The face of public long term care (LTC) funded largely through the Medicaid program is changing rapidly in the U.S. Over the last decade, most states have moved to managed LTC programs in various forms, with a growing number transferring all their programs, home and community based (HCBS) and nursing home services, to a Medicaid (MLTC) model. The amount of rigorously conducted and reported evaluation results on these programs are still very limited. Enough information is available, however, from other sources for at least preliminary comparison of relative cost-effectiveness of MLTC vs. traditional, non-profit models of public LTC services delivery and financing, as discussed in this paper. This comparison will show that, at this point, the MLTC programs are not more cost-effective than the traditional model of LTC administration. In fact, these initial assessments seem to indicate that the traditional model may be superior to the corporate for-profit MLTC model.

ARE NURSING HOME PREFERRED NETWORKS GOOD FOR PATIENTS' OUTCOMES? EVIDENCE FROM THE VETERANS HEALTH ADMINISTRATION

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In the Veterans' Administration (VA), medical centers contract with community nursing homes to provide care to Veterans. As a purchaser, the VA could pursue a strategy of selecting a high-quality network; alternatively, it could focus resources on oversight by its nursing-home coordinators. The question of whether narrow networks are good for Veterans' outcomes, conditional on quality, therefore, needs empirical investigation. We examined the effect of network concentration on hospital admissions, conditional on Veterans' clinical acuity. We operationalized network concentration as the number of Veterans already in residence at the time of admission, and controlled for publicly reported quality measure (star rating). We identified 93,805 VA-paid admissions to nursing homes between 2013 to 2016. To address selectin bias, we estimated effects using a distance- based instrumental variable (IV) for each measure, with the log of distance to the nearest nursing home with a specified number of Veterans at the facility in the previous month (1-4, 5-9, and 10-13, and 14+ Veterans). Going to a facility with 10-13 or 14+ Veterans had a higher hospitalization probability (6.2 and 3.3 percentage points higher, respectively), than going to a facility with 1-4 Veterans. If quality rating improves outcomes, then broader networks are beneficial if consumers (Veterans) choose based on quality, given a broader choice set. Conditional on quality, concentrated networks do not seem to lead to fewer hospital admissions. Our results suggest that the VA could do more in its oversight role to work with these nursing homes to decrease hospital admissions.

EXPLORING THE ROLE OF CONTEXTUAL FACTORS IN MEDICAID NURSING HOMES' PERFORMANCE: A QUALITATIVE PERSPECTIVE

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This study explored the role of tested contextual factors (structural, market, and management) in high Medicaid (under resourced) nursing homes performance. Four nursing homes in geographically diverse states were purposefully selected for site visits based on high and low performance (quality/ profitability) indicators. Eight nursing home administrators and directors of nursing, and twenty-one nursing staff (RNs, LPNs, and CNAs) and providers of support services were interviewed. Data were analyzed using an inductive thematic approach with NVivo 12 Plus. Within and across case analysis was used to compare participants' perspectives across nursing homes and across administrators and staff. Several themes provide insight into varied influences of contextual factors on these nursing homes' performance: focus on quality care, team-based approach, community support and engagement, and staffing retention. Providing quality care to residents was strategic priority in all facilities, which was enhanced by an adopted team-based leadership approach, open-door policy and home-like atmosphere. Community reputation and availability of local training opportunities for CNAs affected nursing staffing which some facilities addressed using creative retention strategies. These research findings will facilitate interventions, such as leadership training and organizational development activities, aimed at improving the performance of low performing facilities in terms of lower costs and better quality.

HOME HEALTH AGENCY OWNERSHIP AND QUALITY OF CARE OUTCOMES AMONG MEDICARE BENEFICIARIES

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Medicare restructured home healthcare reimbursement from a cost-basis to a 60- day risk-based prospective payment system (PPS) in 2000 to implement the value-based payment model for home healthcare services. Currently home healthcare market in the U.S. is dominated by the presence of for-profit (FP) agencies instead of being primarily served by not-for-profit (NFP) agencies. Using data from the 2016-2018 OASIS for beneficiaries participated in the Medicare Current Beneficiary Survey (MCBS) (N=6,115), the current study examines whether home health agency ownership status is associated with length of stay (LOS) and discharge outcome Medicare home health care patients. Our first outcome variable is discharge status (modeled via ordered probit) with three categories: discharge to the community, inpatient hospital and other long-term care facilities. The second outcome variable is LOS and two dummy variables