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Managed care and long-term care : issues and models

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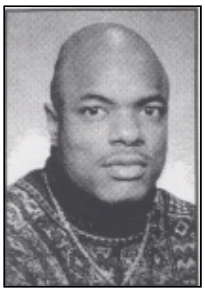
January 2001



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Managed Care and Long-Term Care: Issues and Models

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January 2001

Executive Summary

The public and private sectors increasingly look to managed care systems to control health care costs and improve access to a coordinated continuum of services. In theory, older adults with disabilities, who account for a disproportionate share of health expenditures, could benefit from a more coordinated and comprehensive approach to care. However, designing cost-effective, outcomes-oriented, and consumer-sensitive managed care systems for people with disabilities continues to be a challenge.

This study explores the issues and barriers associated with integrating acute and long-term care services for older adults with disabilities and chronic illnesses in a managed care setting. Medicare managed care, despite some cut backs, has expanded rapidly and includes an increasing number of elderly people with disabilities and chronic illnesses. Decision-makers need a framework for assessing current practices and developing new financing and service delivery strategies for working with this population. In addition, this report presents a conceptual framework for managed care for older adults with disabilities, linking long-term care with concepts of managed care.

This report is based on an extensive review of the literature and interviews with a total of ten program directors, researchers, care coordinators, and public administrators who are involved with these models. Interviews explored models of integration through managed care delivery systems, financial integration, quality assurance, coordination, barriers to integration, risk issues, service coverage and organization, and communication and marketing issues.

Among the major findings from this study are:

- **There is no consensus on the definition of "Integration."** Proposals to "integrate" acute and long-term care services are receiving increasing attention as a way to save money and provide better care. Conceptually, financial integration is relatively straightforward, referring to the pooling of funds from Medicare, Medicaid, insurance, and consumers. On the other hand, there is little consensus about what constitutes "integration" in the delivery system. For purposes of this paper integration was viewed as "the search to connect the health care system (acute, primary medical, and skilled) with other human service systems (long-term care, education, and vocational and housing services) in order to improve outcomes (clinical, satisfaction, and efficiency)" (Leutz, 1999, pp.77-78).

  From a dually eligible beneficiary's point of view, integration of acute and long-term care means that multiple systems feel and act as one. The integrated system is easy to use and provides appropriate care when it is needed, regardless of the type of care required. Thus, the beneficiary has easy access to primary, acute and long-term care through a single, accountable point.

- **Better communication and marketing are critical**. The issue of communication arose in terms of both marketing both to potential members and to potential providers. Communication with providers also entails orienting them to change their practice patterns to align with goals of managed care. Finding providers who are dedicated to meeting the needs of older adults in a managed care setting can be difficult.

- **Quality and Accountability**. The use of managed care in long-term care has led to a more organized system of care, resulting both in improved access and continuity of care and in control of the costs for older adults in the program. The broad public-policy objectives for using managed care techniques in long-term care are the same: to ensure a cost-effective delivery system and workable financing mechanisms while also improving access. Additionally, many states are interested in stimulating innovation and improving effectiveness.

  Different stakeholders have different concerns about the adoption of managed care. An overriding concern for many consumers, advocates, and providers is the quality of care. Providing high-quality care is not necessarily at odds with the ambitions of prudent fiscal managers, since in the absence of quality services a system can be neither effective nor cost efficient. Quite simply, quality services are the vehicle through which a system purchases its intended outcomes.

- **Lessons for States.** States have been motivated to shift to managed care partly in order to exert more control over both the providers of care and the new vendors or managers of care. Once there is a contract, administrators report, a state has a strong mechanism to require accountability, demand or improve performance, and distribute agreed-upon sanctions and rewards when problems arise. This was more difficult in traditional long-term care bureaucracies, which had to negotiate between various grant-in-aid agencies and fee-for-service (both private nonprofit and civil service) providers. With managed care, the state can require data and performance reports not generated previously. In contrast to grant programs, which state administrators said led local providers to act as if they were entitled to continued state funding (almost a franchise), managed long-term care emphasizes a consumer's entitlement to covered services and meaningful outcomes. Consumers have much stronger voices when they have the ability to seek alternative providers.

  While there can be several motivations for shifting to managed care, if a long-term care system is to be successful, the state leadership needs to know what outcomes it wants to achieve and must have the structures in place to purchase them.

  For an in-depth look at what states are doing for "dually-eligibles" see Mehdizadeh, S. (2000). **State practices in providing health and long-term care to dually eligible persons: "a comprehensive review."** Oxford, OH: Scripps Gerontology Center, or visit the University of Maryland's Center on Aging, Medicare/Medicaid Integration Program's web page at: **http://www.inform.umd.edu/aging/MMIP**/

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Introduction and Background

The public and private sectors increasingly look to managed care systems to control health care costs and improve access to a coordinated continuum of services.

The public and private sectors increasingly look to managed care systems to control health care costs and improve access to a coordinated continuum of services. In theory, individuals with disabilities, who account for a disproportionate share of health expenditures, could benefit from a more coordinated and comprehensive approach to care. However, designing cost-effective, outcomes-oriented, and consumer-sensitive managed care systems for people with disabilities continues to be a challenge.

Because of the increasing awareness of the inadequacies of the current system, there is a growing policy interest in finding ways to remedy the existing split between acute and long-term care by bringing these two systems together into a single integrated delivery system (see Table 1 for differences between the two systems) (Fox and Fama 1996).

Table 1
Differences in Caring for People with Acute versus Chronic Illness

	Acute Care	Chronic Care
Underlying objective	Cure	Relief of symptoms, ability to adapt to illness
Focus of patient descriptor	Diagnosis	Diagnosis and functional status
Outcomes	Often objectively defined	Subjectively defined
Elements of care	May be purely physical	Almost always includes a psychological component
Need for patient empowerment	Moderate	Essential
Nature of treatment	Brief and intensive	Long-term and, commonly, low-level
Relation with social service system	Minimal	Significant
Caregivers	Medical professionals	Important roles for family members and nonmedical caregivers

(Source: Fox, P. and Fama, T. (1996). Managed care and chronic illness: challenges and opportunities. Gaithersburg, Md.: Aspen Publishers.)

The premise underlying these attempts is that integration would give persons with disabilities higher quality, more cost-effective acute and long-term care (Newcomer, Harrington, and Kane 1997). These models strive to avoid both the functional decline that can result from unmet needs and the unnecessary costs associated with meeting needs in endlessly expensive settings (Kane, Kane, and Ladd 1998). At least in theory, this coordinated approach would produce acute care savings because lower cost outpatient and home-based services could be substituted for more costly inpatient services when appropriate (Leutz 1999). These acute care savings, in turn, could be used to fund more comprehensive long-term care benefits (USGAO 1995). Moreover, the fixed budget, risk-based financing of some of these models creates strong financial incentives to provide appropriate services at the lowest possible cost (Leutz, Greenlick, and Capitman 1994).

As policymakers consider ways to integrate acute care and long-term care clinically, financially, or both, the idea of using managed care strategies is appealing (Liebig 1997; Kane, Kane, and Ladd 1998). Some managed care concepts are being applied or considered to manage long-term care itself, and some to manage acute and long-term care jointly (Stone and Katz 1997).

Interest in cutting-edge integrated 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 integrated systems, and the expansions of Program of All Inclusive Care of the Elderly (PACE) and Social HMOs in the 1997 Balanced Budget Act. 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 long-term care providers due to knowledge of what is being delivered in the other system.

There are a variety of issues and barriers that administrators must deal with when implementing integrated care systems. The aim of this study is to explore these issues and barriers both in the literature and with state administrators, program administrators, care coordinators, and researchers of existing programs that use integrated care models. The report begins with a definition of integration and then describes some of the issues and barriers to integrated care that have been detailed in the literature and that were identified by interviewees. In addition, more detailed summaries of models are found in the Appendix.

