Managed Care for the Elderly and The Role of the Aging Network

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Preface

This updated paper is an extensively revised version of a paper we printed in 1997 on the same topic: *Managed Care and the Future of Long-Term Care for the Frail Elderly: The Role of the Aging Network*.

It seems that in the current political environment virtually any analysis and discussion of managed care is interpreted in terms of support or opposition which leaves little room for a balanced critique of managed care policy and practice and a careful assessment of alternative strategies for improving managed care outcomes. We do not accept this polarized approach and have tried to conduct as objective and non-partisan an analysis as possible of the current information on managed care and its implications for the chronically ill elderly.

We think managed care is potentially superior to fee-for-service as a health care and delivery system for the chronically ill. We discuss this potential and method of achieving it at some length in this paper. This does not mean, however, that we should overlook the available literature which documents deficiencies in current managed care problems or fail to analyze how these deficiencies function as barriers to achieving the potential that managed care holds for improving the efficiency and quality of care for chronically ill elderly and those with impairments requiring long-term care. Managed care in some form is here to stay; it is the task of the aging advocacy, research and services community to help make it as responsive to the health care needs of the elderly as possible.

CHAPTER 1

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[1] 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 is at financial risk for providing both acute and long-term care, it will have the incentive to ensure close communication between providers in both sectors 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 the integration of domains and the enhanced flow of accurate and timely information that should accompany integration. Providers and health care analysts believe that 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 pre-admission screeners, and case managers and providers of home- and community-based services (HCBS).

Managed care, which is one of the major mechanisms for integrating care across domains, has, in a broad sense, long been an essential component of most HCBS programs in the aging network, 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. Some of these projects will be discussed in this paper.

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 that 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. 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 while ensuring adequate care constitutes the major criterion by which the efficacy of managed care will be measured over the next several years. In describing the advantages of a managed care environment for improving the quality of medical care for older persons with chronic conditions, Robert Kane (1998) points out that:

> Regardless of whether one looks to managed care as the unifying force to integrate acute and long-term care, the two sectors must collaborate to address the growing numbers of older chronically ill people. Managed care could catalyze the development of two families of clinical responses that should improve the management of chronic disease: (1) more aggressive chronic care and (2) using information systems more intensively to help structure and monitor the chronic care.

The managed care environment for Medicare recipients may be profoundly affected over the next several years by the Balanced Budget Act of 1997. Medicare recipients will have the choice of unrestricted fee-for-service (FFS) plans, coordinated care plans or preferred providers, HMOs with and without a point-of-service option, provider sponsored organizations and a limited medical savings account program (a voucher initiative). The Balanced Budget Act also eliminates the requirement that plans have more than half of their members as Medicare beneficiaries. Continuous enrollment and disenrollment from managed care organizations will end in 2002 and beneficiaries will be limited to choosing a plan once during the first three months of the year. The Balanced Budget Act also changes several payment mechanisms:

> . . . The Secretary of the Department of Health and Human Services will be required to implement a risk adjustment methodology no later than January 1, 2000, a prospective payment system (PPS) will be implemented for home health agencies and rehabilitation hospitals by FY 2000 and FY 2001, respectively, capital payments for rehabilitation hospitals will be reduced by 15% for FY 1998-2002, and a case-mix adjusted PPS will be adopted for all skilled nursing facility (SNF) costs. In addition, the costs of home health care beyond 100 visits will now be covered under Medicare Part B rather than Part A.

As these changes are implemented, much of the information included in this paper will become dated and many of the policy issues will have to be readdressed. The next edition of the paper will be a monitoring report based on the best available information about the impact of the Balanced Budget Act and managed care for the elderly.

In the following sections, we summarize and discuss the findings from research on managed care, 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 our concluding section, we offer a series of policy recommendations for the development of managed long-term care strategies.

CHAPTER 2

Managed Care and the Elderly: What Do We Know?

Although research on managed care and the elderly is still in its infancy, enough studies have been completed to support a preliminary assessment of the strengths and problems with the approach to financing and delivering health care for the elderly. As the following review of the literature shows, managed care participants benefit from reduced out-of-pocket costs and less paperwork when compared to those who receive their care in the fee-for-service system.

On the other hand, most of the studies show that managed care is not yet achieving the kinds of outcomes (i.e., functional and health status) most proponents of managed care seem to expect given the theoretical focus in managed care on prevention and follow-up. It should be noted that we are still in a relatively early stage of managed care (only 13% of Medicare beneficiaries are in managed care organizations) and we need many more outcome studies with larger samples and better outcome measures than are now available. Nevertheless, we should be prepared to begin using the information we have to make adjustments and refine procedures, including financial incentives, designed to improve the quality of care in both managed care and the fee-for-service system.

In the second part of this section, we review the available literature on managed care strategies designed to increase the efficiency of long-term care and to integrate acute and long-term care. This literature is even more limited than the literature on managed acute care, largely because there are few initiatives in this area and these involve only a few thousand people. These initiatives and the information we have about their cost-effectiveness are important, however, in that they may indicate methods for maximizing the benefits of managed care for the frail elderly and overcoming two of the major deficiencies of traditional health care for the elderly—fragmented care and dependency on institutional long-term care.

A. Managed Primary Care

Few evaluations of managed care programs for the delivery of acute and long-term care services to the elderly have been conducted and the results of these are mixed. Stone and Niefield (1998) have noted that:

> Given the paucity of research on the comparative advantages and disadvantages of managed care relative to traditional FFS for the Medicare population with chronic illnesses and disabilities, both proponents and opponents continue to find anecdotal

evidence to support their claims. The empirical evidence to date has not suggested significant differences between managed care and FFS for the average Medicare beneficiary. There is some evidence, however, that individuals with multiple health and functional conditions have limited access to certain specialized services and may be encountering quality of care problems.

Findings from a series of studies by Mathematica, Inc. (Brown, Bergeron, Clement, Hill, Retchin, 1993), of the Medicare TEFRA HMO[2] programs, indicated that the HMO enrollees were not as likely to receive as many chronic and long-term care services (home health care, rehabilitative services) as those in the fee-for-service sector (FFS); they had fewer visits with their physicians; and they reported somewhat lower satisfaction with the quality of care received. On the other hand, HMO enrollees were clearly pleased with the lower, out-of-pocket cost of their care and the reduced paperwork. No significant differences in the treatment outcomes (morbidity and mortality rates) were observed between the two groups.

A study by Shaughnessy, Schlenker and Hittle (1994) found that the Medicare HMO enrollees received fewer home visits and had longer intervals between visits than fee-for-service Medicare patients, and that the cost of home services in the HMOs averaged two-thirds of the fee-for-service costs. When patient status outcomes (e.g., bathing ability) and service utilization outcomes (e.g., hospitalization) were compared across groups, the fee-for-service patients had significantly better outcomes than the HMO patients. The authors suggest that at least some unknown portion of the additional services provided to the fee-for-service patients was effective, and was not simply excessive delivery fueled by the financial incentives inherent in the current fee-for-service systems. The authors point out, however, that the study looked at a relatively short period of time (12 weeks), and stated that further study is needed to see if HMO enrollees have the same or better outcomes over a longer period of time.

A study by John Ware et al. (1996) found substantial differences in four-year outcomes for the elderly and poor, chronically ill patients treated in HMO and fee-for-service systems. For elderly patients (those aged 65 years and older) treated under Medicare, declines in physical health were more common in HMOs than in FFS plans (54% vs 28%; $P<.001$). In one site, mental health outcomes were better ($P<.05$) for elderly patients in HMOs relative to FFS but not in two other sites.

The study included 2,235 patients (18 to 97 years of age) with hypertension, non-insulin-dependent diabetes mellitus, recent acute myocardial infarction, congestive heart failure, and depressive disorder sampled from HMO and FFS systems in 1986 and followed up through 1990. Those aged 65 years and older covered under Medicare and low-income patients (200% of poverty) were analyzed separately. Types of practices included both prepaid group (72% of patients) and independent practice association (28%) types of HMOs, large multispecialty groups, and solo or small, single-specialty practices in Boston, MA, Chicago, IL and Los Angeles, CA. Outcome measures were derived from differences between initial- and four-year follow-up scores of summary physical and mental health scales from the Medical Outcomes Study 36-Item Short-Form Health Survey (SF-36) for all patients and practice settings.

In a study of outcomes of stroke patients in Medicare fee-for-service and managed care, Retchin, Brown, Yeh et al. (1997) found no significant differences in relative risk of dying between the HMO and FFS groups 25 to 37 months following hospitalization. They also found, however, that after controlling for age, marital status and characteristics of dependency at

discharge, HMO patients were more likely to be sent to nursing homes (HMO, 41.8%, FFS, 27.9%, P = .001%) and less likely to be sent to rehabilitation hospitals or units (HMO, 16.22%, FFS 23.4%, P = .03%).

The importance of rehabilitative care for stroke patients is demonstrated by findings from a study by Kramer, Steiner, Schlenker et al. (1997). The authors found that stroke patients treated in rehabilitation hospitals were three times more likely to return to the community than patients discharged to skilled nursing facilities, after controlling for baseline propensities predicting each discharge destination. Rehabilitation hospital care was more expensive than nursing home care, but produced significant improvements in the proportion of patients reporting difficulties in activities of daily living (walking, toileting, etc.) six months after hospitalization. They found no differences for hip fracture patients.

