This article reviews the authority and processes for issuing Medicare and Medicaid waivers, highlights waiver-based differences in states' home- and community-based (HCB) service systems, and critiques emerging efforts to capitate, integrate, and privatize the long-term care system. Potential pitfalls relate to payment rates, risk, service substitution, accountability, and drains on HCB infrastructure. Before merging HCB services into larger prepaid systems, policy makers are advised to examine implementation challenges, resist ad hoc fixes, clarify HCB entitlements, and strengthen current infrastructure.

Key Words: Managed care, Long-term care, Infrastructure

Policy Choices for Medicaid and Medicare Waivers

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As a former governor, Bill Clinton came to office promising states more flexibility in their Medicaid programs by loosening up the Medicaid waiver approval process. He has delivered on that promise, and the failure of national health reform redoubled states' efforts to reshape their state health care systems. Additional liberalization in the 1997 Balanced Budget Act (BBA) assures that Medicaid waivers will continue to be central components of states' efforts to create more efficient, effective, and responsive systems.

Although waiver activity around long-term care (LTC) has not been as dramatic as several states' efforts to reform acute care systems (e.g., TennCare in Tennessee), waivers to expand home- and community-based (HCB) services (e.g., personal care, homemakers, adult day care) are in place in all states for at least some Medicaid populations, in large measure to try to reduce nursing home utilization and to respond to beneficiaries' strong preferences to receive care at home rather than in nursing homes (Vladeck, 1995). Now some states are moving beyond stand-alone HCB systems as a basis for community LTC reform to consider systems that are more closely integrated with other service systems, including acute care and nursing home care, and that are paid on a capitated risk basis. The 1997 BBA expansions of Medicare managed care options and incentives promise to accelerate these trends.

This article examines three issues: (1) the statutory requirements for waivers and the strain that extensive new initiatives place on the waiver approval and evaluation processes, (2) the differences across states in the extent of HCB systems built through waiver and other funding, and (3) the new trends to capitate, integrate, and privatize the delivery of long-term care services.

This last development poses special informational, technical, and operational challenges for states. A review of capitated, integrated, and privatized approaches to long-term care raises cautions about throwing HCB services into larger systems, unless certain conditions are met. The conclusion is that while experimenting with broader capitation initiatives, most states are well advised to continue to strengthen conventional HCB service systems.

Description of Medicaid Waiver Funding and Programs

Under Title XIX (Medicaid) of the Social Security Act, states participating in Medicaid must offer a core of acute care (e.g., hospital and physician) and LTC (e.g., home health, nursing home) services to all Medicaid eligibles in all parts of the state. There are also optional services (e.g., personal care and case management) that if offered must be available statewide to all covered groups.

Since the passage of Medicare (Title XVIII) and Medicaid, a series of amendments have been made to give the Health Care Financing Administration (HCFA) power to waive provisions of the law on a limited basis in order to test new approaches. The overriding reason for requesting and justifying waivers has been to test ways to control rising nursing home costs. In 1994, 61% of Medicaid's $45.6 billion in LTC spending was on nursing homes, 20% was on intermediate care facilities for the mentally retarded, while HCB waiver (8%), personal care (7%), and home health (4%) accounted for the remainder (Graves & Bectel, 1996). The policy objective has been to use HCB waivers to substitute cheaper home care for institutional care, while meeting beneficiary preferences to remain at home.

There are two general types of waiver authority under Title XIX. First, under Section 1115, states can...
propose demonstrations that change virtually any provision of the Medicaid program, including eligibility definitions; statewideness; amount, duration and scope of services; level-of-care certification; and how services are reimbursed. HCFA has broad authority to define the features of demonstrations and to require a methodology to test formally the efficacy of the innovation.

Second, Congress has from time to time passed what might be called “programmatic” waiver authority, allowing and encouraging HCFA to waive a specific set of regulations. Some of the most important programmatic waivers were contained in the Omnibus Budget Reconciliation Act (OBRA) of 1981. Section 1915(b) of the Act allows states to limit freedom of choice of providers, which has been used to require enrollment in managed care organizations (MCOs). Section 1915(c) allows states to expand HCB services as an alternative to nursing facility care. The flexibility of 1915(c) waivers was enhanced in 1994, when HCFA removed the “cold bed” policy (which had required states to show they were eliminating payment for a nursing home bed for each person served in an HCB waiver program). By late 1996, there were more than 220 1915(c) waiver programs in existence in all states except Arizona (which operates its LTC program under 1115 authority) (Mitchell, 1996).

