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Elder Law Guys: managed long-term care services becoming a reality

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When meeting with clients and their families, a common theme is the desire to avoid institutional settings (such as nursing homes) as chronic conditions develop. Most folks want to "age in place" — or, as we prefer to say, "age at home," wherever home may be — and avoid radical change in their lifestyles, especially as elderly consumers of long-term care services.

For a variety of reasons, the past several decades have found the majority of Pennsylvanians using facility settings to receive long-term care services. The bottom line is that funds and systems need to be available to keep people in their homes while delivering cost effective long-term care support services.

Since Medicaid (not Medicare) is the primary funding source for long-term care services, the bias toward institutional nursing home settings has continued. Some of the fingerpointing for more cost efficient management of these programs is aimed at government use of taxpayer dollars.

Enter managed long-term services and supports.

The Kaiser Family Foundation identifies long-term services and supports as encompassing "the broad range of paid and unpaid medical and personal care assistance that people may need — for several weeks, month or years — when they experience difficulty completing self-care tasks as a result of aging, chronic illness or disability."

With government-run programs skyrocketing in costs, private management (managed care organizations), under capitated payment arrangements, will now be part of the managing.

Pennsylvania is a newcomer to this game, with about half the states rolling out managed long-term services and supports at this time in various stages of implementation. Our new program

will be called Community Health Choices, a joint effort by the Pennsylvania Department of Human Services and the Pennsylvania Department of Aging.

Community Health Choices will be initiated in various counties throughout Pennsylvania that are contained within five zones. The Southwest zone includes Allegheny County and just happens to be the first zone scheduled to roll out the program beginning Jan. 1, 2017, so things are already happening among several counties to prepare for this transition.

The objectives of the program are to:

1. Enhance opportunities for community-based living for participants;

2. Strengthen coordination of long-term services and supports, physical health and behavioral health;

3. Ensure better coordination between Medicare and Medicaid;

4. Enhance quality and accountability;

5. Advance program innovation;

6. Promote the expansion of team-based approaches to service delivery;

7. Increase consumer access to needed services, especially in rural and underserved areas of the Commonwealth.

The goal is to serve the following participants:

1. Adults age 21 or older who require Medical Assistance (Medicaid) because they need the level of care provided by a nursing facility;

2. Dual eligibles (people who are eligible for both Medicare and Medicaid) age 21 or older whether or not they need or receive long-term services and supports.

The hope is that home and community-based services will become more accessible for those in need, which may provide longer term health prosperity than traditional institutional settings. The concern voiced by critics of managed care is that private industry may sacrifice coverage in an effort to stay profitable, as has been alleged in other states.

Only time will tell, but we are less than a year away from the first of three phases of care transition across the Commonwealth. Stay tuned.

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