WHAT IS INTEGRATION?

What is integration? The concept has generated much excitement and controversy in recent years, yet it remains largely a catchword, meaning different things to different people. Social HMOs, Minnesota Senior Health Options, PACE, and the Arizona Long Term Care System are all commonly cited as examples of integrated care, yet they serve different populations, include long term care services to different degrees, and enjoy varying amounts of success in actually blending Medicare and Medicaid services at the level of the individual beneficiary.

It may be useful to think about integration as an end point on a continuum, with the other end representing completely fragmented care.

It may be useful to think about integration as an end point on a continuum, with the other end representing completely fragmented care. Along the continuum fall the various existing efforts to make acute and long-term care work better for older adults with chronic illnesses. (See Figure 1)

Full integration is extremely difficult to achieve, and may or may not be necessary, depending on a program's goals. Full integration can be broken into particular dimensions, and programs can decide which dimensions are most important and feasible to pursue, given their goals, program development resources, existing state and commercial infrastructure and a host of other variables. Successful integration of any dimension results in an incremental move to the right on the continuum.

Integration is defined as "the search to connect the health care system (acute, primary medical, and skilled) with other human service systems (long-term care, education, and vocational and housing services) in order to improve outcomes (clinical, satisfaction, and efficiency)."

In this paper integration is defined as "the search to connect the health care system (acute, primary medical, and skilled) with other human service systems (long-term care, education, and vocational and housing services) in order to improve outcomes (clinical, satisfaction, and efficiency)" (Leutz, 1999, pp.77-78). Theoretically, by combining funds from Medicare, Medicaid, and consumers, providers would have the flexibility to offer a much wider variety of services without coverage restrictions. Integration also allows resources captured from the acute care side (traditionally a Medicare responsibility) to be used to expand long-term care services (traditionally a Medicaid and beneficiary out-of-pocket responsibility) (Kane, Kane, and Ladd 1998). There are three levels of integration: linkage, coordination, and full integration. (see Table 2) The first level of integration is linkage. This approach "allows individuals with mild to moderate or new disabilities to be cared for appropriately in systems that serve the whole population without having to rely on outside systems for special relationships" (Leutz, 1999, p. 84).

The second level of integration involves coordination where provider behavior is not significantly different than in an unintegrated system, but the range of services to which clients can be referred is wider. Under this approach, integration primarily means improving the transitions and referrals back and forth between the acute and long-term care systems. This approach seeks to ensure that patients are smoothly transferred across settings and

Figure 1

Integration Continuum

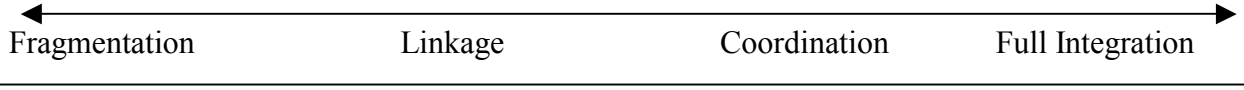

Table 2
Leutz's Integrated Care Continuum

Operations	Linkage	Coordination	Full Integration
Screening	Screen or survey populations to identify emergent needs	Screen flow at key points (e.g., hospital discharge) to find those who need special attention (e.g., CM, MD, consult)	Not important except to receive good referrals (changing needs identified and met through team members)
Clinical practice	Understand and respond to special needs of older persons in primary care, LTC, self-care, etc.	Know about and use key workers (e.g., case managers)	Multidisciplinary teams manage all care
Transitions/service delivery	Refer and follow up	Smooth the transitions between settings, coverage, and responsibility	Control or directly provide care in all key settings
Information	Provide when asked: ask when needed	Define and provide items/ reports routinely in both directions	Use a common record as part of daily joint practice and management
Case management	None	Case managers and linkage staff (e.g., an MD rep on the CM team)	Teams or "super" case managers manage all care
Finance	Understand who pays for each service	Decide who pays for what in specific cases and by guidelines	Pool funds to purchase from both sides and new services
Benefits	Understand and follow eligibility and coverage rules	Manage benefits to maximize efficiency and coverage	Merge benefits; change and redefine eligibility
Need dimensions Severity Stability Duration Urgency Scope of Services Self-direction	 Mild/moderate Stable Short to long term Routine/nonurgent Narrow-moderate Self-directed or strong informal	 Moderate/severe Stable Short to long term Mostly routine Moderate-broad Varied levels of self-direction and informal	 Moderate/severe Unstable Long term or terminal Frequent urgency Broad May accommodate weak self-direction and informal

Source: Leutz, W. (1999). "Five laws for integrating medical and social services: lessons from the U.S. and UK." *Milbank Quarterly*. 77 (1): p.79.

levels of care and that clinical information follows patients (Naylor and Prior 1999). Acute and long-term care is integrated fiscally, usually through capitation, but the delivery systems remain largely separate. Thus, much of the coordination is handled by case managers, who authorize long-term care services, monitor client situations, and coordinate services within the delivery system. Leutz (1999) points out that "coordination identifies points of friction, confusion, or discontinuity between systems and establishes structures and processes to address problems" (p.85).

The third level of integration is full integration which envisions acute and long-term care providers behaving differently than they would in a delivery system that is not integrated (Eleazer and Fretwell 1999). In this model, integration means far more than coordinating separate systems of acute and long-term care; it means creating "new programs or units where resources from multiple systems are pooled" (Leutz, 1999, p.85). Care planning is done holistically, without distinctions between acute and long-term care, through a "multidisciplinary team." A number of studies have reported positive findings from geriatric evaluation and management programs (Boult and Pacala 1999). In addition, some Medicare HMOs have begun to use this approach (Friedman and Kane 1993). The PACE model is a relatively pure example of this approach, unifying acute and long-term care functionally, clinically, and fiscally (Eleazer and Fretwell 1999). For example, in the PACE program, participants attend an adult day health program that provides long-term care and medical care under the supervision of a care planning team that includes both professionals and nonprofessionals (Ansak 1990).

Methods

The source of the data for this report was twofold: a survey of ten care coordinators, program directors, state administrators, and experts who are involved with managed care models and a literature review. The goal of the interviews was to hear from stakeholders from a variety of settings who have experience with managed care models. Models were selected based on a careful review of the literature on integrated care and on recommendations from experts and the National Chronic Care Consortium, an acknowledged leader in the area of integrated care. The models featured in this study are:

- Program of All-Inclusive Care for the Elderly (PACE)
- Social Health Maintenance Organizations (S/HMO)
- EverCare
- Medicare+ Choice
- Minnesota Senior Health Options (MSHO)
- Arizona Long-Term Care System (ALTCS)

Semi-structured telephone interviews (lasting approximately 45 minutes) were conducted with each program's administrator, clinical director, or case coordinator in the spring of 2000. As the intent of the study was to explore the challenges and issues of integrated care, the interview consisted of mostly open-ended questions in order to allow administrators as much freedom as possible in their responses.

SAMPLE

In preparation for soliciting participants, a list of possible agencies and institutions that attempted integrated care using the Social Health Maintenance Organization (S/HMO) and the Program of All-Inclusive Care for the Elderly (PACE) models was generated (see Appendix for programs and descriptions). There are four agencies that use the S/HMO model and twenty-five agencies that use the PACE model. The study sites included those offering specialty and generalist health care services, ambulatory care, home care, acute, subacute and long-term care, and multidimensional services for older persons with chronic illnesses and or disabilities.

After selecting the potential study sites representing a wide variety of integrated care approaches, persons in leadership positions in those settings were identified. In so doing, a purposive sample was constructed by consciously seeking the directors, clinical directors, and/or directors of research. Site selections was based on a geographic representation of the models.

