordination of care,
 - visiting clinical staff for nursing home residents to obviate the need for potentially avoidable hospitalization or emergency room visits,
 - greater oversight of medication usage to avoid adverse reactions and use of multiple prescription drugs for the same symptom,
 - better mental health screening and treatment for depression,
 - more hospice and palliative care options to enrollees, and
 - opportunities for advance care planning.
- **Reduction of waivers:** Because MCOs would be responsible for providing all long-term care, the numerous waiver programs would be eliminated, although beneficiaries would remain eligible for all the services that they would have otherwise received through the multiple waivers.
- **Streamlining of Medicaid bureaucracy:** Managed long-term care would eliminate some of the governmental complexity in the present arrangement. MCO management would relieve DPW, Area Agencies on Aging, and county governments of some of the functions with which they are currently burdened. Because MCOs would be contracting directly with nursing facilities, hospitals, and home health agencies for services, DPW’s involvement with the various agencies and institutions also could be reduced.
- **Reduction of reliance on nursing facility care:** For those beneficiaries still living in the community, it would be in MCOs’ financial interest to provide the supports that would make admission to expensive nursing facilities unnecessary.
- **Improvement in behavioral health:** Currently, under state law, physical and behavioral health needs are treated by different institutions. The state should give MCOs the option of providing more fully integrated behavioral health care. If this integration is carried out, the care should be required to meet the same performance standards as are required of the HealthChoices behavioral health plans; if the carveout is used, there should be effective coordination between physical and behavioral health providers.

The committee recognizes widespread concern that implementation of managed care can lead to the prioritization of cost control over patient needs. The following provisions are critical to the appropriate and successful implementation of managed care:

- Adequate protections to ensure that consumer preferences are honored in the delivery of long-term care services. (See Appendix A for a list of potential consumer protections.)
 - Recognition that, no matter where a person receives long-term care services, that location is the person’s home and his or her rights must be respected. See the enumeration of “Rights of Residents in Nursing Facilities” in Appendix B.
 - Protections to ensure that plans do not inappropriately rely on uncompensated family or other natural supports to provide that care.
3. **When the opportunity again becomes available, pursue participation in the capitated demonstration program for dual eligibles, under which CMS and DPW would jointly purchase managed long-term care and share in the up-front savings.** In addition to the advantages offered by managed care generally and enumerated above in Recommendation 2, contracting with MCOs to provide all physical, behavioral, and long-term care for dual eligibles would remove the perverse financial incentives that have resulted from the division of responsibility for these patients between Medicare and Medicaid, such as the following:
 - Currently, if a long-term nursing facility resident covered by Medicaid goes to the hospital, Medicare pays for the hospitalization and Medicaid for the bed hold. Once the patient is discharged to the nursing facility, Medicare pays the nursing facility at a higher rate than the Medicaid rate until such time as Medicaid again becomes responsible for these payments. In contrast, under long-term managed care, the MCO would negotiate payments with the nursing facility and the hospital, and the perverse financial incentive to cycle nursing home residents in and out of the hospital would be eliminated.
 - Combining Medicaid and Medicare funding streams removes the disincentive for Medicaid to promote hospice for dual eligibles. Currently, Medicaid must pay for hospice services for these patients, but in the demonstration program, the cost savings reaped from increased hospice use will be shared.
 - The joint funding of the program will create an incentive for MCOs to reduce drug expenditures. Currently, this incentive does not exist for Medicaid providers serving dual eligibles because drug costs are paid by Medicare.