Another type of programmatic waiver has allowed particular provider-initiated programs to develop and expand. The two most notable programs for elders are the OnLok and Social HMO demonstrations, which pool prepaid Medicare and Medicaid financing to create managed care programs integrating acute care and LTC. OnLok began with one site; Congress expanded it through the Program for All-Inclusive Care for the Elderly (PACE) to ten states in 1986 and 15 in 1990 (Kane, Illston, & Miller, 1992); and the BBA makes PACE a permanent part of Medicare. Social HMOs began with four sites; in 1990 Congress expanded authority to 8 sites (Leutz, Greenlick, Ervin, Feldman, & Malone, 1991); and the BBA directs the Secretary to submit to Congress, by January 1, 1999, a plan for the integration of Social HMOs as an option under the Medicare+Choice program.

Consistent with the expansion of programmatic waivers, 1115 waivers increasingly are being used to make policy rather than to conduct research-oriented demonstration projects. Recently, HCFA approved large-scale changes in state Medicaid programs and is currently considering numerous additional major 1115 waivers. As of late 1996, 10 states were operating Section 1115 statewide Medicaid waivers to expand coverage and implement managed care. Six others had been approved to operate, and 12 others had applied (Mitchell, 1996).

Much of the action has been to increase the use of managed care, including mandatory enrollment in various types of managed care systems and hiring private corporations to manage access in the system. New authority under Section 4701 of the 1997 BBA gives states the authority to compel certain Medicaid beneficiaries to enroll in MCOs without applying for waivers and also to restrict contracting to a limited number of MCOs so long as this does not “substantially impair access to services.” The provisions also expand the number of MCOs that may participate by including Medicare+Choice entities such as provider service organizations, which can be smaller in size than participating Medicare HMOs (1,500 vs 5,000 Medicare members) and can focus exclusively on elders. However, the power to use these new MCO options in initiatives serving dual eligibles (i.e., individuals eligible for both Medicare and Medicaid) is limited by the fact that Medicare beneficiaries, certain children with special needs, and American Indians may not be compelled to join. Thus managed care initiatives for dual eligibles will continue to require Medicare and Medicaid waivers.

HCFA must implement HBC and dual eligible MCO initiatives through the waiver process, but its ability to evaluate the interventions is challenged as their number and scope grows. The impact of the 1915(c) waiver program in terms of saving money, reducing nursing home use, or other outcomes has never been evaluated thoroughly. In September 1998, a proposal for a contract for such an evaluation was approved. Moreover, the popularity of waiver-backed programs can prevail in policy decisions in spite of evaluation findings. Social HMOs, for example, were expanded despite disputes over evaluation findings (HCFA, 1988; Leutz & Greenlick, 1995; Manton, Newcomer, Lawrimore & Vertrees, 1994). The wide replication of OnLok through PACE has been done prior to completion of an independent, outside evaluation or comparison group study, which is just recently being published (Branch, Coulam & Zimmerman, 1995; Gurenberg & Kaganova, 1997). In summary, political and economic considerations often have outweighed research evidence in decisions concerning the expansions of HCB alternatives.

The Role of Medicaid Waivers in Current State LTC Systems for Elders

Although we lack evaluations of the impact of many major waivers, there is good descriptive information on the strengths and weaknesses of the HCB service systems that states have devised for elders. This section will assess the HCB waiver program in terms of where waiver services fit into broader state systems, and in turn the role of HCB waivers in fostering comprehensive, equitable, efficient, and accessible systems.

One of the central battles in LTC over the last 20 years has been to find resources for HCB care in order to reverse a perceived institutional bias in LTC spending, and Medicaid 1915(c) waiver services have been key tools. However, the focus on nursing home savings as the justification for HCB waivers (created by the cold bed policy in place until 1994) has had three consequences. First, by targeting nursing home eligibles who reside in the community, states are serving a group that is the most difficult to maintain in the community. Individuals with lower levels or different types of needs tend to be excluded. Second, by making the traditional targeting minimum the skilled NH level, HCFA created a medical bias that still exists...
have for the most part developed statewide Medicaid programs. Systems that can meet reasonable standards—Gustice, a stark reflection of the dual federal/state nature of needs and financial resources should have similar access to virtually all citizens (i.e., not just the poor) at least for short periods. The high caps are logical—it seems to make sense to spend close to nursing home costs to keep beneficiaries in cheaper settings that they prefer—but high caps make savings more difficult to achieve.