For an in-depth look at what states are doing for "dually-eligibles" see Mehdizadeh, S. (2000). State practices in providing health and long-term care to dually eligible persons: a comprehensive review. Oxford, OH: Scripps Gerontology Center, or visit the University of Maryland's Center on Aging, Medicare/Medicaid Integration Program's web page at: http://www.inform.umd.edu/ aging/MMIP/

Findings

The primary goals of an integrated system of acute and long-term care services are to ensure that consumers receive the services they need at less cost to themselves and to the public and private insurers.

1. WHAT ARE THE KEY BENEFITS OF INTEGRATION?

Although there are a number of concerns and fears about systems that integrate acute and long-term care, there are potentially many benefits that could accrue from adopting this approach. The primary goals of an integrated system of acute and long-term care services are to ensure that consumers receive the services they need at less cost to themselves and to the public and private insurers. Individuals from the organizations interviewed said that under integrated approaches, providers have more flexibility to design and tailor treatment programs that offer an array of acute and long-term care services to meet the diverse medical and nonmedical needs of people with chronic illnesses and disability. In particular, the integration of hospital and physician services with other services such as maintenance rehabilitation, home health and home care, and nursing home care recognizes the interactions of the acute and chronic care needs of these individuals, as well as the dynamic nature of these relationships.

Focus on the Patient

Integrated care models also have the flexibility to design service packages that are maximally responsive to consumer needs, without over-reliance on traditional and often more expensive services. Integration potentially encourages a shift to less costly, more consumer-responsive services. In addition, integration offers flexibility in tailoring services to individuals; integrated systems encourage providers to expand prevention and maintenance services. These services enhance the quality of life of consumers, and at the same time reduce the incidence of secondary and tertiary illness and disability.

A good integrated care program should focus on the patient, above all.

A good integrated care program should focus on the patient, above all. The clinician should inquire into the client's expectations, experience, and perceptions. The more comfortable a relationship the clinician and patient have, the easier it will be for them to communicate about this key information. One issue that the doctor or nurse must communicate is that clinicians do not have all the answers or all the power. They can not issue a diagnosis with absolute certainty or cure a chronic illness as they would "fix" an acute condition. These "deficits" could cause the patient to lose confidence in the health provider or treatment plan. If the clinician can help the patient understand these uncertainties, however, the patient can become motivated to study his or her own conditions and, thus, to use this knowledge to compensate for the clinician's limitations. Making the patient central to treatment is a goal of all integrated care models in this study. One commenter said:

The patient is central to the management of chronic disease. You start off trying to find out what the disease means to them. How would they like it managed? What do they expect from you? From the visits? How can you fit their educational experience into their lives?

Another one said:

I think the number one thing that has to be there is a comfort level between the patient and me. If we have that comfort level, the patient will open up about many things. Central to the philosophy of our program is that the patient is the core of the team. Our philosophy is, "How can we help you? What are your goals?"

Case Management and Coordination

A second theme that emerged as a benefit of integration was care management and coordination in the current integration models. This activity, or cluster of activities, fulfills the promise that integration will reduce fragmentation and ensure more consistent, reliable, high-quality, and cost-effective care across time, place, and profession.

The majority of interviewees maintained that offering comprehensive benefits alone might not produce an integrated system of care. To ensure that integration of services occurs, communication systems among providers and their clients must be developed. Financing mechanisms can encourage the appropriate mix of available services, but actual provision of care requires a more personal effort. In sum, capitation can set the stage for integration, but without

communication systems, programs will lose sight of consumer needs.

A significant step toward integration through communication will entail expanding the role of physicians and encouraging them to function as part of a team, so that turf boundaries diminish and ultimately disappear among providers. For example, a physician who sees an older adult every two months in a clinic may not clearly comprehend all of the patient's care needs. However, if the physician speaks with a social worker, a dietician, and an informal caregiver, each of whom sees the patient in a variety of settings and activities, a more complete picture of the patient's needs emerges. Services other than medical therapies can then be prescribed and coordinated by these caregivers. Interviewees stressed that the more functionally impaired individual requires a higher level of integration between team members to coordinate services.

A benefit of care coordination appears in the costs of care. Much of the cost savings in current programs for the frail older person result from emergency room use management. Although these savings actually accrue to the Medicare program, the potential exists for making long-term care more efficient as well. Interviewees believe that there are a range of interventions to reduce institutionalization and provide better care, but knowing which interventions really work and why requires further study.

When designing integrated care programs, interviewees felt that clinicians need to ensure that the ideas will not only improve care but also save money.

Address Financial Issues, Along with Clinical Ones

When designing integrated care programs, interviewees felt that clinicians need to ensure that the ideas will not only improve care but also save money. The savings might be in the long term; an intervention might cost some money up front but prevent expensive hospitalizations. Money is not the only issue on clinicians' minds; they want to improve the process of care, patient satisfaction, and the medical outcome. They must, however, convince funders that their plans will save money overall. One person said,

When we put together this program, one of the critical questions in the planning stage was, What is so innovative and so clever about this that is worth testing and worth putting energy into? We discarded a few ideas because they were just not that innovative. There was, conceptually, nothing new. If we prove that a new initiative results in better care (improved health outcomes and reduced costs), then we have every intention of going to our payers and saying that they really ought to pay for, for example, heart medications, up front. It is going to cost them money, but the documented net effect of an intervention is positive.

A prevalent attitude was that the major barriers to integrated care include: marketing and enrollment, financing and incentives, training and education, quality assurance, rate setting, and communication.

2. WHAT ARE THE MAJOR BARRIERS TO INTEGRATED CARE?

There are many financial, organizational, and training barriers to creating and implementing integrated systems of care for older adults with disabilities. These barriers occur at the federal, state, provider, and consumer levels and tend to have an interactive effect. A prevalent attitude was that the major barriers to integrated care include: marketing and enrollment, financing and incentives, training and education, quality assurance, rate setting, and communication.

Marketing and Enrollment

As a practical matter, three interviewees noted that it is impossible to try to construct fully integrated programs from the outset. Instead there are key elements of integration to consider, either as part of a transition to integration, or as a decision to focus resources on the dimensions that most fully advance program goals, are manageable given public and private capacity, are possible within state and federal policy, are politically feasible and are achievable within a time table.

In addition, the interviewees pointed out that there are particular marketing needs of managed care programs for older persons with chronic conditions. Current programs have found that building an integrated system requires more than offering a range of services. In the words of one interviewee,

Communicating information about the availability of services to the appropriate populations in a manner that encourages them to enroll challenges each program.

Three effective methods of marketing were cited: mailings and follow-up tele-marketing; broad-based coordinated marketing, including mailings, brochures, and public appearances; and referral-based marketing. Targeting the appropriate populations and then contacting them requires aggressive and creative strategies in all three methods.

Mailings and follow-up telemarketing were utilized with success by one program. For example, one interviewee said,

We used voter registration data that gave us the demographic characteristics of the area's population. These data helped us to target the appropriate eligible individuals for the program services. Through analysis of the registration data, we [the program] were able to eliminate telephone numbers of individuals not eligible for services, such as those in nursing facilities or living outside the service area. This preliminary analysis resulted in an appropriate contact in over half the phone calls made.

One SHMO program reported using an effective broad-based approach to marketing. Like the Medicaid managed care program, SHMOs target a large group for enrollment. Mailings, brochures, tele-marketing, and public appearances (e.g., at health fairs) all contributed to the SHMO marketing strategy. One SHMO site identified internal markets from their parent organization. This market required less aggressive tactics since consumers were already familiar with managed care. External markets presented greater challenges at the non-HMO sponsored sites since these markets required education about managed care and the value of the SHMO product relative to all other options (i.e., managed and non-managed care).