James R. Webster (1997) comments that:

> These findings, which support results from smaller controlled studies of stroke rehabilitation, make the results of Retchin, et al. even more worrisome.

Caroline Lubick Goldzweig et al. (1997) conducted a study comparing rates of cataract extraction in two prepaid health settings in fee-for-service (FFS) settings in southern California. The study included over 62,000 Medicare managed care enrollees in a staff model HMO and an IPA and 47,150 FFS Medicare beneficiaries (a 5% sample of all southern California FFS beneficiaries). After controlling for age, sex, and diabetes status, the authors found that FFS beneficiaries were twice as likely to undergo cataract extraction as were prepaid beneficiaries. The authors also found that:

> . . . women in the FFS setting had a significantly greater probability of undergoing cataract extraction than men, while there were no differences by sex seen in the prepaid settings. Our FFS results replicate those of previous investigators who used comparable data sources and are also consistent with the estimated 50% greater risk of cataract development in women than in men. Therefore, observed equivalent rates for men and women in the prepaid setting, which are substantially below those for women in the FFS setting, suggest possible underuse for this subgroup.

The authors conclude that:

> of cataract extraction in prepaid and FFS settings indicate that organizational and financial aspects of the different settings influence the likelihood of patients undergoing this discretionary procedure. Given the rapid expansion of prepaid care and the political movement to expand Medicare managed care, we urgently need clinical studies to examine the quality implications of these rate differences, which may significantly impact on the elderly's ability to see.

In a 1997 study of HMO disenrollment rates among Medicare beneficiaries, Riley, Ingber and Tudor found little evidence of widespread dissatisfaction. They did find, however, that disenrollment rates were higher among those who were Medicaid eligible, the disabled, black, and age 85 and older. They conclude that:

> Access problems tend to affect sick and vulnerable subpopulations disproportionately, and their higher disenrollment rates may reflect greater dissatisfaction with care. The tendency of vulnerable enrollees and those in poor health to disenroll to FFS rather than to other HMOs is particularly troubling. Disenrollees to FFS tend to be less satisfied with access to care than are disenrollees to other HMOs. Disenrollment to FFS may reflect displeasure with the basic features of managed care, rather than dissatisfaction with a particular plan.

Morgan, Virnig, DeVito et al. (1997) analyzed HMO enrollment/disenrollment patterns among Medicare beneficiaries by examining enrollment and inpatient billing records for southern Florida from 1990 through 1993. This study is based on an analysis of differences in the use of inpatient medical services by 375,406 beneficiaries in the Medicare fee-for-service system, 48,380 HMO enrollees before enrollment and 23,870 enrollees after disenrollment. The authors found that the results of this study seem to support the view that many Medicare recipients join and remain members of HMOs when they are healthy but return to the fee-for-service system when they become sick and need to make relatively extensive use of medical services.

> Medicare beneficiaries who use fewer services than average are more likely to enroll in HMOs, and beneficiaries who disenroll from HMOs subsequently use more services than average. These findings are consistent in subgroups of beneficiaries classified on the basis of age, race, and income level.
>
> The substantial increase in use of inpatient services by beneficiaries after their disenrollment from HMOs suggests that they move into the fee-for-service system in order to obtain needed services, returning to Medicare HMOs after they have obtained these services. In contrast, those who remain out of the HMO system for a year or more may be more likely to need long-term care or to have other reasons for disenrollment. The high levels of use of inpatient services in our HMO-disenrollment group dovetail with the previously reported high levels of out-of-plan use by Medicare-HMO enrollees before their disenrollment and return to the fee-for-service system, reported in a previous study.

A study of California HMO enrollment/disenrollment rates for 1993-94 by the U.S. General Accounting Office (August, 1997) found that:

> . . . beneficiaries with a single chronic condition were 19% less likely to join an HMO than those without . . . and those with multiple chronic conditions enrolled at a rate 27% below those with none of the conditions.
>
> Reflecting both age and health status, beneficiaries over 85 years old who had multiple chronic conditions enrolled at about half the rate of those aged 65 to 69 without any of the conditions.

These findings in California by GAO are significant, not only for their confirmation of earlier studies that indicate that HMOs benefit from favorable selection "despite the fact that California HMOs' coverage of more services (particularly preventive care and prescription drugs) with less cost sharing would be expected to attract beneficiaries with chronic conditions."

An analysis of Medicare HMO disenrollment data by the Families USA Foundation (1997) found that:

> Disenrollment rates vary dramatically by state and some states have very high disenrollment rates. . . . In 1996, Medicare HMO disenrollments as a percent of average monthly membership ranged from a low of 2.7 percent in Hawaii and 4.2 percent in Minnesota to a high of 31.6 percent in the District of Columbia, 25.3 percent in Florida, 21.8 percent in Kentucky, and 19.4 percent in Texas. This comapres to a national rate of 13.0 percent. . . . The high disenrollment rates in both Florida and Texas are the result of high disenrollment rates in a large number of HMOs.
>
> . . . In 1996, six of the 10 Medicare HMOs with the highest disenrollment rates were in Florida, three were in Texas, and one was in California.
>
> Low disenrollment rates are related to nonprofit status of plans. Seven of the ten plans with the highest disenrollment rates were for-profit, while nine of the 10 plans with the lowest disenrollment rates were nonprofit. . . .
>
> In communities with a large choice of HMOs, Medicare beneficiaries who disenroll from one HMO tend to join another HMO instead of going back to fee-for-service Medicare. In southern California and southern Florida, two-thirds of Medicare beneficiaries who disenrolled joined another Medicare HMO plan (61.1 percent and 68.8 percent, respectively).

The report concludes that most Medicare beneficiaries are satisfied with their HMOs as indicated by low disenrollment rates in many plans and the fact that most who disenroll from one plan join another HMO. The report also points out, however, that too many plans are characterized by the kind of revolving door documented by Morgan, et al. in their analysis of disenrollment data in southern Florida. The report also points out that disenrollment rates appear to be increasing. The report warns that:

> . . . the future holds significant uncertainty about the nation's ability to protect Medicare beneficiaries in HMOs and other managed care plans. The Balanced Budget Act of 1997 dramatically expands the choices available to Medicare beneficiaries and, by the year 2002, limits their disenrollment rights. The sheer number of choices, the variety of plan benefits and cost-sharing alternatives, and our limited understanding of how best to educate Medicare beneficiaries about their choices mean that we need to do a better job of oversight and education in the future than we have done in the past.
>
> As we look to the future, federal policymakers need to allocate adequate funding and staff to ensure that Medicare beneficiaries have the information they need to make an informed choice of their health care plan. They must also use information, including disenrollment data, to monitor plans so that Medicare beneficiaries receive the benefits promised them and that "choice" does not mean "chaos."

In a survey of 37 recent studies comparing managed care and fee-for-service delivery systems, Miller and Luft (1997) found that the 15 studies addressing quality of care showed an equal number of significantly better and worse HMO results compared with non-HMO plans. The authors point out that:

> The results show something that is simple, obvious, and yet sometimes underemphasized: HMOs produce better, the same, and worse quality of care, depending on the particular organization and particular disease.

They also note, however, that:

> On the other hand, three of the five observations with significant negative HMO results focus on patients with chronic conditions or diseases who need care the most: chronically ill low-income enrollees in worse health, impaired or frail social health maintenance organization (SHMO) demonstration enrollees (who influenced the overall negative mortality results), and Medicare home health patients, many of whom have chronic conditions and diseases . . . the three significantly negative HMO quality-of-care results for Medicare HMO enrollees with chronic conditions and diseases warrant attention, especially since the studies that provided the data tended to collect substantial information on enrollee characteristics.

Schlesinger and Mechanic (1993) have identified several factors that may account for the relatively high HMO disenrollment rates among Medicare beneficiaries and the less than optimal outcomes reported in most of the studies. These factors include the following:

1. Pressure on physicians to reduce utilization of medical and speciality care services. Some plans make primary care physicians' incomes dependent on meeting utilization targets for their patients. The frequently high and persistent costs of chronic care increase the risk that providers will exceed their targets. This may lead to strict limits on the enrollment of patients with chronic or potentially chronic conditions, and efforts to disenroll those who become chronically ill, which disrupts continuity of treatment.

2. Lack of clear practice parameters for geriatric care. In the absence of well-defined professional norms of treatment, incentives under managed care capitation plans can lead to substantially reduced levels of chronic care. Professional norms for chronic care are currently vague and costs are unpredictable and frequently high. Chronic care needs vary greatly among individuals and are difficult to meet in a uniform fashion with utilization targets.

3. Failure of gatekeepers to make use of a team approach with ancillary disciplines. A number of plans depend on primary care physicians as "gatekeepers" controlling access to other providers. Primary care physicians frequently lack expertise in diagnosing and treating some chronic conditions, which frequently require a multidisciplinary team approach, including access to geriatric specialties and coordinated, non-medical supports.