Evaluations of earlier HCB demonstrations found that most individuals served would not have entered nursing homes had the waivered services not been available (Kemper, 1990; Weissert, Cready, & Pawelak, 1988). Therefore, expansions in the number of people served easily can eat up whatever limited savings in nursing home care are realized (hence the previously mentioned cold bed policy). An additional reason that HCB savings are difficult to achieve is that community beneficiaries’ incomes are still being spent on housing and food. Once they enter the nursing home, all their income save a small allowance goes to the nursing home, thus reducing Medicaid costs below the average per diem payment rates. Although rigorous proofs of savings in waiver applications and extensions have not been required, an argument can be made that states that manage carefully do achieve savings (Alexch, Lutzky, & Corea, 1996).

Depending on one’s views on the merits of national benefit and service standards under Medicaid versus states’ rights to take different paths, the state systems that have evolved since the 1981 expansion of waiver authority illustrate either the worst or the best features of waivers as a cornerstone of national Medicaid policy. Some states have developed relatively coordinated and comprehensive HCB systems, whereas others offer relatively limited and fragmented HCB care. In one view, the vast differences violate the notion of equity that some might like in a national program, i.e., that persons with similar health care needs and financial resources should have similar access to public benefits. In another view, differences are a normal and reasonable response of a political system that reflects the variation across states and the relative desires of citizens to support these sorts of programs and initiatives. In short, the use of waivers is a stark reflection of the dual federal/state nature of the Medicaid program.

The states that commonly are acknowledged to have the strongest infrastructure of management, quality control, and service availability—e.g., Connecticut, Illinois, Massachusetts, Minnesota, Oregon, Washington—have for the most part developed statewide systems that can meet reasonable standards (Justice, 1991; Leutz, Capital, MacAdam, & Abrahams, 1992), including:

- Be accessible to virtually all citizens (i.e., not just the poor) at least for screening and referral.
- Perform preadmission screening prior to nursing home admission and present an alternative community care plan.
- Use case managers to assess applicants and place them at a level of care appropriate to their needs.
- Facilitate access to various public benefits (e.g., financed through Medicaid, Older Americans Act, state or local funds) at a single entry point.
- Authorize care from a range of HCB and institutional services available from contracted providers who meet state standards.
- Encourage consumer and caregiver participation in decision making.
- Have basic systems for considering grievances and complaints.

The agencies that manage waiver and other services at a local level are varied both across states, and in some instances, within states. Models include local offices of state agencies (e.g., departments of social service), local government (e.g., county departments of social service or public health), area agencies on aging, private providers or contractors, and agencies specially designed to manage the community LTC system (as in Massachusetts and Connecticut). In the most powerful models, the waiver services are managed in conjunction with other federal and state HCB services, and the management agencies have control over nursing home preadmission screening as well as authorization of HCB services to divert applicants to HCB care. Pooling funds and management has allowed these states to overcome some of the weaknesses of Medicaid and waivers, including requirements to target only on the poor and to serve only those who qualify for nursing home admission (others can be served through state or Older Americans Act (OAA) funds).

In contrast to these examples, most states with waiver programs have not developed such integrated programs (Leutz et al., 1992). First, not all states have waiver programs for all covered groups. Second, some states with waivers do not offer the services statewide. This means that beneficiaries in neighboring jurisdictions may have vastly different services available to them. Third, and related, in the states that do have waiver programs, there is a wide variation in the proportion of beneficiaries being served and in the amount being spent per capita.

Data show that some states have been much more aggressive and successful in obtaining waiver “slots” and waiver funds than others. One way to compare equity is to see how much is being spent on a population basis: either the population of aged SSI eligibles or the population of all elders in the state. Among waiver states in 1990, the range of 1915(b) spending per aged SSI eligible averaged $42 per month but ranged from $1 per month in Louisiana to $165 per month in Washington. The proportion of all aged people not in nursing homes who were served averaged 0.6% across waiver states but ranged from 0.2% or less in Florida, Louisiana, Mississippi, Ohio, South Dakota, Tennessee, and Vermont to between 1.7% and 2.0% in Illinois, Oregon, South Carolina, and Washington (Leutz, Sadowsky, & Pendleton, 1992). When all sources of HCB funding are combined (Medicaid waiver, Medicaid personal care, state, and OAA), the inequity again stands out: In 1990, only four states (CT, DC, MA, and NY) spent $10 or more per elder
New Directions in Waivers