One of the PACE sites also shared its marketing strategy. PACE programs usually

have relatively small enrollments that target very frail elderly persons. In establishing this target population, the PACE site first determined how many elderly lived in the service area and then refined that number to reflect those eligible for PACE services. To ensure that the right people enrolled from this eligible group, the PACE site focused on educating providers--including hospitals, physicians, and nursing facilities--who typically advise frail elders of the availability of the PACE services. In this way, the PACE site was able to enroll roughly 10 percent of the eligible population in its service area.

Perhaps the most important lesson gleaned from the models is that educating the public to the value of services provided in an integrated managed care program takes aggressive tactics.

Perhaps the most important lesson gleaned from the models is that educating the public to the value of services provided in an integrated managed care program takes aggressive tactics. Helping consumers to understand their choices in these plans gives them a sense of control over their care and assists program administrators in designing service packages that reflect consumers' desires.

Financing and Incentives

Another major barrier to integrated care is the fragmented sources of financing. Medicare is the primary payer for acute care services for elderly and eligible younger disabled; Medicaid is the primary payer for long-term care services for low-income elderly and younger people with disabilities. In addition, the Social Services Block Grant, the Older Americans Act, and the Veterans Administration all provide financing for chronic care. Each uses different policy assumptions and directives under a different program authority; separate administrative authorities exist for each program. These multiple layers of policy governing the continuum of acute and long-term care significantly impede movement toward more integrated approaches. This was summarized by one administrator, who said:

In the fee-for-service arena, there is no incentive to manage patient care efficiently. While providers are committed to offering their patients the best available medical care, they generally are not reimbursed for preventive care or for patient monitoring outside of the physician's office. At the same time, there is no existing incentive to minimize expenditures. Physicians have little financial reason to minimize the number of office visits, emergency room visits, or hospital admissions. However, I believe that creating financial risk sharing arrangements is often key to motivating program participants and realizing the full scope of potential improvements in outcomes.

The bifurcation of Medicare and Medicaid policy causes many dilemmas for federal and state governments as well as for health plans and providers. Because states do not control Medicare, they are not able to establish comprehensive managed care plans that include both acute and long-term care services. States, therefore, find it difficult to hold Medicaid contractors accountable for the care of beneficiaries who choose to receive Medicare services from different providers. Furthermore, states may be reluctant to invest in an integrated program where most of the savings accrue to the federal Medicare program and not to their

own program. In addition, Medicare and Medicaid law regarding risk contracting differ in several key areas, which impedes the development of unified managed care plans.

Training and Education

Another barrier to integration of acute and long-term care is the lack of knowledge and information needed by health care providers to offer this wide array of services. Graduate medical education, nursing, social work, pharmacy, and therapy programs have not tended to focus on the interdisciplinary needs of people with disabilities, and few models of training have been developed to achieve this goal. The geriatrics and rehabilitation models begin to provide alternative frameworks for designing educational programs that promote an integrated approach. The field of geriatrics, for example, is devoted to the care, treatment, and rehabilitation of older adults, as well as health promotion and disease prevention.

Quality Assurance

Another issue raised was the application of current tools to assess quality in managed care settings: Should quality assurance focus on people or on diseases? Should quality assurance focus on the process and structure of giving care or on outcomes? If the latter, what are the outcomes in a long-term care setting? Often, outcomes are determined by function, not cure. Whereas many quality assurance tools for collecting data in the hospital setting can be applied to the long-term care settings, the standards for evaluation may differ.

Many regulatory bodies currently exist, but an integrated system will require a single system of accreditation, with one annual review sufficing for all programs. This presents hurdles for regulatory agencies needing to ensure that care meets acceptable standards. States or other sponsors need to apply for a different license for the various services they deliver. For example, On Lok Senior Health Services operates in four sites in San Francisco and has nine different licenses, two for each site's adult day care and community health center and another one for On Lok's home health agency. A single license to operate as a PACE program does not exist. A contributing factor to the fragmented regulatory system is the newness of the quality assurance field itself. Programs do not yet have data against which to compare performance of integrated systems.

Rate Setting

Finally, interviewees described the difficulties of providing integrated care under current financing mechanisms. All of the models in this study are paid capitated rates to provide member services. The rate-setting process for both Medicare and Medicaid presents challenges to these programs.

Currently, rates are based on fee-for-service expenditures by Medicare, Medicaid, and private paying individuals for a comparable population. For example, the comparison populations for PACE are the nursing facility populations in the same geographic areas at the different PACE sites. The capitation rates reflect what Medicare and Medicaid could expect to pay to care for the nursing facility population in a fee-for-service setting with a 5-15 percent savings for these funding sources built into the rate.

Since the comparison population for programs such as PACE and SHMOs vary, different reimbursement rates result.

Difficulties in identifying the appropriate comparison group can result in over- or underpayments to a specific site. An example is the difference in the Medicare adjusted average per capita cost (AAPCC) rate across SHMO sites, resulting in widely varying charges to members. Perhaps over time, experience from the programs themselves can provide appropriate comparison data.

Another challenge to rate setting is that of estimating the total cost of care of the comparison group. Medicare pays for most acute care services and Medicaid pays for many long-term care services for the poor elderly, but the cost data for these programs are not linked. Thus, it is difficult to track the costs of an individual's care across acute and long-term care settings.

Communication

Communication among team members is vital for integrating care delivery, alerting clinicians about changes in patient condition, educating clinicians and patients, and gathering information for assessing team performance. Although communication can be organized and carried out in many different ways, both formally and informally, interviewees felt that organizations should structure communications so that they impose a minimal burden on physicians. Only in that way can integrated care become an integral part of primary care physicians' practice. In the PACE model, all the care members (excluding the patient) meet regularly to review the patient's status and progress. This type of approach is not likely to be feasible for primary care physicians in most practices. As one care coordinator said:

If they [primary care physicians] view communication demands as excessive, they will resist implementation and the integrated care will not be sustainable over time. Instead, communication with primary care physicians should be carried out on a more informal, as-needed basis.

A second communication issue raised relates to the need to support, educate, and listen to the patient on an ongoing basis. For an integrated care program to work, the patient should function as an integral part of the care process. To facilitate this, patients should communicate with clinicians as needed, rather than waiting for regularly scheduled appointments or acute flare-ups of the chronic illness. This type of communication is most likely to happen if a supportive, trusting relationship exists between the patient and the care-coordinator. One interviewee said:

The best way to build such a relationship is for the care coordinator to call the patient. During the phone call, the care coordinator can offer support; solicit information about medication compliance and other critical treatment issues; and identify physical, social, or financial barriers to treatment.

Accountability Issues

Having shifted their systems to managed care, policymakers will quickly be challenged to prove that goals are being achieved, costs are under control, consumers have real access and choice of quality services, and the performance-based contract is providing the best practice and leading to good outcomes. Legislators, governors, and the public expect an adequate level of quality at a reasonable cost. In addressing this issue, policymakers must decide the appropriate role for government oversight and regulation, balancing opposition to government

regulation against public-accountability needs.

Managed care, with improved performance and outcome measures, provides one means by which to demonstrate accountability. The more comprehensive information systems used by managed care providers enable states to require reporting of key data and to demand outcomes, thereby holding plans accountable for what they do. This can provide greater understanding of what is actually occurring in the system and can enable a state to know whether its goals are being reached. At the same time, managed care gives plans great flexibility about how to achieve those outcomes, thus still permitting innovation.

Policymakers find that the challenges of accountability depend on whether the state has contracted with a for-profit company or used the existing network of nonprofit providers.

Policymakers find that the challenges of accountability depend on whether the state has contracted with a for-profit company or used the existing network of nonprofit providers. Generally speaking, commercial companies need to be monitored to ensure that the population with serious disorders is being served adequately, while the nonprofit networks need to demonstrate that they have the necessary data and financial-management systems to be able to manage for outcomes.