Robert Kane (1998) has recommended several steps that managed care organizations should take in response to the kinds of organizational and provider deficiencies described by Schlesinger and Mechanic. In Kane's view, implementation of these initiatives could help managed care achieve its potential to provide chronic care that is superior to the quality and efficiency available in the fragmented fee-for-service system. In order to take full advantage of what we have learned about the cost-effectiveness of geriatric care models, like geriatric evaluation and management (GEM), which has demonstrated the efficiency of aggressive efforts to detect problems early and tracking them closely,[3] Kane recommends that MCOs incorporate the following components of chronic care practice supported by a comprehensive management information system.

> An annual screening survey of all the enrollees to identify those who may benefit from greater attention because they may have potentially treatable (cf.

curable) problems or have a general risk score that indicates the likelihood of their being hospitalized in the near future. . . . Our experience with one large Medicare MCO suggests that at least 15% of enrollees had risk scores that indicated a need for further comprehensive assessment).

An assessment program to establish the underlying etiologies of the risk conditions and to develop a plan of care to address them.

A tracking system to assure that the plan of care is implemented (i.e., referrals followed up and acted on).

A clinical tracking system to help clinicians follow the progress of their patients and identify when they are not faring as well as expected.

A clinical outcomes system that collects aggregated information on patient outcomes, including the effects of care on function and quality of life; the system compares actual outcomes with expected results (i.e., adjusts for case mix) to identify areas for improvement; outcome reports would be generated and disseminated periodically; outcome data would be combined with process information to establish the most effective approaches to providing care to patients with defined characteristics.

As the Health Care Financing Agency (HCFA) moves toward implementation of a risk-adjusted payment system for managed care, which will be designed to limit the affects of favorable selection increasing the number of HMO members who are chronically ill, the kind of protocols and client-tracking procedures recommended by Kane are likely to become increasingly attractive to managed care organizations.

B. Integrating Acute and Chronic Care through Managed Care

The managed care strategies described in this section include, to varying degrees, features designed to remedy current deficiencies in managed care arrangements for elderly persons who are chronically ill. That is, they attempt to incorporate incentives designed to encourage the enrollment of older persons with chronic conditions and to improve the quality of care by emphasizing geriatric knowledge and involvement of ancillary disciplines.

What we know about managed care initiatives specifically designed to integrate acute and chronic care, including long-term care for the frail elderly, has been learned in three major integrated care initiatives in the last decade. These efforts over the last decade to deliver a comprehensive array of services to frail elderly persons through managed care strategies were designed to reduce the fragmentation and unneeded care, which may be needlessly expensive and lead to iatrogenic conditions that constitute the major criticisms of the fee-for-service system. The Social Health Maintenance Organization (SHMO) project, the Program for All-inclusive Care of the Elderly (PACE) and the Arizona Long-Term Care System (ALTCS) have also been designed or modified, over the course of their implementation, to address some of the problems identified in the studies of managed care programs discussed earlier, including the provision of geriatrically oriented chronic care. We do not yet have conclusive information on the effectiveness and efficiency of these initiatives. Enough data are available, however, to begin identifying the implications of these programs for the future of health care policy for the elderly.

The deficiencies of managed care for the frail elderly that have been identified in the research literature should not be seen as fatal flaws inexorably woven into the logic of managed care. Instead, a frank recognition of these issues should stimulate aging advocates, program

managers, policy makers, analysts and managed care administrators to begin thinking seriously about how to make managed care more responsive to the health care needs of the elderly and other vulnerable populations.

The following summary of the findings from evaluations of the Social Health Maintenance Organization (SHMO) demonstration, Program for All-Inclusive Care of the Elderly (PACE) and the Arizona Long Term Care System (ALTCS) programs clearly indicate that there are features of the managed care approach that could potentially improve the quality of care for the elderly. In addition to lowering out-of-pocket expenses for the elderly, managed care can provide a coherent framework for measuring outcomes and provide a better organizational environment for fostering a genuinely geriatric model of coordinated care than the fee-for-service systems.

Social Health Maintenance Organization (SHMO). The SHMO program is designed to finance, within a capitated rate, and deliver a comprehensive package of acute, ancillary, short-term nursing home and community long-term care services for a representative population of recipients. SHMO members are eligible for all basic Medicare-covered acute and ambulatory health care services, plus preventive medical care. The SHMO also provides chronic and long-term care services to members who are assessed as eligible for nursing home care.

In order to avoid adverse selection, the first generation of SHMOs was allowed to limit the number of members with one or more activities of daily living (ADL) deficits to 5% of the total enrollment. SHMOs receive 100% of the Medicare average adjusted per capita cost (AAPCC) for the geographic area they serve. (Medicare HMOs receive 95% of the AAPCC.) SHMOs also receive the nursing home rate of the AAPCC for all members who are nursing home certifiable. SHMOs receive this rate for the nursing home eligible members regardless of whether the members actually live in a nursing facility. This arrangement, plus funds generated from monthly premiums and co-payments, allows the SHMO to pay for community services not traditionally covered by Medicare. Each of the four first-generation SHMOs, described by Leutz, Abrahams, Altman et al. (1993), shares the following features:

> A simple organizational structure at financial risk to provide a full range of acute and chronic care services to Medicare beneficiaries who voluntarily enroll in the program and pay a monthly premium for services. The premiums for enrollees eligible for both Medicaid and Medicare (dually eligible) are paid by Medicaid;
>
> A coordinated care management system to authorize long-term care services for members meeting specific disability criteria through an assessment process for nursing home eligibility—this would be comparable to the CARES process in Florida. Chronic care benefits, including short-term nursing home placement, are covered up to $7,500 to $12,000 per year in service costs, depending on the demonstration site. If the chronic care cap is exceeded, the member (or Medicaid, if eligible) must pick up the difference, except for case management costs which are not charged against the member benefit limit;
>
> An enrollment profile and service package designed to serve a cross-section of the elderly population, including functionally impaired and non-impaired

people. The service package is also designed to reduce or slow the rate of decline in functional abilities; and

A financing mechanism based on a prepaid capitation from pooled Medicare, Medicaid and member premium and co-payment funds.

The SHMO evaluations that have been completed thus far do not include data on the kinds of process, structure and outcome variables that were part of the Mathematica studies (Brown, Bergeron, Clement, Hill, Retchin, 1993) of the Medicare HMOs. With this caveat in mind, however, we can infer from the available information that these delivery systems may have deficiencies in common.

Favorable Selection. Both systems (SHMOs and Medicare HMOs), for a variety of reasons which may operate differently in each, have been characterized by favorable selection of members. This means that they have benefitted financially from including fewer of the sicker, more expensive patients than are present in the general patient population. Until favorable selection is substantially reduced by either reducing reimbursement rates or recruiting more medically involved members, neither of these delivery systems can be considered more cost-effective than the fee-for-service sector.

Geriatric Care Focus. It does not appear that either system has achieved qualitative change in the way health care for the elderly is practiced. That is, the delivery of acute care has not acquired a geriatric focus based on a systematic recognition of age-related medical conditions. Chronic care protocols, which include preventive and rehabilitative care and thorough, continuous monitoring of chronic conditions, have not become routine within either system. The latest information from the SHMO literature indicates that major efforts to develop geriatric care protocols have been recently initiated, but it is too early to determine their success.

Coordinated Patient Care. The failure to provide care characterized by a geriatric focus may be related to the third deficiency shared by the two delivery systems. Both systems have had difficulty linking acute, chronic and long-term care services in the interest of coordinated patient care. This is, of course, a larger problem for the SHMOs, whose *raison d'etre* is largely dependent on creating such linkages. It is not an insignificant issue, however, for the Medicare HMOs. Successful care of the elderly in managed care environments free of favorable selection will have to include the capacity to provide complete chronic care and well-organized access to long-term care services.

Linkage expectations are much more exacting for SHMOs than regular Medicare HMOs. In order to meet these expectations, the SHMOs, as noted in an early SHMO evaluation report (Leutz et al. 1993), will need to restructure relationships among the domains of care. This will mean involving acute care physicians and nurses in all phases of care, including long-term care, and creating seamless conduits for the rapid flow of accurate information throughout the delivery system. Well-trained and accountable case managers are critical to these tasks, but they cannot be expected to accomplish them alone. New roles, including expanded responsibilities for geriatric nurse practitioners, will need to be created; and new relationships with the home- and community-based services, especially those provided by the aging network, will have to be

established. These changes are now being implemented in a second generation of SHMO projects.

Program for All-Inclusive Care of the Elderly (PACE). The other major federal demonstration project designed to integrate acute and long-term care is the Program for All-Inclusive Care for the Elderly (PACE), based on the On Lok Senior Health Services program which was founded in the Chinatown section of San Francisco in the 1970s.

The main goal of the PACE program is to provide a continuum of acute care and long-term care to the frail, Medicaid-eligible elderly in order to enable them to live as independently as possible and avoid institutionalization. All participants must be certified by the state as nursing home eligible. Members are eligible for all Medicare and Medicaid acute and long-term care services. The provider assumes the risk for the provision of services; if the cost of services exceeds the capitation rate, the provider must cover the difference.