4. In all requests for proposals from MCOs (whether to serve long-term care recipients generally or as part of the capitated demonstration program for dual eligibles), require specific evidence-based quality-of-care measures as a contract requirement. When HealthChoices, Pennsylvania’s medical assistance managed care program, was first developed, best-practice requirements were included in the request for proposals (RFP), ensuring that HealthChoices providers would deliver excellent care. Best-practice requirements that could be included in long-term managed care RFPs include:

- increasing staffing complements of nurses, nurse practitioners, and physician assistants in long-term care facilities. This support has been linked to decreased hospitalizations from nursing homes, which will reduce government spending. This will be especially important if Pennsylvania moves toward expanding home- and community-based services (HCBS), which will increase the average care needs of patients in long-term care facilities. An MCO could meet this requirement either by providing additional clinical staff support to supplement the staff available at nursing facilities or by contracting with nursing facilities that meet the prescribed staffing levels. Additionally, DPW could facilitate consumer choice of quality long-term care facilities by creating a transparent rating system based on a ratio of clinical staff to patients.
- developing methods and programs to improve communication of clinical information between care settings and during transitions of care. For example, DPW could provide incentives for long-term care facilities to implement electronic health records, which can improve the accurate transfer of information.
- ensuring that important services that support provision of long-term care in the community, such as Meals On Wheels, medical transportation, and respite services, are available.
- developing resources and strategies for making better decisions about hospitalizing long-term care patients, both at long-term care facilities and in hospital emergency departments. For example, geriatricians or geriatric care teams could consult with nursing homes (except in emergency situations) on decisions of whether to hospitalize a patient; in some cases, they could make recommendations on how to provide clinical care without a hospital admission. Also, hospitals could develop geriatric case review systems, which would provide oversight with regard to admissions of the elderly from long-term care facilities. MCOs could fulfill this criterion either by providing their own geriatric review staff and resources or by contracting with hospitals that have geriatric case review systems in place.

- increasing the availability and intensity of mental health services and medication review by pharmacists in long-term care. These steps can prevent excess drug costs; reduce hospitalizations due to polypharmacy, altered mental status, or psychiatric issues; and thereby improve quality of care.
- developing programs for end-of-life planning and promoting advance directives to document patient preferences. Conversations between patients and physicians about end-of-life preferences and the use of advance directives, palliative care, and hospice care are associated with lower costs and higher quality of care.
- expanding programs to prevent infections in long-term care facilities.

5. Should Pennsylvania develop managed care delivery systems for Medicaid long-term care beneficiaries, Area Agencies on Aging (AAAs) will be freed from their prior responsibilities for these patients. AAAs should instead target services to older Pennsylvanians not eligible for Medicaid who are at risk of nursing home placement and who ultimately might become dependent on Medicaid after spending down their own resources. The goal should be to help these persons to avoid having to enter a nursing home if possible, consistent with consumer preferences.

6. While working toward implementation of managed long-term care, expand the availability of HCBS across Pennsylvania and expand programs to help long-term care recipients to receive care in the community first, reserving nursing home placement for the frailest patients. As HCBS are expanded, DPW should assess, given projected demographics, anticipated demand for nursing homes and, where possible, work to reduce the number of nursing home beds. LIFE programs have been especially successful in enabling elders to live independently, and encouraging MCOs to contract with them for services could further expand the service capacity of LIFE programs.

7. Implement an expedited Medical Assistance eligibility determination and care planning process for people not already on Medicaid but who may be able to avoid placement in a nursing facility through the delivery of appropriate HCBS. Currently, the determination process can take several months, during which time the prospective beneficiary’s health status may deteriorate further.

8. Develop educational programs to support consumer choice of long-term care settings and, to promote the benefits of advance care planning, use of advance directives such as the Pennsylvania Orders for Life-sustaining Treatment (POLST) form, hospice, and palliative care. The presence of such programs would contribute to the prevention of nursing home placements, assisting consumers while reducing costs.

9. Maximize grant opportunities to improve the long-term care system, including:

- **The Medicaid health (medical) home state plan option**, which would provide various services to persons with multiple chronic conditions. Forms of assistance covered encompass comprehensive care management; care coordination and health promotion; comprehensive transitional care, including appropriate follow-up, from inpatient to other settings; patient and family support; and referral to community and social support services, if relevant. The grant offers a 90 percent federal match for two years and will pay up to \$25 million in federal funds. It would further the Pennsylvania Medicaid program’s efforts to provide patient-centered medical homes for recipients.
- **Money Follows the Person Rebalancing Demonstration Program** extension and expansion grants, which facilitate moving long-term care recipients into the community and assisting them with housing needs.^{iv} This support would allow Pennsylvania to continue its previous successful efforts. This federal grant program has been funded at \$450 million per year.
- **The State Balancing Incentive Payments Program**, which provides enhanced federal matching funds to states that adopt strategies to increase the proportion of their total Medicaid long-term care spending devoted to HCBS. It also supports implementation of delivery system reforms that will increase consumer accessibility to needed services and supports. States such as Pennsylvania that currently