A wealth of data can be produced, but the value of those data depends greatly upon whether the most appropriate reporting requirements have been selected and whether the purchaser (or some other independent contract agent) has the capacity to analyze and interpret them. State long-term care systems have been criticized in the past for collecting data passively, without clear purposes and without the ability to retrieve it in useful ways.

In addition to reporting by the plans themselves, some states have found it helpful to have independent evaluations of their managed care systems. Program audits, fiscal audits, assessments of grievance and appeals data, and analyses of performance and outcome data can all assist in ensuring real accountability. State officials believe the plans, in addition to having a strong vested interest, are not as capable of doing this themselves.

However, the highly sophisticated indicators offered by new data systems may not provide all of the hoped-for insight about what is happening in a system. The field's ability to measure and understand outcomes is in its infancy. As a result, several states use performance measures to assess processes, as a proxy for measuring client outcomes. For example, the performance measure of how soon outpatient services are provided after an inpatient stay is used as a proxy for improved community tenure. But states need to be clear about their longer-term plans for data systems and indicators that can lead to effective assessment of outcomes. A blueprint for data management should ensure that proxy measures will not become institutionalized.

Lessons for States

States and providers clearly consider managed care a potentially useful tool for addressing many systemic issues in long-term care, but they are also aware that it can create other problems and that it requires careful administration. In addition, state officials report that managed care can improve accountability significantly. While there is no single solution, and while it is impossible to say in advance what approach will work best, the greatest successes have come when policymakers start with a vision for what they want the service system to achieve and then use managed care as a strategy or toolbox to realize it.

Careful planning allows time to deal with the significant challenges providers and states have encountered. Policymakers have found they must approach reform through a process that permits consensus building, even though in the end some may still oppose the plan. Nevertheless, the planning process itself provides an invaluable review of the system.

Managed care contracting offers obstacles, pitfalls, and difficulties. Policymakers have found they must wrestle with various problems, including some that were previously unaddressed, such as integration of long-term care with other health or social service systems. Putting consumer needs at the center of any change has proved to be effective in planning for a system of managed care.

Innovation is fundamentally a local matter of adapting ambitious hopes to existing constraints and opportunities.

Innovation is fundamentally a local matter of adapting ambitious hopes to existing constraints and opportunities. There are limits to how fully the experience of one state can be translated to another. Nonetheless, the general principles discussed here seem to be reasonably applicable across states and localities.

Public-sector approaches to managed long-term care are relatively new but already evolving rapidly. Lessons from states involved in these shifts emphasize that the complexities of the issue require states to set clear goals, in collaboration with key stakeholders, so that the managed care strategy can further improve a state long-term care system. States ignore these complexities at their peril. Managed care has the potential to exacerbate the problems of cost shifting, and this makes it all the more imperative to deal with the integration of services, systems, and funding streams. Managed care can, eventually, help blur the boundary between public and private for-profit managed health care and facilitate movement toward a single system of care for all.

Using managed care appropriately, states are in a position to demand far greater accountability from long-term care providers than they have ever been able to in the past.

In sum, states have found managed care to be a useful technology for achieving

cost efficiency and responding to the demands of a dynamic system in a way that balances risks and protects consumers, while encouraging more independence and mainstreaming for them. Using managed care appropriately, states are in a position to demand far greater accountability from long-term care providers than they have ever been able to in the past.

Conclusion and Implications

This study intends to set the stage for further thinking about the role of integrated care and managed care, recognizing that these are rapidly changing areas. It does not address some policy questions that may be included in a more comprehensive discussion of integrated care and managed care. Such questions include the people who need integrated services (How complex must their needs be?), the limits of integration (At what point are the benefits of additional services outweighed by the burden of the increased complexity of care?), and how to share the costs and the rewards of integration (How can funders, insurers, providers, community agencies, clients, and families participate equitably?) These issues were omitted largely because so little is known, either about their current impact or about how they will be affected by the Balanced Budget Act of 1997.

Integrated care has proven to be a powerful policy instrument for creating numerous and various models to deliver long-term care services. The models described in this report document that the advantages of integrated care are the opportunities to deliver more effective and coordinated acute and long-term care services. These interviews show that many new lessons have been learned about each of these models that will help these and other programs begin to define which strategies need to be discarded and which are more promising in achieving their goal: to distribute scarce Medicaid and other state resources more cost-effectively to purchase quality, fully integrated, and coordinated services for those older adults most in need.

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Appendix

Medicare+Choice

Medicare+Choice, a new program authorized by the Balanced Budget Act (Off Site) of 1997, allows greater flexibility in the Medicare program. This new program, also known as Medicare Part C, allows Medicare beneficiaries to enroll in a variety of plans beyond the traditional fee-for-service and managed care options, including:

- health maintenance organizations (HMOs) (i.e., current Medicare managed care);
- preferred provider organizations (PPOs);
- provider-sponsored organizations (PSOs);
- religious fraternal benefit society plans which may restrict enrollment to members of the church, convention or group with which the society is affiliated;
- private fee-for-service plans which reimburse providers on a fee-for-service basis, and are authorized to charge enrolled beneficiaries up to 115% of the plan's payment schedule; and medical savings accounts (MSAs).

While these new offerings will increase consumer choice, Medicare beneficiaries with disabilities may have difficulty understanding the various options and comparing the costs and benefits of different plans. Although HCFA will undertake a massive education effort related to Medicare+Choice, Medicare beneficiaries with disabilities may not receive materials that directly address the specific requirements of their medical situation.

Services covered: All Medicare+Choice plans, except high deductible/medical savings account plans, must cover Medicare Part A (Off Site) and Part B (Off Site) benefits. Plans may provide additional services with approval from the federal government.

Eligibility: All persons eligible for Medicare (persons over 65, persons with disabilities or permanent kidney failure) can enroll in any of the Medicare+Choice plans offered in their geographic area. Medicare+Choice plans are specifically prohibited from denying or limiting coverage based on health status or pre-existing conditions. Thus, unlike Medicare Supplemental policies, they cannot prevent individuals with disabilities from enrolling. This makes these plans the only option for supplemental coverage for most Medicare beneficiaries under the age of 65.

Financing: The federal government and beneficiary premiums will finance Medicare+Choice. Plans can also charge deductibles, coinsurance, and copayments. Plans will receive a monthly capitation payment, which is adjusted for beneficiaries' age, disability status, gender, institutional status, and other factors. In the future, HCFA will adjust capitation rates to account for cost variations based on health status and other factors.

Source: http://managedcare.hhs.gov/program descriptions/medicare/dual_eligibles.htm

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

The Program of All-Inclusive Care for the Elderly (PACE) is a new capitated benefit authorized by the Balanced Budget Act of 1997 (BBA) that features a comprehensive service delivery system and integrated Medicare and Medicaid financing. The program is modeled on the system of acute and long term care services developed by On Lok Senior Health Services in San Francisco, California. The model was tested through HCFA demonstration projects that began in the mid-1980s. The PACE model was developed to address the needs of long-term care clients, providers, and payers. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than be institutionalized. Capitated financing allows providers to deliver all services participants need rather than be limited to those reimbursable under the Medicare and Medicaid fee-for-service systems.

The BBA establishes the PACE model of care as a permanent entity within the Medicare program and enables States to provide PACE services to Medicaid beneficiaries as a State option. The State plan must include PACE as an optional Medicaid benefit before the State and the Secretary of the Department of Health and Human Services (DHHS) can enter into program agreements with PACE providers.

The BBA also limits annual growth of the PACE program. It limits the number of PACE program agreements in the first year after enactment to no more than 60; the limit increases by 20 each year thereafter. The statute further provides for priority processing and special consideration of applications for existing PACE demonstration sites and to those entities that applied to operate a PACE demonstration project on or before May 1, 1997.

Participants must be at least 55 years old, live in the PACE service area, and be certified as eligible for nursing home care by the appropriate State agency. The PACE program becomes the sole source of services for Medicare and Medicaid eligible enrollees.