PACE is funded by pooling Medicare and Medicaid premiums. Persons who are eligible only for Medicare may pay a monthly premium. Persons who participate only in Medicaid or in both Medicare and Medicaid pay no premiums. The ten PACE programs are funded through the same AAPCC methodology used to reimburse Medicare HMOs, which is based on 95% of the average adjusted per capita costs (AAPCC). Rather than using the traditional rate cell adjusters for age, sex and institutional status, PACE sites are reimbursed the AAPCC rate multiplied by a single adjuster of 2.39 to reflect the frailty of the PACE population. The Medicaid rate is based on the estimated costs to Medicaid for a long-term care population. A 5% savings is built into the capitation rate, the average of which is $3,388 per month (Eng et al. 1997).

> Overall, state Medicaid agencies estimate that payment to PACE represents a cost savings of between 5 and 15% for a comparable long-term care population (Eng et al. 1997).

The PACE programs operate as staff model HMOs (i.e., physicians are employees of the HMO) and each uses a multidisciplinary case management team to coordinate and provide most services. As an HMO, PACE owns most components of the service system and directly provides or contracts to provide all services in the system. The multidisciplinary team includes all staff who provide care or who have personal contact with the individual, including the physician, nurse, social worker, nutritionist, as well as physical and occupational therapists, aides, and drivers. A geriatric treatment approach is used by the team members who have received special training and developed expertise in the service delivery system from their experiences in dealing with the health and social problems of the frail elderly. Each program is based on a day care model that is integrated with primary care. Participants attend an adult day health center, with transportation provided as needed, for supportive, rehabilitative and social programs.

The results of initial assessments of the PACE projects are very encouraging in terms of enrollee outcomes and cost containment. For example,

> . . . PACE enrollees have spent far less time in nursing homes than would be expected of a group of older people, all of whom are certified by an independent state representative as eligible for nursing home placement. Only 5% of PACE capitation days are nursing home days (Eng et al. 1997)

The PACE model seems to provide very effective and efficient care of the frail elderly who are at the greatest risk of expensive institutional placement and the diminished quality of life that institutionalization may cause. With the recent Congressional release of the PACE model from demonstration status (as part of the Balanced Budget Act of 1997) to that of a recognized Medicare option, it can be anticipated that additional providers, including for-profit hospital integrated delivery systems and aging network organizations, will offer new combinations of acute and long-term care. The strengths of the PACE model, however, may limit its utility as a comprehensive approach to changing the structure of long-term care and linking it with the acute care system. These limitations include:

> **Adult Day Center Attendance**. The delivery of care in the PACE model is organized around regular member participation in adult day health care centers. This approach seems to work very well for the frail elderly who are able or willing to attend the centers several days a week. Many others, however, will not attend centers on such a frequent basis and would be beyond the reach of a program based on the PACE model. Recent expansions of the PACE model are experimenting with more flexible day center attendance, and are expected to appeal to a greater number of potential participants.
>
> **Intensive Geriatric Focus**. The intensive geriatric care focus and team approach of the PACE model make it a feasible option for a relatively small number of organizations with the resources and experience required to meet these more rigorous geriatric care standards.
>
> **Limited Enrollment**. Finally, the relatively narrow focus on the Medicaid eligible, frail elderly who are living independently in the community at enrollment may prevent the PACE model from becoming a focal point for the comprehensive provision of managed care, which links acute and long-term care for a broadly representative population of older persons.

None of these concerns should be interpreted to mean that the PACE model should be anything other than what it is: an extraordinary resource for highly effective care of the frail elderly. PACE has many lessons to teach health policy analysts, policy makers, health care providers, advocates for the aged and others about providing effective care in settings that preserve the dignity and autonomy of the frail elderly to the maximum extent possible, or at least to a greater extent than has been achieved anywhere else, for this highly vulnerable, ethnically diverse[4] population. The PACE projects have, on the whole, demonstrated the ability to contain costs by reducing hospital and nursing home utilization.

In light of this success, consideration should be given to the possibility of incorporating the PACE approach into larger managed care networks, including those designed to serve not only the elderly, but also other vulnerable groups as well, including the physically handicapped and severely mentally ill. Experience with PACE demonstrations in Wisconsin and Massachusetts has led to the development of managed care innovations in these states designed to combine state-operated community-based service programs with the PACE program in order to extend the reach and enhance the efficacy of both programs.

Integrating PACE and SHMO programs into larger networks, such as those represented, potentially, by the aging network's home- and community-based services system could help resolve some of the basic design problems confronting both programs. Weiner and Skaggs (April, 1995) indicate that these problems arise from the strengths of the programs.

> The Social HMO model seeks to voluntarily enroll a mix of nondisabled and disabled, mostly middle-class, enrollees. The advantage of this approach is that it can address the problems of persons with short-term disabilities and has enrollment potential beyond simply the low-income, Medicaid-eligible population.
>
> This approach, however, has two disadvantages. First, in order to keep premiums at a financially manageable level for the middle-class and to compete with other HMOs, the level of long-term care benefits is decidedly modest . . . plan rather than a long-term insurance policy. Second, especially within the demonstration context, the relatively small number of severely disabled enrollees has made it difficult for plans to develop distinct services for them.
>
> At the other end of the spectrum is the On Lok/PACE demonstration . . . The advantage of this approach is that the needs of the severely disabled population are the entire focus of the program and input from a wide range of disciplines makes it more likely that the needs of the "whole" person will be addressed.
>
> The dilemma is that the single-minded focus on the disabled elderly is also its weakness. By enrolling only high-cost nursing home eligibles, the per person expenditures are so high that insurance premiums would be out-of-reach for the average person. Effectively, this means limiting enrollment to the dually eligible Medicaid and Medicare population, with Medicaid paying for the long-term care costs.
>
> In addition, the model is so resource intensive, especially in its use of adult day care programs, that it is limited in the number of persons that it can serve. . . . The geriatric multidisciplinary team, which is the heart of the On Lok/PACE approach, is also difficult to organize and run. Not only are geriatricians scarce, but the egalitarianism of the team is hard for many physicians to accept.

By integrating these programs with a larger network, like the aging network or some reconfigured version of it, the SHMO could substantially expand its membership of more seriously impaired elderly and generate the economies of scale required to develop a distinct set of geriatric services for frail elderly needing chronic care. This integrative strategy could also be used to link a PACE program with a large population which could be organized to ensure access to a large pool of frail elderly persons who need the intensive geriatric care offered by the PACE model.

Arizona Long-Term Care System (ALTCS). Unlike PACE and SHMOs, ALTCS is a statewide Medicaid managed care program, administered by state agencies, primarily the Arizona Health Care Cost Containment System (AHCCCS). The ALTCS program serves over 13,100 elderly and physically disabled (ELPD) and 8,000 developmentally disabled (DD) Medicaid recipients.[5] ALTCS's eligibility criteria limit participation to individuals with incomes up to 300% of the Supplemental Security Income (SSI) level per month, who are certified by a standardized institutional (nursing home, ICF/MR) pre-admission screening process to be at risk

of institutionalization. The screening instrument is administered by an ALTCS-employed nurse or social worker during an interview with the applicant.

The ALTCS covers virtually all traditional Medicaid program services, including mental health services, for those 18 and younger and 65 and older. Nursing home care, intermediate care in facilities for DD recipients, as well as 11 home- and community-based services (personal care, attendant care, etc.), are also covered benefits. ALTCS is also beginning to cover the cost of care in a variety of community-residential programs, including adult foster care and assisted living.

The percentage of elderly recipients receiving home- and community-based services has increased from 5% of all ALTCS recipients in 1989 to 35% by 1994. Over 90% of the DD recipients are receiving home- and community-based services and fewer than 10% are institutionalized, which helped keep costs for this part of the program at even lower levels than those achieved for the elderly recipients. As a result, ALTCS was able to contain costs 13% below levels reached by other state Medicaid programs in 1991. Total cost savings (including program and administrative costs) averaged 17% per year in the four-year period, 1990-1993.[6] The per capita costs of caring for the elderly and disabled adults were slightly higher than in the traditional programs. The higher costs among the ELPD group may be a temporary phenomenon caused by pent-up demand for care and the provision of preventive services.

Under the ALTCS model, the state contracts with one entity in each county to assume responsibility for providing services to elderly and physically disabled (ELPD) clients within the county. These entities are referred to as program contractors. The Arizona Department of Economic Security (DES) is required to serve as the program contractor for all MR/DD beneficiaries statewide. Program contractors receive a monthly capitation payment per enrollee from ALTCS. In turn, the contractors must arrange for the provision of a bundle of services that include both long-term care and acute-care services.

ALTCS has established quality of care indicators designed to ensure access to care. These include such requirements as contact by a care manager with the member within five days of enrollment; placement and receipt of long-term care services within 30 days; availability of emergency services 24-hours a day, seven days a week; availability of specialty care as needed and routine care within three weeks; and, automated case management reports. ALTCS is now developing outcome indicators for influenza immunization, pressure ulcers, emergency room/hospital utilization, fractures related to falls, use of psychotropic drugs in relation to appropriate diagnoses, and changes in activities of daily living (ADLs: walking, eating, dressing, bathing and transferring).

One essential way to ensure an acceptable level and quality of care is to implement solid quality indicators like those either in place or being developed in Arizona. This approach would be in line with the emerging consensus among policy makers and health care advocates that accountability for quality of care in managed care systems is dependent on the effective use of quality indicators, and that managed care systems are far better prepared to implement these than the fee-for-service system.