Although the dominant thrust in HCB waivers has been to support networks of agencies that authorize supportive services on a fee-for-service basis, there have been concurrent efforts to improve the efficiency and cost-effectiveness of these systems by changing structures and incentives. These efforts have followed several themes from acute care reform and can be summed up in three words that have become something of a mantra in the 1990s: capitate, integrate, and privatize. As in acute care, the belief is that part of the source of LTC programs’ failure to control costs lies in fee-for-service reimbursement for discrete services to independent providers. An alternative is for states to:

- **Capitate**: prospectively pay for a broad package of acute and LTC services for a designated set of enrolled beneficiaries.
- **Integrate**: pool multiple payment streams and coordinate delivery of the broad service package to allow substitution of less expensive for more expensive services.
- **Privatize**: give the management of the whole system to private organizations, which are thought to be more efficient than government administration.

Interest in cutting-edge capitated, integrated, and privatized LTC systems has been shown in various quarters, including the demonstration provisions of the Clinton health reform proposal, current initiatives of several major foundations to encourage provider and state innovation, and the expansions of PACE and Social HMOs in the 1997 BBA. The hope is that there can be efficient and effective cross-substitutions of services, more continuity of care, and smarter care by both acute and LTC providers due to knowledge of what is being delivered in the “other” system (Leutz et al., 1992; Leutz, Greenlick, & Capitman, 1994; Wiener & Skaggs, 1995).

So far, managed LTC initiatives have come primarily from some of the states that have made the most substantial commitment to the development of HCB systems and the provision of HCB services (e.g., MN, MA, OR, WI). What models are being put forward for these systems? What are the potential pitfalls in terms of their capacity to perform and their impacts on beneficiaries and costs? What will happen to current systems of HCB care if we proceed with creating new systems?

Models Under the Mantra

Three basic models can be identified for capitated, integrated, privatized systems:

1. **Integrated HMO for All**.—Delivery systems are capitated by third party payers to deliver acute care and long-term care services to a membership that includes a cross-section of the population in terms of functional levels. The Social HMO fits this model, but enrollment to date has concentrated on private-pay Medicare beneficiaries. A demonstration of integrated HMOs serving dual eligibles for some counties in Minnesota began in 1997 (Minnesota, 1997), and several other states are preparing even more ambitious plans (e.g., Massachusetts, 1997).

2. **Integrated HMO for the Frail**.—Delivery systems are capitated by third parties to deliver all acute care and LTC services, but only for frail or chronically ill beneficiaries. The PACE initiative, which serves only nursing home certifiable (NHC) elders, is the most prominent exemplar of this model (Kane et al., 1992).

3. **Carveouts**.—A single organization is paid to manage a specified subset of publicly funded services. Mental health carveouts are the best known examples (Callahan, Shepard, Beinecke, Larson, & Cavanaugh, 1995), but an LTC carveout, through which a single organization would be paid to manage all publicly funded LTC services has been tested in Florida (Wiener & Skaggs, 1995) and Arizona (McCall & Korb, 1994). Under more limited risk arrangements, Massachusetts and Oregon use variants of this model for payment and management of HCB services for elders (Leutz et al., 1992).

Potential Pitfalls of Emerging Models

Each of these emerging approaches has appeal because each gives providers and managers more responsibility for managing a broad range of services, as well as more power to do so. Public officials also appear to gain predictability and control of costs by paying a capitation that is fixed in advance. However, each model also has a distinctive way of shifting risk from the public sector to the private sector, and each private sector organization has opportunities for protecting itself in ways that could hurt the public or beneficiaries (Tanenbaum & Hurley, 1995). In order for the public and beneficiaries not to be hurt by initiatives like these, five issues need special attention.

1. **Getting the Rate Right**.—Prepaid approaches can save the government money only if less is paid out than would have been paid under FFS. This is not difficult to calculate in a unitary provider or manager model (such as Arizona) where a budget is set for the entire population in a geographic area, and the management agent is responsible for holding total costs within it. However, in enrollment models such as the two integrated HMO approaches, states set rates per individual. Because individuals differ in their expected costs in systematic ways, case-mix rates based
on actuarial formulas are recommended. The problem is that few states have Medicaid spending data stored in a way that it is easy to link data with beneficiary characteristics other than aid category, age, gender, and residence. The ability to link spending data to functional, cognitive, or illness characteristics for all beneficiaries is rare if it exists in any state. Even if data were available, few states have the funds or expertise to perform the complex statistical modeling that is needed to develop and maintain rate systems even as sophisticated as the much-maligned Medicare adjusted average per capita costs (AAPCC) methodology (Gruenberg, Silva, & Leutz, 1993; Gruenberg, Tompkins, & Porell, 1989; Kronick, Zhou, & Dreyfus, 1995).