An interdisciplinary team, consisting of professional and paraprofessional staff, assesses participants' needs, develops care plans, and delivers all services (including acute care services and when necessary, nursing facility services) which are integrated for a seamless provision of total care. PACE programs provide social and medical services primarily in an adult day health center, supplemented by in-home and referral services in accordance with the participant's needs. The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team for the care of the PACE participant.

PACE providers receive monthly Medicare and Medicaid capitation payments for each eligible enrollee. Medicare eligible participants who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or other type of Medicare or Medicaid cost-sharing applies.

PACE Programs

Program and Location	Census
Hopkins Elder Plus Baltimore, MD	94
Comprehensive Care Management Bronx, NY	684
ESP of the Cambridge Hospital Cambridge, MA	103
Alexian Brothers Community Services Chattanooga, TN	104
Tri-Health Senior Link Cincinnati, OH	65
Concordia Care Cleveland Heights, OH	86
Palmetto Senior Care Columbia, SC	405
Total Long-term Care Denver, CO	276
Center for Senior Independence Detroit, MI	149
ESP of Harbor Health Dorchester, MA	97
ESP of Mutual Health Dorchester, MA	105
Elder Service Plan (ESP) of EBNHC East Boston, MA	343
Bienvivir Senior Health Services El Paso, TX	315
Senior BeunaCare Los Angeles, CA	133
Elder Care Options Madison, WI	94
Community Care for the Elderly Milwaukee, WI	573
Independent Living Services North Syracuse, NY	78
Center for Elders Independence Oakland, CA	197

Providence ElderPlace Portland, OR	456
Independent Living for Seniors Rochester, NY	344
Sutter SeniorCare Sacramento, CA	186
Eddy Senior Care Schenectady, NY	80
Providence Eldercare Seattle, WA	125
ESP at Fallon Worchester, MA	130
On Lok Senior Health Services San Francisco, CA	823

Pre-PACE Programs

Program and Location	**Census**
St. Joseph Senior Care Albuquerque, NM	127
REACH Chicago, IL	107
PACE Hawaii at Maluhia Honolulu, HI	78
ESP of the North Shore Lynn, MA	286
LIFE St.Agnes Philadelphia, PA	61
LIFE University of Pennsylvania Philadelphia, PA	71
Sentara Senior Community Virginia Beach, VA	109

Source: PACE Profile 2000. Integrated Acute and Long-Term Service Delivery and Financing. National PACE Association.

Social Health Maintenance Organizations (Social HMOs)

Social Health Maintenance Organizations (Social HMOs) extend the concept of health maintenance organizations by including certain long-term care services not normally covered in traditional plans (Boult and Pacala 1999). Initially conceived by researchers at Brandeis University, a Medicare and Medicaid demonstration has been underway since 1985 (Leutz, Greenberg, and Abrahams 1985). The initial four demonstration sites were Medicare Plus II in Portland, Oregon; Seniors Plus in Minneapolis-St. Paul, Minnesota; Elderplan in Brooklyn, New York; and SCAN Health Plan in Long Beach, California (Leutz 1997). Medicare Plus II and Senior Plus were sponsored by large, ongoing HMOs, while Elderplan and SCAN Health Plan were sponsored by long-term care organizations (Boult and Pacala 1999). While Seniors Plus terminated its program at the end of 1994, the three remaining sites had an enrollment of nearly 17,000 at that time (Leutz 1997). Brandeis University provided technical assistance for the demonstration sites; the University of California at San Francisco conducted a HCFA-sponsored evaluation.

The first generation Social HMO model includes five basic organizational and financing features (Leutz, Greenberg, and Abrahams 1985). First, a single organizational structure is at financial risk to provide a full range of acute and long-term care benefits to Medicare beneficiaries who voluntarily enroll in the program and pay a monthly premium for services (Leutz 1997). Dually eligible Medicare and Medicaid beneficiaries may also enroll, with Medicaid paying the premium (Newcomer, Harrington, and Kane 1999). Members receive all Medicare covered acute, post acute, and ambulatory services, as well as supplemental benefits such as prescription drugs, eyeglasses, hearing aids, and nonemergency transportation (Leutz, Greenberg, and Abrahams 1985).

In addition, those who qualify for long-term care benefits may also receive services such as nursing home and home health care, as well as homemaker, personal care, and adult day care services. The Social HMOs either provide services themselves or contract with other providers to do so (Newcomer, Harrington, and Kane 1997).

Second, while Social HMOs provide coverage for a range of long-term care services that are not covered under Medicare or standard Medigap policies, all of the sites attempt to control costs by limiting expenditures for these services to a fixed, fairly modest cap of $7,500 to $9,600 per person per year (Newcomer, Harrington, and Kane 1997). Thus, Social HMOs do not provide coverage for extended-stay nursing home care or long-term, highly intensive home care (Kane, Kane, and Ladd 1998).

Third, a coordinated care management system authorizes long-term care benefits for those who meet the established eligibility levels (Leutz 1997). Case managers aid older people with disabilities and their families in assessing the need for care and in planning and arranging services. In addition to this advocacy component, case managers are also gatekeepers, controlling the amount of long-term care resources used (Newcomer, Harrington, and Kane 1997).

Fourth, the Social HMO enrollment and service package is designed to serve a cross-section of the elderly population, including both functionally impaired and unimpaired elderly persons (Leutz 1999). In fact, the overwhelming majority of enrollees do not have disabilities (Kane, Kane, and Ladd 1998). In order to protect against adverse selection in enrollment, sites are allowed to create a waiting list for persons with severe disabilities once a threshold number are enrolled (Leutz 1999). All plans, with the exception of Medicare Plus II, queued applicants with disabilities for at least some period of time. However, second generation Social HMO sites will not restrict enrollment by disability levels (Leutz et al. 1993). Instead, an adjustment to the AAPCC based on disability at enrollment is used, theoretically minimizing incentives for favorable selection (Kane, Kane, and Finch 1995).

The goal of enrolling an elderly population with a wide range of disability levels allows the Social HMOs to operate under the classic insurance principle of risk pooling, whereby many people contribute a modest amount to fund the extraordinary expenses of a few. Thus, premiums in the Social HMOs are much lower than for PACE, which solely enrolls a high-cost population with severe disabilities (Leutz 1999). This strategy also allows the Social HMO to enroll moderate-income persons, instead of only the Medicaid population (Leutz 1997).

This approach also makes Social HMOs responsive to those persons who have short-term disability or need help with transitions, recovery, or skilled and supportive services beyond what is covered through traditional Medicare benefits (Leutz, Greenlick, and Capitman 1994). Substantial numbers of persons with disabilities become disabled as a consequence of an acute care episode, but some of these individuals eventually regain independence (Naylor and Prior 1999).

Fifth, the Social HMO financing mechanism involves prepaid capitation, pooling funds from Medicare, Medicaid, member premiums, and copayments. Initially, the Social HMOs and HCFA shared financial risks, but the Social HMOs assumed full financial risk after the first 30 months of the demonstration (Newcomer, Harrington, and Kane 1999). Long-term care and expanded acute care benefits are funded through premiums, copayments, and acute care savings; they do not involve additional public expenditures. Thus, Social HMOs are designed to be budget neutral for the Medicare program and are intended to produce modest savings for Medicaid (Leutz, Greenberg, and Abrahams 1985). In order to reduce the financial risk involved in covering long-term care as well as acute care, Medicare pays 100 percent of the AAPCC for Social HMO members, rather than the 95 percent that HCFA normally pays HMOs (Newcomer, Harrington, and Kane 1997). Moreover, Social HMOs receive the Medicare AAPCC payment rate for nursing home residents for all members who meet their state's criteria for nursing home admission, regardless of whether or not the patients actually receive nursing home care (Kane, Kane, and Ladd 1998). Other categories of the AAPCC are adjusted downward to compensate for the higher payment for this particular class. Without this adjustment, Social HMOs would have an incentive to institutionalize persons with severe disabilities in order to receive a higher acute care reimbursement rate.