A second important issue is the role of the aging network in a managed system of integrated care like ALTCS. It does not appear that the aging network currently plays a major, systematic role in the ALTCS program. It is not difficult to imagine a scenario, however, where

area agencies on aging and providers consolidate their resources to contract with a managed care organization and to provide home and community services under either a capitated or unit-of-service reimbursement arrangement. In states or counties where the aging network already provides an extensive array of community services and operates with some degree of fiscal sophistication (can manage under a capitated system), this scenario seems entirely feasible if willing managed care partners can be found.

The SHMO, PACE and ALTCS programs demonstrate a wide range of managed care approaches to the organization and financing of long-term care and to the integration of acute and long-term care. These initiatives, however, are too limited to permit convincing generalizations about the efficacy of managed care strategies for long-term care. It is not yet clear that we know much about how to provide cost-effective chronic care in managed care environments for most Medicare recipients and we know less about how to link this care with the even less defined and accurately priced world of long-term care, which is still far too dependent on institutional care in most states. The best strategy at this point would seem to be to continue experimenting with a variety of designs, including approaches which incorporate carefully managed and evaluated aging service networks and their wide range of community-based providers. Stone and Niefeld have noted that:

> Despite the rhetoric of integration, the dearth of experimentation in this area is not surprising. One of the primary barriers to integration of acute and long-term care are the fragmented sources of financing at the federal and state levels, particularly Medicare and Medicaid. The multiple layers of policy governing the continuum of acute and long-term care significantly impede movement toward integrated approaches. A second barrier is the overwhelming concern about financial risk; the incentives that would encourage providers to develop integrated approaches within managed care arrangements are largely lacking. Two types of financial incentives are being explored to try to address the special challenges to integrating acute and long-term care services—risk-sharing strategies between payers and providers and risk adjustment methodologies to differentiate among enrollees with varying service needs and costs.

CHAPTER 3

The Role of the Aging Network

The aging network consists of state units on aging and area agencies on aging, which were established under the Older Americans Act over 20 years ago, and a wide range of home-

and community-based service providers. The aging network, in many states and communities, has the capacity to improve the quality and efficiency of acute and long-term care provided through managed care arrangements. In most communities, the aging network has been planning, providing, advocating for and ensuring the quality of community-based care for the frail elderly for over two decades. This repository of knowledge and experience, if properly organized and directed, can be used to address many of the problems identified in the research on the results of current managed care policies and practices affecting the frail elderly. Aging network experience in providing a wide array of in-home and community-based services to impaired elderly persons with chronic medical conditions contains the potential to reshape the way care is provided to this population in managed care environments by expanding the focus of conventional managed care organizations to include cost-effective forms of high-touch, low-tech support services and community-based alternatives to institutional care and broadening the service environments and population bases of more integrated managed care arrangements like the SHMO and PACE programs.

Aging policy makers and administrators at the state and local levels should be prepared to take the initiative in forging linkages with HMOs, integrated networks, provider consortia and other managed care entities. The success of these initiatives will depend on the development of organizational structures, benefit packages, capitation strategies, payment mechanisms, quality assurance methods and other features of a managed care approach to organizing home- and community-based services within the aging network itself. Success with these initiatives could lead to partnership arrangements with managed care providers. In addition, this approach would expand and diversify the array of services available to clients through the aging network than is typically available to HMO members and give the long-term care component equal standing with acute care.

A. Managed Care Functions and Potential Aging Network Roles

The specific roles to be played by components of the aging network in emerging managed care systems will probably vary from state-to-state, depending substantially on the manner in which roles are currently arrayed. States vary in terms of which components (area agencies on aging, contract service providers, state units on aging) engage in planning, provide services, conduct quality assurance, and carry out the other roles traditionally associated with the aging network. Regardless of the specific arrangement of roles, the aging network as a whole should be expected to play an important part in organizing and delivering care in integrated managed care systems. The aging network should advocate and plan for a continuation of its traditional roles (planning, monitoring, advocacy, etc.) and for the development of new roles as managed care programs emerge. Kane et al. (1996) have provided the following description of potential roles for the aging network in managed care systems:

Benefits Counseling. Activities that help elders understand and select policies and resolve issues with their Medicare, supplement insurance, managed care plans and long-term care insurance can be valuable components of the aging network's advocacy role.

Enrollment. By conducting assessments for state Medicaid managed care programs, aging network organizations can reduce opportunities for managed care organizations (MCOs) to engage in the practice of beneficial selection of members. With an independent (meaning not contractually aligned with managed care organizations) area agency on aging or other aging

network organization performing assessments, there should be more confidence that the consumer would be referred to the most appropriate service.

Problem Identification. In addition to identifying and developing strategies to eliminate barriers to services for elders, AAAs and other aging network organizations can become an intrinsic part of an effective quality assurance program for chronic and long-term care.

> Quality assurance is an important component of state policy and managed care. Well-defined roles for the aging network have not been determined in this area. One possible role is in identifying problems in the first place. Aging network organizations have a variety of formal and informal channels to get feedback on MCOs—through their advisory committees, through their contracting senior centers and meal programs, and through service providers and case managers in the network.

Ombudsman Roles. The aging network can build on its experience with nursing home, assisted living, discharge planning and home health ombudsman programs by expanding this service into the realm of managed care.

Becoming Providers in MCOs. The authors suggest that aging network organizations consider the following roles in providing services for MCOs and their enrollees.

> **For Medicare MCOs** (where long-term care is not ordinarily part of the benefit package), the roles typically involve information and referral, and linkage of the enrollee to low-cost community services (such as home delivered meals, transportation, friendly visiting).
>
> **For Medicaid MCOs**, network agencies may be involved in the kind of activities just mentioned. They may also provide a range of homemaking, personal care, home health services, day care services, and case management. Depending on the configuration of the network in the state, the arrangements may be with the AAA, with a lead case management contractor to the AAA or state unit on aging, or with network contractors.

Aging network organizations can provide these services to MCO enrollees through a variety of financial arrangements, from full-risk contracts, sub-capitation agreements, fixed budget amounts, fee-for-service or combinations of these methods.

Another option would be to develop a managed care strategy within the aging network through a contract with the state department responsible for long-term care. As noted by Tom Hamilton, Director of Community Programs for the Wisconsin Department of Human Services, in an address given at a National Academy for State Health Policy Conference in Portland, Oregon in 1995:

> Since over 80 percent of Medicaid spending for the elderly goes for long-term care services, why not organize a managed care program in the aging network, with a focus on community-based long-term care services, rather than rely on contracts with HMOs from the acute care side as the anchor for integrating acute and long-term care through a managed care framework?

The state has set up a program, the Wisconsin Partnership Program, to activate this concept. A contract between the state and a private, nonprofit community-based organization, is initiated through a request-for-proposal process. The community-based organization then subcontracts for a wide array of services including physician services, prescription drugs, nursing home care and the whole range of home- and community-based services, including residential care. In effect, the community-based organization acts as an HMO. The strategy calls for capitating one-to-two services at a time, including hospital services, once the state receives approval for a 1115 Medicaid waiver. The program is designed to limit the amount of financial risk borne by the contracting agency by spreading the risk across a network of subcontracting organizations, including other aging network providers, in a fashion similar to conventional HMO arrangements. This strategy of spreading risk, plus some sharing of risk by the state for the first three years of the contract, reduces the risk borne by any one agency and allows the network to achieve economies of scale, which generate resources for the development of common management information and claims payment systems.

It should be noted that this strategy requires considerable cooperation within the aging network. A collective commitment among aging network agencies must be demonstrated through responses to the request for proposals (RFP) and then maintained operationally through contractual agreements and collaborative management.

This type of aging network-based approach to managed long-term care could help a state counter the potentially negative effects of giving large managed care organizations complete control over long-term care resources.

B. Preparing for Aging Network Involvement in Managed Care

Walter Leutz and Mark Sciegaj (1997) suggest that aging network organizations may need to assemble "community provider networks" to pool their expertise and financial resources:

> Local aging agencies may need to come together under umbrella organizations that negotiate contracts, raise capital, take financial risk, manage information, and oversee quality. Challenges in organizing these new networks include finding providers in all locales, negotiating payment rates that will cover provider costs, and developing integrated care management systems. Assembling a community provider network and care management system is one niche that aging network agencies could fill in this market.
>
> If the public and private advocates of MCO expansions want cooperation rather than conflict, they must be careful to keep community care services visible, accessible, and responsive. The aging network can play a constructive role by offering to participate in managed care development where that development makes sense, while working to strengthen traditional models of finance and service delivery where managed care is not the answer.

Contracting with MCOs, however, to provide long-term care services as part of an integrated delivery network will be a difficult financial venture for aging network organizations. Practicing "due diligence"[7] in negotiating contract terms, especially when presented the "standard" or "model" contracts typically employed by MCOs, is essential. Aging network organizations will need legal advice from experts in managed care contracting to avoid excessive financial risks.

Leutz and Sciegaj recommend that aging network organizations initiate a systematic strategic planning process designed to develop:

1. **Mission and Vision Statements.** Mission and vision statements that clearly describe what the aging network does in providing community based care, and how its mission differs from that of other, more medically oriented organizations and identifies the aging network's "hopes for its future directions in relation to managed care."