In addition to the data problems are conceptual challenges concerning how to set LTC rates. The rate-setting method for PACE illustrates the dilemmas. In half of the PACE sites, Medicaid pays a capitation that equals (a) an estimate of the balance of acute and ancillary costs not covered by Medicare, and (b) a high proportion of the average local nursing home per diem charges (e.g., 85% in the original OnLok site in California; 95% in New York) to cover LTC (Branch et al., 1995). As with 1915(b) waivers, the logic to the LTC rate component is that so long as the state capitation is less than nursing home costs, there are savings.

There are two big differences from 1915(b) waivers. However, first, in the HCB waiver programs the cap serves as a limit on authorizations, with the average spending typically much lower than the cap (Leutz et al., 1992), whereas PACE prospectively is paid at a rate similar to the cap. With a capitation set at 75% of the nursing home per diem, for the state to save money, it would be necessary to assume that three-quarters of PACE members would have been in nursing homes since the day they enrolled in PACE, and that nursing home users paid nothing towards their nursing home care. These assumptions are difficult to defend, and in fact half of the PACE sites and states use smaller percentages of nursing home costs or base rates on costs of non-nursing home long-term care populations. The second difference from fee-for-service HCB waiver programs is that PACE is at risk for all LTC costs. This makes the cost of errors in the rate much higher for the state (or the provider). (This cost of risk will be addressed later.)

The Social HMOs’ Medicaid rate-setting methods were each unique and different from the PACE approach (Leutz et al., 1985), but each also showed drawbacks. The Oregon site took many years to reach agreement on a Medicaid payment and benefit system with the state: Eventually the state agreed to purchase the private benefit at an actuarially adjusted rate. The California site initially had to disenroll institutionalized dual eligibles because the state could not calculate an institutional payment rate cell. The New York site and state moved to a fee-for-service payment system for dual eligibles after risk-based payment led to disputes over interpretation of complex arrangements. Only the Minnesota site maintained a stable payment system for all categories of dual eligibles, but it was reported that the site profited substantially from the arrangements (Leutz & Hallfors, 1993).

2. Paying the Costs of Risk.—Private sector organizations will not assume risks formerly held by the public sector unless there is a good chance they can control the risks and/or make commensurate profits. Additionally, in order to operate a managed care program, considerable costs for administration and marketing must be covered from the flow of funds that formerly went to providers for direct services. The hope of managed care is that these costs as well as profits can be covered through a variety of efficiencies. Some skeptics fear that they will be covered by depriving beneficiaries of needed services (Batavia, Delong, & McKnew, 1991; Schlesinger & Mechanic, 1993), but it is also worth worrying that providers will protect themselves by manipulating other risks that affect their bottom lines. The risks that may or may not be shifted in these types of prepaid, managed systems include:

- **Unit cost risk:** the chance that producing a unit of service will be more or less than an agreed upon cost. This is the only risk normally assumed by FFS providers. MCOs will find it difficult to cut rates in an LTC system characterized by low wages, reimbursement rates held low by Medicaid, and shortages of nursing home capacity.

- **Utilization risk:** the chance that more or less of each service will be used. MCOs seek to reduce unnecessary utilization or substitute less expensive for more expensive services. Some examples from current models illustrate the issues and dangers. Social HMOs defined limits on LTC costs per eligible member and then used case managers in the dual role of advocate for the member and gatekeeper for the sponsor (Abrahams, Capitman, Leutz, & Macko, 1989). This model works only if sponsors value the service and the advocacy; there is clearly room for imposing tighter controls if management decides to reduce utilization. This may have happened in some Social HMO sites in recent years, where spending on LTC has not kept pace with overall spending growth (Leutz, 1996). OnLok has developed in-house resources—most notably provision of skilled and supportive care in congregate housing owned by OnLok—to control utilization of expensive outside services (Kane et al., 1992). Although PACE has worked on quality assurance in LTC, in other systems methods to assure the quality of LTC provided in participants’ homes and congregate settings has lagged behind health care quality assurance (Capitman, Abrahams, & Ritter, 1997).