Site Characteristics of S/HMOs

	Elderplan	Kaiser Permanente Senior Advantage II	SCAN
Location	Brooklyn, NY	Portland, OR	Long Beach, CA
Type of Sponsor	Comprehensive LTC organization	HMO	Case management agency
Type of S/HMO	Own HMO	New benefit program	Own HMO
Location of CM unit	HMO hqtrs	Research center	HMO hqtrs
Monthly member premium	$29.89	$49	$40
Expanded Care Benefits			
-Home and community	$6500/yr	$1000/month	$6250/yr
-Nursing home	$6500/yr	100 days/spell	$6500 lifetime
-Overall limit	$6500/yr	$12000/yr	$6250/yr
-Home care co-pay	$10/visit	10% of charges	20 % of charges

Social HMO Site Benefit Summary: Expanded HMO Services

Expanded HMO Services	Kaiser Permanente Senior Advantage II	SCAN	Elderplan
Prescription Drugs	No limit ($5 copay per prescription)	No limit. (Copay per prescription is $3.50 for generics and $10 for brands if generic unavailable.)	No limit. ($5 copay/30 day script from local pharmacies; $2/90 day script by mail.)
Eyeglasses	One set every two years ($118 credit toward frames)	One set every two years ($20 per lenses and $55 per frame copay)	One set every two years ($100 credit toward frames and lenses)
Hearing Aid	50% of charges	One set every two years ($150/aid/ear)	$600 allowance for first hearing aid. 20% discount on second.
Dentures	Covered in expanded LTC benefit cap	$350 member charge for upper and lower adjustments	$450 member charge for upper and lower. $425 for partial (one set every/3 years)
Emergency Response System	Covered in LTC expanded benefit cap	$10 per month	$15 per month
Foot Care Beyond Medicare	Covered in LTC expanded benefit cap	Medical benefit, no copay	$2 copay/visit
Transportation Beyond Medicare	Covered in LTC expanded benefit cap.	$2 copay for taxi rides to medical copayments. 5 copay for wheelchair.	Up to $25/calendar quarter reimbursement for car service (Taxi) to medical appointments.

Social HMO Expanded Long-Term Care Services

Expanded Long-Term Care	Kaiser Permanente Senior Advantage II	SCAN	Elderplan
Overall cap	Annual maximum of $12,000 gross for HCBS, nursing facility, dentures, and other covered LTC	No overall cap	Annual maximum of $7,800/year gross and monthly maximum of $650 gross, including copays
Home and Community Care	KP pays 80% up to $800/month member pays 20% up to $200 per month ($1,000 per month gross benefit)	SCAN pays net after copay to $625/month. $8.50/visit copay for most services. $153/month out-of-pocket maximum.	Elderplan pays balance up to $650 monthly in gross costs. Homecare copay is $12 per visit. Adult day care is $12 per day.
Nursing Facility (custodial/respite care)	KP pays 80% up to 14 days per period of confinement; 20% copay by member.	SCAN covers up to 14 days per period of confinement. No copay, but $7,500 lifetime limit applies.	Elderplan covers ten days lifetime for non-respite stays and unlimited respite stays, but subject to copays and $7,800 annual cap.

EverCare

EverCare, a subsidiary of United Health Care, began operating in 1993 with the primary goal of providing better case management for permanent nursing home residents. It is a demonstration designed to study the effectiveness of managing acute care needs of nursing home residents by pairing physicians and geriatric nurse practitioners, who function as primary medical caregivers and case managers. The major goals of the program are to reduce medical complications and dislocation trauma resulting from hospitalization and to save the expense of hospital care when patients could be managed safely in nursing homes. As of April 2000, EverCare had enrolled 10,725 nursing home residents. Unlike PACE and S/HMO, EverCare does not expand the Medicare benefit package significantly. Three sites are operational in Georgia, Maryland, and Massachusetts.

Services covered: Medicare-covered services. Medicaid-covered services, such as nursing facility care, are not covered.

Eligibility: Permanent residents in a nursing home participating in EverCare who are eligible for Medicare and enroll in the program voluntarily.

Financing: EverCare receives a capitated rate from Medicare to provide Medicare-covered services. EverCare does not pool Medicaid and Medicare funds; it simply provides Medicare covered services in a case management setting.

Comparison of PACE, S/HMO, and EverCare

	PACE	S/HMO	EverCare
Number of sites	25 in 13 states	3 S/HMO I 1 S/HMO II	6
Approval/enrollment dates			
Approved	1983 On Lok: 1986 PACE replication; and in 1997, the BBA made PACE a permanent Medicaid state plan option	1984 S/HMO I; 1990 S/HMO II	1992
Enrollment commenced	1983 On Lok; 1990 for PACE replication sites	1985 S/HMO I; 1996 S/HMO II	1993
Eligible population	Frail, elderly persons aged 55 or older who meet states standards for nursing home placement and reside in the area served by the PACE org.	S/HMO I and II: Individuals over age 65 years of age who are entitled to Medicare part A and part B.	Permanent nursing home residents. Enrollees require assistance with an average of 4 to 5 ADL's
Enrollment			
Cap	Some states establish a maximum number of enrollees	Cap for all sites: 324,000	None
Current enrollment	6,000 enrolled (as of Dec. 1999)	S/HMO I: 46,458 S/HMO II: 35,260 as of April 2000)	10,725 (as of April. 2000)
Health plan characteristics	25 plans. One-third are freestanding community-based provider entities. PACE resembles a small, staff model HMO, in which interdisciplinary team members are employees of the health plan.	Total of 4 HMO's. S/HMO I has 3 plans. S/HMO II has 1 plan (Health Plan of Nevada)	1 HMO-United HealthCare

Unique features	Program generally requires that enrollees attend the adult day health center and use only the plan's providers. The BBA made PACE a permanent program under Medicare, giving states the option of offering PACE to their Medicaid enrollees by amending their state Medicaid plans and gradually expanding the authorized number of PACE sites.	S/HMO I offers basic Medicare, expanded benefits, and community-based long-term care. The latter is only available to nursing home certified enrollees. S/HMO II plans incorporate practices developed by geriatricians into the operations of the plans.	Physician and nurse practitioners assigned to provide primary care in nursing homes to reduce use of hospital and emergency room care.
Waivers Medicaid	 Section 1115	 Section 222	 Section 222
Medicare	Section 222		

Source: United States. General Accounting Office. (2000). *Medicare and medicaid: implementing state demonstrations for dual eligibles has proven challenging*: report to the Chairman, Special Committee on Aging, U.S. Senate/United States General Accounting Office. Washington, D.C. The Office; Gaithersburg, MD, p.35-36.

The Arizona Long-Term Care System (ALTCS)

The Arizona Health Care Cost Containment System (AHCCCS) is a demonstration project that finances medical services for the Medicaid-eligible population through prepaid contracts with providers (USGAO 1995). Beginning in 1989, the ALTCS program incorporated long-term care services into the AHCCCS program (Johnson 1997). The goal of ALTCS is to provide appropriate long-term care and acute care services, including mental health, through a managed care system which serves older people and persons with physical or developmental disabilities in the least restrictive setting (McCall and Korb 1997). Individuals with incomes up to 300 percent of the Supplemental Security Income level (which is $1,374 per month in calendar year 1995) and who are certified to be at risk of institutionalization are eligible (Johnson 1997).