^{iv} For older Pennsylvanians to receive home- and community-based services in lieu of nursing facility placement, they must have affordable, accessible housing. Medical Assistance pays for housing when a resident is in a nursing home but not in the community. Pennsylvania’s Money Follows the Person project found that elderly people of relatively low economic status often were forced to enter nursing facilities because they could not afford suitable housing. The issue of adequate housing for lower-income persons needing long-term care services is beyond the scope of this study but needs to be addressed separately. Some states have permitted managed care plans to make supplemental housing payments intended to keep enrollees living in a community setting.

devote less than 50 percent of their total Medicaid long-term care expenditures to HCBS are eligible to compete for up to \$3 billion in enhanced matching payments for increased spending in this category.

- **Community transformation grants**, aimed at helping communities to implement projects proven to reduce chronic diseases. Grants focus on tobacco-free living, active living, healthy eating, evidence-based clinical and preventive services, social and emotional wellness, and healthy and safe physical environments. States can receive grants from the federal government of up to \$10 million.

10. Pursue quality and coordination improvements throughout the long-term care system. As shown in Chapter 4 of this report, there is considerable room for improvement in long-term care. No statutory or regulatory changes are required to permit care providers to undertake on their own, with all patients, the quality provisions suggested in Recommendation 4. Where cost is a factor, state policy could encourage improvement through regulatory mandates, incentives, or a published rating system. In addition, Pennsylvania could ask the Office of the National Coordinator for Health Information Technology to include skilled nursing facilities in its purview, thereby creating a federal incentive for nursing facilities to adopt use of electronic health records.



Voluntary Implementation Approach for Long-term Medicaid Managed Care

Pennsylvania could implement long-term Medicaid managed care just as it introduced managed care for physical and behavioral health (known as HealthChoices), starting on a voluntary basis in counties that have the infrastructure and leadership to ensure a successful rollout. In selecting counties to pilot long-term managed care, DPW should look for:

- a county AAA organization eager to expand its function to working more extensively with older residents who do not yet qualify for Medicaid but who need services to help them remain safely in their homes;
- a hospital system that will work collaboratively with the AAA, primary care practices, and the Medical Assistance (MA) HMO on discharge planning to enable older patients to experience safe, seamless transitions from hospital stays to ongoing in-home care, thereby minimizing unnecessary nursing facility placements;
- primary care practices that proactively manage patients who have long-term care needs, using the principles of patient-centered medical homes;
- nursing facilities willing to work with the AAA to transition patients from hospitals to nursing facilities and back to their homes and that will work with MA HMOs to supplement clinical care in their facilities so as to reduce the number of residents requiring acute hospital care; and
- a county support network capable of serving persons with long-term care needs effectively in their homes, including Meals On Wheels, transportation services, and visiting nurses.

DPW should form a local advisory board in each implementing county to provide feedback on implementation, monitor consumer satisfaction, and ensure ongoing program improvement.

This voluntary, gradual rollout process was highly successful in the transition of physical and behavioral health services to mandatory managed care under HealthChoices. It allowed for development of infrastructure in the counties and enabled problems to be addressed while they were still small in scale. It also built trust among providers and consumers as they saw the ways in which mandatory Medicaid managed care was superior to the fee-for-service alternative.

The Time to Act Is Now

If Pennsylvania does not respond soon to the challenges of Medicaid long-term care, the commonwealth will miss a strategic opportunity for systemic improvement and continue to suffer the costs that result from weaknesses in the current program. The policy recommendations contained in this report, if implemented, could both save public funds and provide better, more appropriate care for older Pennsylvanians.