- **Selectivity risk:** the chance that more or less healthy members will be enrolled than is assumed in the rates. There are various ways to manage selectivity—the appeals and distribution of marketing materials, benefit design, health screening and waiting lists, enrollment and disenrollment provisions, price—but each public attempt to create fairness to its interests can be countered by ac-
tions by the managed care provider in its interests. Recent expansions of PACE have corrected an initial weakness in selectivity control by requiring that disability status be reevaluated. This is consistent with Social HMO procedures and research, which show that only about half of those certified as nursing home eligible stayed eligible for an entire year after initial certification (Hallfors, Leutz, Capitman, & Ritter, 1994).

- **Enrollment rate risk:** the chance that more or fewer members than projected will be enrolled during a target period. Slow enrollment rates have been a common problem in health care demonstrations (Leutz & Hallfors, 1993), and marketing challenges and costs could increase as more types of Medicare+Choice plans come on line. Without protection from the government, failure of some plans and stranding of beneficiaries could occur, as happened with one long-standing Social HMO demonstration site (Fischer, Wisner, Leutz, & Ripley, 1998).

- **Prevalence and incidence risks:** the chance that the proportion of eligibles (e.g., NHCs) in a population at baseline (prevalence) or due to changes in status over time (incidence) will be different than projected. This risk can be cushioned financially if payment systems (both from government to MCOs and from MCOs to contracted providers) are sensitive to case mix and allow for reclassification. Because capitated providers will have an interest in classifying more individuals to the higher rate categories, the government should have a system to check or directly control risk classifications, as is done in the Social HMO (Leutz, Abrahams, & Capitman, 1993).

- **Total cost risk:** the chance that total costs of a provider system will be more or less than projected. Even when an MCO assumes full risk for total costs, other risks continue to operate and can undermine payers' attempts to shift risk to providers. For example, with voluntary enrollment models, selectivity risk still operates in systematic and nonsystematic ways. If MCOs experience favorable selectivity, the government has not successfully shifted total costs of caring for a population to providers.

3. **Substituting Upward.—**The traditional dynamic in capitated, integrated systems is to substitute less expensive for more expensive services. Similarly, LTC policy has sought to substitute HCB services for nursing home care. This is the source of the appeal of even more integrated systems. There is, however, another possibility that must be considered: HCB systems could be neglected and resources substituted “upward” to support services that are more highly valued or better understood by medical care system managers. Acute care and institutional services are likely to have more powerful proponents and constituencies in integrated acute/LTC MCOs than will paraprofessional home care providers, stemming both from the former groups’ larger shares of budgets and from their positions closer to top decision makers. Will social support services be able to hold their own at budget time? The generally flat or falling proportions of budgets spent on LTC at some Social HMO sites do not bode well on this score (Leutz, 1996).

4. **Accountability.—**One of the hopes for private systems is that they will be more responsive to consumer preferences than public bureaucracies. Integrated systems also promise more accountability for outcomes than independent, fragmented providers; and competing systems give beneficiaries options to quit and switch if not satisfied.

Although these are positive features, there are still reasons for concern about accountability. First, large private systems are not necessarily responsive, even if they are more responsive than government bureaucracies. Second, the availability of alternative systems does not necessarily make them good alternatives. It may mean a longer trip for service or that beneficiaries need to change providers. Third, private systems may not be responsive to the same kinds of political and moral pressure that advocates and consumers can put on politicians and government agencies. Finally, the transfer of delivery to private systems does not necessarily get the government off the hook. If these systems fail to perform as planned or if they fail altogether, the government is still responsible for the welfare and services to which beneficiaries are entitled. Privatization may proceed but it can never become complete.

5. **Drains on State HCB Infrastructure.—**If MCOs are given the responsibility for delivering HCB services, they will need to be paid for those services. Each enrollee will bring rights to the several pots of money and services to which he or she may have been eligible had he or she stayed in fee-for-service (assuming MCO enrollment is voluntary). The integrated model expands MCOs’ power, but it increases challenges for the parallel public infrastructure where enrolled eligibles may still receive some of their HCB services (e.g., Older Americans Act, Meals on Wheels), and where non-enrolled eligibles will receive all of their HCB services. Transferring HCB service funds to the expanded HMO means transferring funds and management authority out of the hands of the local public infrastructure for each individual who joins an MCO. This creates complex accounting challenges, enrollment tracking requirements (so that MCO enrollees do not “double-dip” in traditional systems), and erosion of the financial base and planning ability of the traditional HCB infrastructure.