ALTCS covers acute care services, as well as care in nursing facilities, intermediate care facilities for the mentally retarded, and home and community-based services (HCBS)(ALTCS 1999). To control utilization, HCFA limited the number of persons who could use home and community based services (Johnson 1997). The cap has increased steadily since the program began, and was set at 35 percent of elderly and physically disabled enrollees for fiscal year 1994. Imposition of the cap reflected uncertainty about whether Arizona would be able to provide extensive home care services for older people and persons with disabilities in a cost-effective manner (Johnson 1997). There is no cap on home and community-based services for persons with mental retardation and developmental disabilities because Arizona started with very few persons in institutions. All beneficiaries are assigned a contractor-employed case manager, who is responsible for formulating a care plan for each beneficiary upon enrollment, and determining whether to place the beneficiary in home or institutional care, and how their care is to be administered (ALTCS 1999).

The main difference between this Medicaid program and traditional ones is the presence of an intermediary, the program contractor, who manages acute and long-term care payments within an overall budget (Johnson 1997). Under the ALTCS model, the state contracts with one entity in each county to assume responsibility for services to elderly and physically disabled eligibles (McCall and Korb 1997). In the overwhelming majority of cases, the contractor for elderly people and persons with physical disabilities is the county government. Private contractors serve the more rural areas.

Program contractors receive a monthly capitation payment per enrollee from ALTCS in return for arranging for the provision of the required services, and contractors are required to bill Medicare for covered services for dually eligible enrollees (Johnson 1997). The capitation rates, which differ by county, are set through a bidding and negotiation process and take into account the expected Medicare reimbursement (McCall and Korb 1994). Contractors, in turn, either use fee-for-service or capitation arrangements with providers to serve ALTCS beneficiaries (Johnson 1997). Whereas some financial integration has occurred in that Medicaid covers both acute and long-term care services, it is not clear how much service delivery integration is actually taking place. Anecdotally, the primary care physician and case manager often work together on the overall plan of care (McCall and Korb 1997).

Minnesota Senior Health Options (MSHO) Program

The Minnesota Senior Health Options (MSHO) program combines Medicare and Medicaid financing and acute and long term care service delivery systems (United States. Congress. Senate. Special Committee on Aging 1998a). This program was formerly known as the Long Term Care Options Project. (The name was changed after focus group research recommended a name, which more accurately reflected the true nature of the program.) The program is authorized under Minnesota Statutes 256B.69 subd.23.

The demonstration facilitates the integration of primary, acute and long-term care services for persons over age 65 who are dually eligible for both Medicare and Medicaid (United States. Congress. Senate. Special Committee on Aging 1998a). Out of about 550,000 persons over age 65 in Minnesota, about 48,000 receives Medicaid (MDHS 2000). Minnesota's Medicaid program is called Medical Assistance (MA). About 46,000 seniors are dually eligible for both Medicaid and Medicare. About 18,000 of these dually eligible seniors reside in a seven county metro area (MDHS 2000).

Minnesota received federal Medicare 222 and Medicaid 1115 waivers from the Health Care Financing Administration (HCFA) to put this demonstration into practice (United States. Congress. Senate. Special Committee on Aging 1998a). The waivers allow the State to combine the purchase of both Medicare and Medicaid services into one contract managed by the state (MDHS 2000). Minnesota is the first state ever to be granted such a combination of waivers (Newcomer, Harrington, and Kane 1997). The waivers also allow contracting with smaller HMOs and Community Integrated Service Networks (CISNs) which are currently not eligible to be Medicare+Choice contractors (MDHS 2000). In addition, the federal waivers granted Minnesota a Medicare risk adjustment payment for frail elderly dual eligibles in the community as an incentive to prevent unnecessary institutionalization (Newcomer, Harrington, and Kane 1999). The demonstration is being implemented in the seven county metro areas and will cover a five-year period (MDHS 2000).

MSHO serves dually eligible seniors who are required to enroll in PMAP in the seven-county metro area. Enrollment is voluntary and enrollees can disenroll every 30 days. Services plans are responsible for: all Medicare services, all PMAP services, all elderly waiver (home and community based) services, and 180 days of nursing facility care for community enrollees. After 180 days, nursing facility care is paid on a fee-for-service basis but residents remain enrolled in the demonstration and receive all other services from the plan (Newcomer, Harrington, and Kane 1999). MSHO home and community-based services include case management, companion services, caregiver training, extended home health aide, extended personal care assistant, adult foster care, adult day care, assisted living, residential services, homemaker services, home delivered meals, respite care, home modification, and extended supplies and equipment (MDHS 2000).

Plans must hold a PMAP contract. The state holds a Medicare risk contract with HCFA and the state chooses the health plan contractors. There is one contract for Medicare and Medicaid for health plans, which is managed by the State. The contract merges Medicare and Medicaid managed care requirements (Newcomer, Harrington, and Kane 1999). Most plans are

contracting with newly formed geriatric care systems to provide all or part of the MSHO benefit package. Care systems vary in their organizational structure and risk-sharing arrangements but all attempt to increase integration of primary, acute and long-term care services for the elderly population (United States. Congress. Senate. Special Committee on Aging 1998a). Long-term care providers who contract with clinics for primary care services sponsor several care systems. Others are sponsored by hospital-based organizations sharing risk with long-term care providers. Some are partnerships with health plans. Several care systems are operating at full risk or partial risk for the benefit package (MDHS 2000).

Care management and clinical models differ among plans and care systems, but must meet basic contract criteria (United States. Congress. Senate. Special Committee on Aging 1998a). Each enrollee gets a "care coordinator" to assist with care planning and service access (MDHS 2000). Some care coordinators work for the clinics, some for the Care Systems and some for the plans, depending on the clinical model. Care coordinators balance dual roles of gatekeeper and advocate for the enrollee (United States. Congress. Senate. Special Committee on Aging 1998a).

While a large number of MSHO enrollees already reside in nursing homes when they enroll, MSHO plans work hard at preventing premature nursing home placement of their community members (MDHS 2000). Since its inception, only 34 community enrollees (out of about 1037 unduplicated community enrollees) have been permanently placed in nursing homes (MDHS 2000).

Key concepts being tested by MSHO

- How is care delivered to dual-eligible beneficiaries through the integration of Medicare and Medicaid administrative requirements and processes as administered by the state? How are managed care organizations, the state, HCFA, and beneficiaries affected?

- How well do complex network arrangements deliver integrated Medicare and Medicaid services and care coordination to dual-eligible beneficiaries, including frail elderly community-dwelling and institutionalized members?

Managed Care and the Balanced Budget Act (BBA) of 1997

The BBA of 1997 makes significant changes in the managed care options under Medicare and Medicaid. The major components of the Act include:

Medicare

- Medicare beneficiary options are expanded beyond fee for service and Medicare HMOs to include preferred provider organizations (PPOs), provider sponsored organizations (PSOs) and, for a limited number of beneficiaries, medical savings accounts (MSAs).

- Beginning in January 2002, an annual open enrollment period will be held during which Medicare beneficiaries will make their Medicare choices. Beneficiaries will be able to change their selection once during the open enrollment period but must otherwise remain in the plan of their choice for the remainder of the year.

- Changes in the adjusted average per capita cost (AAPCC) payment methodology will, over time, bring high and low payment areas closer together, making Medicare risk contracting more attractive to MCOs in rural and other low payment areas.

- The Medicare HMO 50/50 composition rule is replaced by enhanced quality standards.

Medicaid

- States have the option to implement mandatory risk-based managed care and primary care case management programs without waivers, through amendments to their state plans. However, states can not use the state plan option to require dually eligible beneficiaries to enroll in Medicaid managed care.

- States may continue to seek waivers under sections 1915 or 1115 to implement programs that exceed the authorization contained in the new state plan option.

- Beneficiaries enrolled in managed care plans may change plans once during the first 90 days of enrollment and at least every 12 months thereafter.

Source: Muskie School of Public Service, University of Southern Maine, and National Academy for State Health Policy, 1997.