2. **Assessments of Aging Network's Strengths and Weaknesses.** The central question you need to answer is whether managed care poses any threat or opportunity to your clients and your business. Produce internal and external assessments of the aging network's strengths and weaknesses vis a vis managed care. The internal assessment should include a realistic review of staff and infrastructure (information system) capacities, working capital and less tangible resources like community reputation and relationships. The external assessment should include an analysis of institutional threats and opportunities presented by competitors, allies, and managed care organizations.

3. **System and Organizational Strategies.** The system strategies should describe how aging network agencies might fit in a larger system that is moving toward managed care. They include various management and oversight roles in the system: MCOs contract with HCB [home and community based] providers and care managers, and maintaining a core of HCB services apart from MCOs. Unless there is movement at the systems level, it may not be possible for aging network agencies to pursue some of the strategies at an organizational level.

   The organizational strategies illustrate what aging network agencies—either individually or in combination—might pursue as managed care strategies. They include geographic expansion, service specialization, MCO contracting, and enrollment brokering. Organizational strategies represent specific steps a group of aging network agencies intends to take in implementing a managed care approach to community based long-term care. These steps might include geographic expansion, service specialization, contracting with managed care organizations, enrollment brokering, monitoring and other activities identified by Kane et al. (1996) *[Managed Care Handbook for the Aging Network*].

4. **Action Steps.** Identify implementation action steps—leadership roles, objectives and a clear time frame for achieving them.

To successfully develop and implement managed care partnerships or alliances, the aging network will need to:

Know its clients, their needs, preferences, functional status, diagnoses, socio-economic status, and services currently received. In addition, aging network agencies will need to collect data about clients who are enrolled in managed care plans and the type, amount and costs of aging network services they receive. With this knowledge, aging network agencies will be better prepared to approach MCOs for possible service contracts or improved coordination of benefits.

Develop a clear understanding of its costs for each service. This will mean consistently applying a thorough cost allocation methodology.

Learn how to price services. Price is more than cost, and is influenced by competition, demand, supply and the unique features of the local business environment.

Learn about the contracting process for managed care, including rate development, capitation, and federal and state, Medicare and Medicaid regulations for contracting with managed care organizations.

Examine and understand the benefits and risks of mergers, limited liability partnerships, service networks and other business structures employed in managed care arrangements.

Design a strategy to assume risk, involving key investors and stakeholders to develop a risk reserve, and consulting with public (AAAs, state unit on aging, county government, etc.) officials.

Conduct scientifically sound assessments of the health needs and resources of the community. A survey of providers and current service recipients, the strategy employed by many area agencies on aging, is not sufficient to determine unmet need or utilization of other services.

Develop new services when the need is demonstrated.

Employ reliable techniques to evaluate the effectiveness of services. This will entail more than an annual consumer satisfaction survey of a small percentage of its constituency. It will mean collecting data about the consumer outcomes from service

delivery, producing reports on a regular basis that enumerate and aggregate not only consumer demographics and types and amounts of services received but also trends in service utilization and service costs correlated by a number of critical variables. This will require investing in effective data automation systems; without reliable, accurate and timely data, outcomes and true costs from services cannot be gauged

Hire or contract with medical professionals who are long term care specialists, such as geriatric advanced nurse practitioners and physicians, to help design and implement the integrated care system. Train aging network staff on managed care principles.

Educate the community as to the benefits it can expect to receive from an integrated care system, including short-term and long-range outcomes such as better trained personnel, improved community health and quality of life.

Recruit and train knowledgeable and involved persons for boards of directors and advisory committees.

Area agencies on aging and aging network service providers can join forces, either in formal associations, alliances or in subsidiary corporations, to explore the managed care market within a state or region; inventory the network's long-term care services options; analyze their ability to assume risk; and make changes and improvements where necessary. By pooling expertise, information systems and its considerable public relations capital, the aging network can prepare itself to appeal not only to MCOs as contractors or partners but also to state units on aging and state Medicaid offices as able and willing colleagues to help responsibly and effectively distribute state resources to unmet needs where the greatest public benefit can be achieved.

In reality, aging networks in most states are just now beginning to employ their strengths in new models of managed long-term care. A recent survey of Area Agencies on Aging by the national Association of Area Agencies on Aging (Coleman and Graves-Tucker, 1997), found that few area agencies on aging have entered into formal relationships with managed care organizations; only 28% of AAAs that responded to the survey indicated that they even made contact with a managed care organization to arrange a meeting to inform MCOs of AAAs' programs and services. Twenty-six percent of AAAs responding to the survey indicated that MCOs were beginning to refer clients to the AAA for service.

Several AAAs, however, have taken the initiative to establish relationships with MCOs and some now have contracts or agreements to provide such services as enrollment assistance, eligibility/risk screenings of potential members, training and education about long term-care for primary care practices and advocacy services for enrollees of managed care organizations (Coleman and Graves-Tucker, 1997; Mollica and Riley, 1997). A sampling of aging network forays into managed health care follows.

C. Examples of Aging Network Managed Care Initiatives

Case management/risk assessment for managed care organizations. Elder Services of Merrimack Valley, Inc., an Area Agency on Aging located in Lawrence, Massachusetts, has initiated a risk assessment process under contract with one or more Medicare managed care organizations to identify enrollees who may be in jeopardy of serious and costly consequences from chronic health problems. Highly trained AAA staff employ a copyrighted risk assessment

instrument that covers several domains including medical, functional, cognitive, social supports, values and preferences, spiritual perspectives, nutrition, financial and others.

To obtain the risk assessment, a new enrollee in the MCO undergoes a brief screening, which generates information that goes to the primary care physician in the form of an introductory patient profile. The indicators for this profile or screening tool were selected and tested by a panel comprised of AAA and MCO representatives. The primary care physician or nurse case manager may then prescribe a voluntary in-depth assessment for the enrollee, based upon risk indicators from the screening. A licensed social worker, employed by the AAA conducts the in-depth risk assessment in the home of the enrollee. During consultation with other AAA staff, including a nurse, interventions are identified, and a recommended care plan, comprised of home- and community-based services, is developed and presented to the primary care physician. In most cases, follow-up by AAA staff, has confirmed that the AAAs care plan recommendations have been accepted and implemented by the MCO.

The MCO pays Elder Services a negotiated rate for the assessment, from $150 to $230 (1997 figures), depending upon the degree of follow-up requested by the MCO. An additional rate for on-going "risk management" of high risk enrollees may also be negotiated between Elder Services and MCOs.

In addition to conducting risk assessments for MCOs, Elder Services of Merrimack Valley has made its tested risk assessment available for a license fee to other organizations. The risk assessment tool is now being automated, which should make it more attractive to other aging network organizations. The tool has been updated and revised to incorporate a risk assessment for the medically and emotionally disabled, including substance abusers and younger mentally ill enrollees.

According to Rosanne DiStefano, Executive Director of Elder Services, considerable training was needed for staff that was more accustomed to assessing need for services, not risk. As part of the risk assessment contract, the AAA also conducts, at no additional cost, seminars for MCO enrollees on how to avoid risk and where to obtain caregiver support and retirement planning, activities which extend Elder Services' visibility in the wellness/prevention arena. There was no resistance on the part of HMOs to the plan, according to DiStefano. The first MCO contractor reported that it received favorable comments from its enrollees who appreciated being referred by their physician for a risk assessment. Recently, in addition to its MCO contracts, Elder Services has secured contracts with local corporations to provide risk assessments to elders of working caregivers.

Elder services database. In the information age, managed health care organizations and other providers are willing to pay for fast and accurate information that results in prompt service delivery and cost savings. The Atlanta Regional Commission/Area Agency on Aging (ARC) has organized information that sells, through a project called *Aging Connections Plus*. Although the ARC has developed several initiatives in the managed health care arena, its most notable and successful effort to date has been its electronic database of over 1,800 elder service providers and 2,200 services in the region. ARC maintains and updates the database, called *Connect,* which is sold for $10,000 to MCOs, hospitals, home health agencies and other businesses that want to locate public and private services for elders and disabled persons. In addition, the special aging information software, developed in association with a software vendor, can be purchased

for a $2,500 license fee by other AAAs outside the State of Georgia. The software has several screens that allow clients to be matched with services, individualized listings of services to be generated for callers and follow-up contacts to be prompted.

Other benefits for license holders include the ability to collect information about service requests and consumers for marketing purposes, to customize aging service directories for customers and to efficiently provide information and training for their staff members on community resources.

According to Cheryl Schramm, Chief of ARC's Aging Services, several AAAs in other states, including Minnesota, Illinois and Connecticut have purchased the software; the National Association of Area Agencies on Aging has expressed interest in using the product to help strengthen the AAA infrastructure and to expand opportunities to work with managed care companies, the Social Security Administration and the Health Care Financing Administration, and other organizations that track service utilization.

ARCs's Aging Connections Plus is expected to help realize other successes in the managed health care field. For example, ARC is now negotiating an arrangement with an MCO to develop an integrated care program for chronically ill enrollees. The system is expected to play an important part in arranging care plans, coordinating and monitoring services and in providing choice among providers for enrollees.