Conclusions

Waivers have proven to be a powerful policy instrument for creating numerous and varied models to deliver LTC services. The advantages of waivers are the opportunities to devise and test approaches different and more generous than the standard Medicare and Medicaid service packages. But the advantages contain the seeds of waivers’ shortcomings. Because of the voluntary and flexible nature of waivers,
the Medicaid program has become increasingly differentiated both across and within states.

Evaluation of statewide reforms is challenging not only because of the expense of evaluating numerous waivers, but also because it has become difficult in many states to identify the underlying state plan to which the waiver is being compared. And after the waiver reform has been in place for several years, it may no longer be practical to return to the former approach. In short, the waiver process has become a de facto vehicle for policy change rather than a process for deliberate policy testing.

The interplay of HCB waivers and managed care waivers presents another policy challenge. After years of HCB waivers, several states have created strong infrastructures for managing LTC and assuring its quality. At the local level states use both public and private agencies to manage several funding sources and to screen nursing facility applicants for possible diversion to home care. Because these states are the most sophisticated, it is not surprising that several of them now are leading the charge for a new level of service integration through managed acute and long-term care.

The mantra of "integrate, privatize, and capitate" has promise but also numerous potential pitfalls for beneficiaries and state finances. Before these states dismantle some of the nation’s most extensive systems of HCB services for frail elders (and before other states follow them down this path), four cautions are in order.

1. Examine Implementation Challenges.—Capitated, integrated, privatized approaches have prevailing political ideologies on their side, but they are extremely complex to develop. There are difficult informational, financial, analytical, operational, and evaluative problems that need to be solved for these approaches to guarantee better outcomes for beneficiaries and savings for the public. There are numerous ways that the public and beneficiaries could be hurt (e.g., through confusing enrollment choices, favorable selectivity, upward substitution). Researchers, advocates, and public servants should work for open and systematic examination of how these issues are being addressed, and they should require that waivers be fully and fairly evaluated.

2. Resist Ad Hoc Fixes.—At a recent conference aimed at developing capitated, integrated, provider-initiated systems in New York, a state official remarked that it is relatively easy for providers to win legislative approval of localized demonstrations but very difficult for state bureaucrats to win approval of even modest, widely supported, system-wide reforms. The former tend to have a few strong supporters but concentrated and ultimately effective opposition. These dynamics too often have led to an ad hoc and back-room approach to reform and to adoption of innovation based on politics rather than objective assessments. Waivers and other innovations should be considered and adopted in the context of a larger plan that is subjected to open and fair review and approval.

3. Clarify Entitlements to HCB Benefits.—Under HCB waivers and other funding for HCB services, states must operate with clear eligibility procedures, defined service packages, and explicit benefit caps. Integrated MCOs may resist replicating these traditional system controls internally because they would inhibit flexibility to manage total resources more efficiently and effectively. Policy makers need to be clear whether HCB benefits are offered in their own right or only as substitutes for more expensive health or nursing facility services. If the latter is the policy, HCB services may be particularly vulnerable in integrated systems because HCB advocates cannot point to strong evidence that downward substitutions work. If the intention is to ensure access to HCB services because they are important in their own right, MCO contracts should ensure that the terms of entitlement are defined clearly to members and staff. The Social HMO demonstration’s definition of a discrete dollar entitlement for a package of LTC services for eligible individuals is an example of a way to define and maintain these benefits. Inflation protection also should be considered.

4. Attend to LTC Infrastructure.—There are numerous legitimate complaints that can be raised about the quality and responsiveness of our public infrastructure for managing LTC funds and services—even in the best states. These include poor training, high caseloads, a profusion of forms that don’t respect user autonomy, confusing eligibility and benefit systems, and underfunding. The approaches that are needed—more training, more attention to consumer preferences and participation, more autonomy for local decision makers, among others—are not a mystery, but they will take political will and modest new resources to accomplish. Even if Medicaid beneficiaries and funding are shifted to managed care, many LTC users and important funding sources (private, AoA, state) will likely continue to rely on traditional service delivery systems. Maintaining and improving these systems—and working out how they coordinate with services available through managed care—should remain high on state and federal agendas.

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