

Managed Care and the Future of Long-Term Care for the Frail Elderly: The Role of the Aging Network

by

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Introduction

Two of the most commonly mentioned deficiencies of health care for the elderly in the U.S. are the relative scarcity of affordable or publicly sponsored home- and community-based long-term care alternatives to nursing homes and the lack of integration between acute care and long-term care. Supporters of managed health care for the elderly argue that managed care represents the best strategy for addressing both of these deficiencies. According to this perspective, a managed care organization (MCO) which is paid a capitated rate for both acute and long-term care services would have the incentive to serve members in home- and community based programs (in-home care or assisted living facilities), when appropriate, rather than in nursing homes, which would usually be more expensive. If the MCO were also responsible for providing acute care, it would have the incentive to ensure close communication between acute and long-term care providers in order to prevent acute episodes and chronic conditions from becoming costly long-term care problems.

Although this argument for the efficacy of managed care may still be largely theoretical, there can be little doubt that efforts to improve the quality of health care for the elderly and the efficiency of care delivery within each domain (acute, chronic and long-term care) are substantially dependent on improved integration and the enhanced flow of accurate and timely information that comes with improved integration. Opportunities to divert hospitalized frail elderly from expensive and avoidable nursing home placements to home- and community-based care are frequently missed in the absence of a well organized communication link between hospital discharge planners, nursing home pro-admission screeners, and home- and community-based services (HCBS) case managers and providers.

Managed care is emerging as one of the major mechanisms for integrating care across domains. Managed care, in a broad sense, has long been an essential component of most HCBS programs, with case managers planning and negotiating for services within flexibly capped budgets, which often operate as a form of capitation. Over the last decade, managed care projects specifically designed to integrate HCBS with institutional care and acute and long-term care have been initiated in several states.

In addition to being a vehicle for integrating care, managed care may also be a means of containing long-term care costs and increasing the array of service choices available to the frail elderly and those who may require some form of long-term care. As noted above,

a managed care organization which is responsible for providing acute care, primary care, home- and community based services and institutional care has an incentive to divert its members to the generally lower cost, community-based services and to delay institutional care as long as possible. This shift in the focus of care seems to have occurred in Arizona's managed long-term care system for Medicaid recipients, which is described in Chapter 3.

Incentives to contain costs, however, worry some advocates for the elderly who fear that they may lead to loss of access to essential services. Containing costs and ensuring adequate care in terms of access and quality constitute the major criteria by which the efficacy of managed care will be determined over the next several years.

The most extensively documented of the projects designed to integrate care and increase the efficiency with which it is delivered are described in Chapters 2 through 4 of this paper. The descriptions are organized by national projects, state, local (county or city) and Florida-specific initiatives and include evaluation findings, when available. In Chapters 5 and 6 of this paper, we summarize the major policy issues related to managed care in the context of long-term care and discuss the potential role(s) of aging network agencies in the development and management of managed care approaches to the financing and delivery of long-term care. In the final chapter, we offer a series of policy recommendations for the development of managed long-term care strategies in Florida.

At this early stage in the development of managed care approaches to the financing and delivery of long-term care, any policy recommendations are by necessity highly provisional. We need to know much more about the mechanics, outcomes, ethics and true costs of managed care particularly as it applies to long-term care, before drawing any definitive conclusions about its value and the relative efficacy of different strategies. Given the rapid growth of managed care, however, there should be ample opportunity to generate this kind of information over the next few years and to develop a far more informed perspective on the strengths and weaknesses of managed long-term care.