MCO enrollee advocacy. Alliance for Aging, an AAA in Miami, is in the process of setting up a unique HMO Patient Advocate Program that embodies and extends the advocacy role so familiar to AAA staffs. Fran Kramer, coordinator of the new program, explained that the Alliance for Aging noted that it was receiving a large number of requests for assistance from HMO enrollees or their family members who were unhappy with various aspects of their health care plan and who felt that the consumer relations personnel from their health care plans did not adequately resolve their concerns. In response to this unmet need, the AAA, in partnership with the Dade County Medical Association, decided to set up a more organized and responsive method to resolve service and quality of care issues.

Following consultations with the consumer affairs personnel with several of the Medicare and Medicaid HMOs in the Miami area, which has deep penetration by managed care, Alliance for Aging developed a model advocacy program that would provide consumers with a medically knowledgeable advocate (retired physician or registered nurse) who could do more than forward their complaint to the proper clinical or administrative authority within the HMO, but who would have the power to negotiate with the HMO representative on behalf of the caller about health care services, cost sharing, disenrollment and other disputes. MCOs, according to Fran Kramer, were very cooperative for the most part in providing Alliance for Aging staff and volunteers access to information about their benefits, procedures and cost-sharing requirements. In addition, agreements were reached to permit the Alliance advocate to have direct access to clinical or administrative decision makers at the MCO.

Typical calls to the Elder Helpline, which preceded the creation of the HMO Patient Advocate Program, have most frequently involved disputes with plans about services physicians have ordered that are not covered in the benefit plan, difficulties in disenrollment from HMOs, and questionable enrollment tactics on the part of HMO enrollment brokers.

By employing a cooperative and consultative approach with MCO quality assurance personnel, by seeking MCO assistance in setting up lines of communication, and by employing medically expert personnel to handle consumer complaints, the Alliance for Aging has opened new channels for advocacy and education on behalf of elder HMO enrollees. And by avoiding an adversarial approach, the Alliance for Aging may find other ways to work with MCOs to the benefit of its constituency.

Service provider alliance. The Adult Day Services Network (ADNet) of Orlando, Florida exemplifies a provider alliance approach to service provision. ADNet's brochure describes it as a "consortium of adult day service providers committed to provide and strengthen the accessibility, coordination and delivery of adult day services." By late 1997, ADNet consisted of six non-profit adult day centers, the local chapter of Alzheimer's Association and the organizing entity, Christian Service Center. Through the consortium, the six independent centers have been able to consolidate some management, operations and transportation activities, including marketing, staffing, education/training, care management and quality assurance monitoring, improving efficiency and reducing operating expenses. Callers who request adult day services benefit from the single entry point for assessment and referral. By coordinating transportation for some of the centers through a unified system, duplication of routes is a avoided and additional cost savings and efficiency are realized. As a demonstration program of the Health Resources and Services Administration of DHHS, ADNet received grant funds to participate in the Alzheimer's Managed Care Demonstration Study.

Through its consortium, ADNet expects to be able to compete with other adult day care centers, and to be able to position itself for managed care contracts that are expected to emerge as part of Florida's Nursing Home Diversion Pilot Project under development in the Orlando area. ADNet has an agreement pending with Blue Cross/Blue Shield to participate in the managed care study.

Managed care organization. Employing the rationale that AAAs and their affiliated service providers know more about managing long-term care resources than providers of acute care, several of Michigan's Area Agencies on Aging are developing an alliance to become a Medicaid Qualified Health Organization, as designated by the Health Care Financing Administration.

This designation would permit the alliance to assume risk and to contract for Medicaid-paid primary, acute and long-term care, including hospital care. The federal vehicle for this alliance is a 1915(c) Medicaid Waiver. Though Michigan officials recognize the value of integrating Medicare-funded acute care with Medicaid long-term care services, a Medicare Waiver has not been applied for at this time. According to Mary Alban, Executive Director of the State Association of Area Agencies on Aging, Michigan health officials will be keeping abreast of developments in Minnesota, the state that has advanced Medicare/Medicaid integration the farthest, before adding this component to its own long-range elder services plan. The State of Michigan is interested in developing an Arizona-type arrangement for its Medicaid services.

Plans call for Region IV Area Agency on Aging, Inc. in St. Joseph to become the managed care organization and to incorporate three contiguous AAAs for the purpose of spreading risk across a larger pool of enrollees. Region IV will contract with physicians,

hospitals, ancillary medical providers and nursing homes. Quality assurance and utilization/review of the acute and long-term care Medicaid services will also be conducted by the Region IV AAA. At present, Region IV AAA provides case management, information/referral and nursing home pre-admission screening (PAS). To avoid a possible conflict of interest, the State of Michigan will probably contract with a private organization for the PAS, according to Alban.

Overview of potential aging network roles in managed care. Managed care clearly has the potential to facilitate the integration of acute and long-term care services, to redirect resources from institutional to home- and community-based long-term care, to focus greater attention on the provision of prevention and wellness services and to make more efficient use of scarce health care resources. The aging network, through a renewed commitment to its advocacy, ombudsman, evaluation and planning functions, can play a major role in ensuring that frail elderly persons receiving publicly supported services benefit fully from this potential. The aging network at the national, state and local levels should play an assertive role in protecting the interests of the elderly in our rapidly changing health care system, particularly in the area of long-term care. Aging network leaders should vigorously resist the perception that the aging network is not equipped to significantly influence the directions of change.

The area agency on aging or a provider agency in the network can play an effective role through case management, which could even include contracting with managed care organizations to conduct assessment, care planning, enrollment and monitoring functions like the state Medicaid program does in the Arizona Long-Term Care System and some area agencies do in Oregon. The contracts, however, need to be written and implemented in a manner designed to protect the independence of the aging network agencies. The relative autonomy of the AAAs is a necessary, if not singularly sufficient, condition for effective client advocacy.

The aging network, with the leadership of the state unit on aging and area agencies on aging, can work with managed care organizations to develop planning processes that focus on preserving client dignity and delivering high quality care and conduct process and outcome evaluations of managed care programs that could become the foundation for quality improvement, accountability and innovation. Alternatively, aging network agencies can play a managed care ombudsman role through a contract with the state unit on aging and/or the state Medicaid office. In this role, which some area agencies now play in Arizona, an aging network organization could become a part of the formal grievance process for publicly supported managed care programs and play an effective advocacy role at both the individual client and system levels. System level advocacy can be based on the accumulation of individual incident data, which can be employed to identify problems in the overall structure and operations of a managed care program.

Those aging network agencies not in a position to become major managed care service delivery organizations should not assume that they will be marginalized if they choose to focus on advocacy, planning, ombudsman and quality assurance activities. Aging network agencies that do become major managed care players should not allow their responsibility for these activities to atrophy. They may have to employ imagination and energy to develop new organizational structures to fill these roles. They are likely, however, to receive substantial support in these efforts as the demand for increased accountability for managed care practice and outcomes grows in the legislative bodies, consumer organizations and the public at large. For

example, the National Association of Area Agencies on Aging could join forces on the national level with the National Chronic Care Consortium, the National Committee on Quality Assurance, the Health Care Financing Administration, etc., to develop and test long-term care quality outcome indicators, or operate/oversee the consumer grievance process.

Aging network agencies, particularly state units on aging and Area Agencies on Aging should not neglect their planning, ombudsman, quality assurance and advocacy functions—the non-service delivery roles they have performed since the implementation of the Older Americans Act in the early 1970s. On the contrary, with so little current oversight of managed care operations by federal and state governments on behalf of vulnerable, chronically ill citizens, the AAAs should be preparing to *expand and strengthen* these functions, which they are uniquely positioned to perform. In many communities, there are no other existing organizations to play these roles.

While no one can accurately predict where the current evolution of the health and long-term care sectors will lead, the comprehensive approach suggested above can place the aging network in a position to preserve and strengthen its roles as advocates and providers uniquely prepared to serve the frail elderly in a rapidly changing and highly competitive health care environment.

CHAPTER 4

Conclusion

It is becoming increasingly clearer that regardless of what form managed care may take over the next several years, the conventional fee-for-service system of delivering and financing medical care will probably play a diminishing role in the U.S. health care system. Managed care has obvious advantages for the elderly, especially those with chronic medical conditions and limited resources. Managed care reduces out-of-pocket spending for health care and has the potential to provide a more geriatrically oriented form of integrated care.

The findings from the studies reviewed here, however, indicate that managed care as a whole has a long way to go before achieving the quality of care benefits described by Webster and Feinglass. Achieving the potential of managed care to improve the quality of care for the elderly will require a shift in priorities within many managed care organizations. The goal of integrating care and improving the quality of outcomes, including quality-of-life outcomes, will have to be given at least equal priority with the gatekeeping functions.