To that end, the University of Pittsburgh Institute of Politics will seek to engage elected officials and key stakeholders through the dissemination of this publication as well as through educational forums. ■

APPENDIX A: POTENTIAL CONSUMER PROTECTION PROVISIONS IN MANAGED LONG-TERM CARE

The following steps might help to ensure that consumers' rights and preferences are protected in any implementation of managed long-term care in Pennsylvania.

- Availability of consumer-directed services.
- Integration or effective coordination of physical and behavioral health services.
- Giving all dual-eligible recipients access to social services and other community supports for the primary care physician and the consumer.
- Administration of consumer satisfaction surveys by an independent entity.
- Ensuring that managed care organizations (MCOs) providing services have a sufficient network of providers with expertise to serve the covered population. Define direct- or related-experience requirements for MCOs applying for acceptance as qualified Special Needs Plans.
- Establishment by the Department of Public Welfare (DPW) of an advisory committee that would help to monitor the development, implementation, and operations of the demonstration program. The committee also would aim to proactively promote continuous quality improvement.
- Establishment by DPW and MCOs of a help line that is staffed at all times and capable of responding immediately to urgent long-term care needs.
- That the MCO contract contains the medical necessity definition in the existing HealthChoices contract, with additional language to cover long-term care services. Where consumers have a disability, services also must be furnished in the most community-integrated setting available and appropriate to the individuals' specific needs.
- That the MCOs will provide rapid-response teams capable of putting immediate long-term care services in place to avoid an unnecessary nursing home placement. These teams also could work with hospitals to assist with discharge planning for patients who might otherwise be steered toward nursing homes. ■

APPENDIX B: RIGHTS OF RESIDENTS IN NURSING FACILITIES

From the Pennsylvania Department of Health, bit.ly/UwpsYR

The right to be informed in writing of your rights and the policies and the procedures of the facility.

The nursing home must have written policies about your rights and responsibilities as a resident. You must sign a statement saying that you have received and understood these rights and the home's rules when you are admitted.

The right to know about services and charges.

You must be informed, in writing, by the home of all services available and the charges for those services.

The right to know about your medical condition.

You must be informed of your medical condition and of any changes.

The right to participate in your plan of care, including the right to refuse treatment.

The nursing home must develop a plan of care for you. You must be given the opportunity to participate in the planning of your care and treatment.

The right to choose your own physician and to use the pharmacy of your choice.

You do not have to use the nursing home's physician or pharmacy.

The right to have your personal and medical records treated as confidential.

Your written consent is needed to release information from your record to anyone who is not authorized by law to see it.

The right to manage your own personal finances.

You can either manage your own funds or authorize someone else to manage them for you. If you authorize the home to handle your funds, you have the right to:

- Know where your funds are and the account number.
- Receive a written accounting every three months.
- Receive a receipt for any funds spent.
- Have access to your funds within seven banking days.

The right to privacy and to be treated with dignity and respect.

The right to privacy takes many forms. You are free to communicate and meet privately with anyone, including family and resident groups. Your mail should arrive unopened, unless you request otherwise. You should be treated with courtesy and privacy for personal needs like bathing and toileting. Curtains should be used when you are being bathed or dressed. Bathroom doors should be closed while bathrooms are in use. No one should enter your room without knocking first.

The right to use your own clothing and possessions.

The amount and kind of possessions depend upon available space and whether other residents' rights would be violated.

The right to be free from mental, physical, and sexual abuse; exploitation; neglect; and involuntary seclusion.

No one may mistreat, threaten, or coerce you in any way.

The right to be free from restraints.

Chemical restraints (drugs) and physical restraints may be used only if ordered by a physician for a limited time in order to protect you or others from injury.

The right to voice a grievance without retaliation.

The nursing home may not take any action against you because you voiced a grievance.

The right not to be transferred or discharged, except for medical reasons, your own welfare or that of another resident, nonpayment, or if the home ceases to operate.

You must be provided with 30 days' advance written notice of the transfer or discharge. The law gives you the right to appeal your discharge or transfer. ■

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