The currently prevalent practices of micromanaging utilization, providing financial incentives to reduce use of tests and procedures, and failing to contract for specialized services, including community-based long-term care and rehabilitation services, will have to give way to a greater emphasis on individual needs and consumer choice, integration of acute, chronic and long-term care and on quality of life and functional status outcomes. This shift in priorities will require a change in how we define and measure cost-effectiveness in the care of the frail elderly. Current managed care practices tend to value:

> . . . routine services for a well population over expensive or complex services dedicated to improving quality of life for frail, ill elderly patients. This approach can be justified with recourse to cost-effectiveness comparisons heavily weighted by life expectancy and the assumption that the elderly routinely have poorer quality of life than younger individuals. Outcomes research findings from this type of managed care are ominous for chronically ill, poor, and disabled older patients. Because elderly stroke patients are among the 2% of the severely ill population that annually consumes 40% of medical care costs, rationing care under the rubric of cost-effectiveness will unjustly limit the services they receive. (Webster, 1997)

Placing a higher priority on quality of care and outcome effectiveness may limit the short-term capacity of managed care organizations to reduce health care costs. In the long run, however, improved quality of care and outcomes may save as much as constricting care in the

short-term; and even if savings are less, the improved effectiveness of care could more than compensate for the savings shortfall. For example, Horn, Sharkey, Tracy et al. (1996), in their study of HMO cost-containment strategies, found that formulary limitations on drug availability were related to higher rates of emergency room use, hospital admissions, office visits and even total drug costs. The HMO site with the least restricted formulary had the lowest utilization rates. In short, cost savings in one service may lead to much higher costs for other services and higher costs generally.

Robert Kane (1998) has pointed out that:

> . . . Theoretically, managed care offers a framework for more systematic and sustained attention. However, these benefits are not likely to emerge spontaneously. At a minimum, appropriate incentives must be created and barriers removed. Observers of the field describe an anticipated evolution in managed care from its present fixation with price discounting and access reduction to a new era of emphasizing efficiency. In that milieu, the potential of effective chronic care delivery can be well realized. Although there is little or no empirical data to support many contentions about how best to manage chronic disease, some directions seem intuitively attractive. Managed care organizations (MCOs) can establish a population-based information system that can screen for high risk persons and direct attention to their care before serious problems erupt. They can afford the investment in hardware and software necessary to create the information systems to track patient progress and share the data with members of the clinical team wherever they are located. This more sophisticated record system can improve the continuity of care. MCOs can underwrite the front-end costs of geriatric assessment in the expectation of down stream gains from subsequently reduced utilization. They can support the employment of geriatrically trained staff, who can assist many practitioners in adapting care to the needs of frail older persons. They can permit downward substitution (i.e., using personnel with lesser amounts of training to perform tasks previously thought to require higher levels of skill or experience) to find the best mix of personnel needed to provide high quality care.

Improved quality of care for the frail elderly is substantially dependent on the integration of acute, chronic and long-term care. The SHMO, PACE and ALTCS programs have clearly demonstrated the feasibility of care integration for the frail elderly, including those who are poor enough to be Medicaid eligible. Broader efforts to integrate care, however, should be designed to draw on the resources of the aging service networks that exist in every state. These networks contain the knowledge and experience in community-based care that is missing in most more medically oriented managed care organizations (MCO), and are increasingly attaining the financial and administrative capacities required to play a major role in managed care systems.

In lieu of an essential community provider designation[8] that would statutorily require MCOs to contract with aging network organizations, states should support initiatives designed to preserve private, non-profit provider agencies represented by the aging network. These initiatives should be designed to create mutually beneficial relationships between the proprietary and nonprofit HMOs and the private, non-profit agencies and help ensure an effective mix of incentives in the delivery of long-term care services. Some states, as they move toward expansive Medicaid managed care programs, have developed or plan to develop strategies designed to protect safety net providers, especially public hospitals which are substantially dependent on Medicaid disproportionate share funding to cover the cost of serving a large

Medicaid patient population (Sparer, 1996). The same kind of priority should be given to protecting the aging network agencies that constitute the safety net for the less affluent frail elderly who require long-term care services.

As managed long-term care programs are implemented and evolve, states should consider conducting demonstrations designed to test the relationship between managed care and a consumer control-oriented approach to long-term care. For example, four states are implementing a Robert Wood Johnson-funded cash and counseling project which, in combination with the managed long-term care project, could provide the framework for managed care/consumer control projects designed to test mechanisms for merging the cost-containment, efficiency-oriented features of managed care with the client autonomy-oriented features of a consumer-control model.

There is no avoiding the fact that programs designed to feature consumer choice and autonomy will not be fully compatible with a conventional managed care approach. This does not mean, however, that they are completely inconsistent in terms of some fundamental logic. The conventional managed care approach could be modified to permit a wide range of choice and discretionary decision-making on the part of the client within a capitated system.

States should also be prepared to address the ethics of managed care and long-term care. Interest in the ethical dimension of medical care is increasing. Most of the interest focuses on acute care issues related to “end-of-life” decisions. There is evidence, however, that chronic and long-term care are gaining attention from medical ethicists. Managed care approaches to long-term care are likely to increase their interest, and that of policy makers, in the ethical aspects of how we organize and fund long-term care.

Rosalie Kane (1996, Summer) points out, however, that our perspective on these ethical concerns should be informed by the reality that:

> The current fee-for-service and private insurance situation does not provide inclusive and fair access for seniors; managed care must be evaluated against this reality rather than some mythic ideal. Second, we must recognize that increasingly much of the American public receives some form of managed care. Despite the great reluctance to toy with the Medicare program’s structure, advocates for the elderly population must take the need to contain the costs of health care seriously.

Finally, states should develop systematic program monitoring and quality assurance strategies based on client satisfaction and client care outcome measures and program report cards. These strategies should be developed cooperatively with providers and include a major monitoring quality-assurance and advocacy role for the area agencies on aging and other aging network agencies.

Maureen Booth (1996) of the National Academy for State Health Policy has noted that:

> While it is too early to conclude whether managed care is an effective service delivery system for these more vulnerable populations, early experience suggests that design features of most state quality management systems for AFDC managed care programs are insufficient to monitor the special needs of older persons and persons with disabilities.

> A system must be constructed which is capable of assessing program performance where very few absolute standards of care exist and where quality of life factors into decisions as much as quality of care. It is a system which looks at the decision-making process as much as the outcome and care process. These are new perspectives for state Medicaid agencies that demand a new set of skills and expertise. More importantly, these roles require that state agencies step out of the confines of their regulatory responsibility to monitor quality and look to other state agencies, community organizations, advocacy groups, consumers, and their caregivers to become meaningful partners in quality management process.

A quality management system of the kind recommended by Booth would be designed to cover virtually every activity of a managed care program, including marketing and enrollment, consumer empowerment, access to care, care coordination, complaint and grievance procedures, outcome performance and quality improvement procedures. At this point, few publicly or privately funded managed care programs are close to implementing such a comprehensive quality management system. Many more organization, however, will acquire this capacity over the next few years as the HEDIS and CHAPS outcome assessment systems are implemented across the country and the data are routinely reported by HCFA.

Nevertheless, enough progress has been made in the development of managed care performance measures to establish a provisional framework for a comprehensive quality management system that could be implemented in managed care programs for the elderly within the next few years. We will not know how effective the measures we have are until we gain experience from implementation efforts and are in a position to learn from practice. The aging network, especially the area agencies on aging, should be expected to play a major role in the development and implementation of quality measures for managed care programs serving the elderly.

No one should assume that managed care will become the only method for delivering and financing long-term care. Moreover, managed care, however we define it now, may undergo so many changes over the next several years that it will become something qualitatively different from, and hopefully superior to, the current model.

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[1]**Endnotes:**

1. A capitated rate is the set amount of money, usually paid monthly, a managed care organization (MCO) receives to meet the health care needs of each of its members. The MCO is responsible for costs incurred in excess of the amount provided under the rate.

[2]2. TEFRA HMOs are Medicare primary/acute care health maintenance organizations which became operational in 1985 under the Tax Equity & Fiscal Responsibility Act. TEFRA HMOs receive a prescribed amount from Medicare each month to pay for all medical services needed by enrollees.

[3] A comprehensive review of the research literature on geriatric care by Hongbin Chen found extensive evidence supporting the effectiveness of several models of care in a variety of settings compared to more conventional styles of care.

[4] The National PACE Association provides the following ethnic distribution of its participants: African American, 29%; Latino, 13%; Asian/Pacific Islander, 7%; other, 2%. This distribution may be considered another indicator of PACE's cost effectiveness, since ethnic enrollees in all health care systems tend to have more chronic conditions.

[5]4. ALTCS Enrollment Summary Report (HP07M77D-7/1/96), as reported by Suzanne Stearns, Financial Manager, Arizona Long-Term Care System, August 11, 1996, at a conference entitled, "Managed Care and Dually Eligible Persons: Connecting Acute and Long-Term Care," St. Paul, MN.

[6]5. Laguna Research Associates Summary of Findings, as reported by Suzanne Stearns, Financial Manager, Arizona Long-Term Care System, August 11, 1996, at " Managed Care and Dually Eligible Persons: Connecting Acute and Long Term-Care," St. Paul, MN.

[7]6. In a four-part presentation in December 1996 on *Contract & legal considerations to protect your organization*, Mark J. Waxman of the law firm Foley, Lardner, Weissburg & Aronson (Washington, DC) reviewed capitation and risk-sharing issues, anti-trust concerns, enrollee termination and grievances typical in contracts with MCOs.

[8]7. Essential Community Providers are designated by state legislatures or state government agencies as exclusive or preferential providers of certain services in certain geographic areas. Typically, local public health units and community mental health agencies have been awarded ECP designation.