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TRANSFORMING HEALTH CARE SYSTEMS FOR THE 21ST CENTURY ISSUES AND OPPORTUNITIES FOR IMPROVING HEALTH CARE

FORUM

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TRANSFORMING HEALTH CARE SYSTEMS FOR THE 21ST CENTURY ISSUES AND OPPORTUNITIES FOR IMPROVING HEALTH CARE

WEDNESDAY, MAY 13, 1998

UNITED STATES SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 9:36 a.m., in room SH–902, Hart Senate Office Building, Hon. Charles E. Grassley, (chairman of the committee), presiding.

Present: Senator Grassley.

OPENING STATEMENT SENATOR CHARLES GRASSLEY, CHAIRMAN

The CHAIRMAN. Good morning, everybody. I am Senator Chuck Grassley. I am chairman of the Committee on Aging and also a member of the Finance Committee that deals with legislation that a lot of you are interested in and probably your purpose for being here today. I thank you for coming.

I have the privilege of just opening this meeting and then, obviously, the workhorses are the people that are the moderators and the experts that are up here with me. We thank you all very much for coming, and we do welcome you. I appreciate your being here to discuss the potential for improving chronic care for elderly Americans.

I am especially grateful, of course, to our distinguished panel of witnesses and to Andrea Gerstenberger, who has traveled all the way from California to be here with us as moderator.

Obviously, you know that we are here to discuss the special care needed by seniors with chronic conditions and to develop recommendations for improving the health care system in that specific area. In particular, the discussion will examine the existing barriers in the Medicare and Medicaid programs that stand in the way of efficiently serving persons with chronic conditions.

Unfortunately, individuals and family members coping with chronic conditions are much too experienced with the fragmented system that we have. Too often the fractured system prevents elderly Americans with chronic conditions from receiving the appropriate medical and social services that they desperately need. We must work to improve the delivery of care for these individuals.

We have learned much about how the system works and we have learned much from the people who are experts in this field, specifi-

cally in health care. But we now know that elderly persons who are dually eligible for Medicare and Medicaid have poorer health than Medicare-only beneficiaries. They often have chronic conditions, such as Alzheimer's disease, diabetes, cancer, arthritis, mental illness, and chronic heart conditions.

We also know that these chronic health conditions require very special attention. It takes coordination of the individual, the family, doctors, nurses, and other health experts to care for a person with these special needs and conditions. Fortunately, advances in medicine have provided many ways of managing chronic conditions. But fragmentation in the system often creates roadblocks that prevent chronically ill individuals from receiving the best care possible.

Without proper care, chronic conditions can quickly worsen, and fragmented care can mean skyrocketing cost. Average nursing home care can cost $40,000 per year. Home health care can range from $50 to $200 per day. When paid by an individual such health care expenses can quickly exhaust a lifetime of personal and family savings. When paid for by Medicare and Medicaid programs like this cost into the billions of dollars.

So I am glad to announce that Senator Wyden and I are working together to craft legislation to address the specific needs of individuals who have chronic conditions. My bill would create a commission to study chronic care needs. Senator Wyden's bill would create a demonstration project for integrated care. We plan to introduce both bills in the near future.

I am confident that this forum will provide a constructive debate on the barriers in the Medicare and Medicaid programs that stand in the way of serving people with chronic conditions. So I look forward to hearing the recommendations for actions that will emerge from your discussion this morning.

Ms. Gerstenberger will introduce the panelists and will lead today's discussion. After we hear from each of the panelists she will take written questions from the audience. My staff has provided question cards that we will be collecting during the forum.

Now I am pleased to introduce Andrea Gerstenberger, the moderator. She is a senior program officer at the California Health Care Foundation, and in that position she specializes in health care for special populations and managed care. Previously she worked for the Robert Wood Johnson Foundation where she developed and managed a number of projects related to serving individuals with chronic conditions. We are very pleased that you, Andrea, are able to join us. Thank you very much and please take over.

STATEMENT OF ANDREA S. GERSTENBERGER, SC.D., SENIOR PROGRAM OFFICER, CALIFORNIA HEALTHCARE FOUNDATION, OAKLAND, CA

Ms. GERSTENBERGER. Good morning, and thank you very much, Senator Grassley. It is really an honor to be here to participate in this forum. You have brought together a distinguished group for this discussion and I am honored to help facilitate it, even though it definitely feels like 6:30 in the morning to me right now.

You have set out a complex task for us this morning, asking us to take on three things. To outline and discuss the care needed by elders with chronic conditions, to outline the problems within our

current system or non-system of care for them, and to highlight some current innovations that are designed to improve things. Beyond that, to highlight some areas for policy innovation. I am excited to hear that Senators Grassley and Wyden are taking active steps to address both documenting chronic care needs and fostering more innovations.

Before we go into the presentations I want to take two minutes for a little more background. Senator Grassley has listed some chronic conditions, things such as diabetes, cancer, arthritis, mental illness. The main feature of these conditions is that they fade in and out, they have acute episodes, and they last for a lifetime. Now I want to give you four more quick facts before we begin.

One, over 100 million Americans of all ages have a chronic condition, 40 million of these experience a functional limitation as a result of their condition, meaning they cannot perform activities of daily living.

Second, an estimated 70 percent of the care given to these chronically ill people comes from informal, unpaid sources. That is, family members, friends, and neighbors. In fact, one estimate says that one in four Americans is currently an informal caregiver.

Third, most chronically ill people are not in institutions. They go into nursing homes and institutions when their functional status worsens or when they do not have informal care available to them.

Last, the cost of medical care for the chronically ill was 470 billion in 1995, which represented 70 percent of total U.S. medical costs. This 470 billion does not include institutional costs like nursing homes, nor does it estimate the cost that would have occurred if informal care had not been available.

So chronic illness does represent a growing challenge. As all of these over 100 million Americans age and develop secondary conditions and comorbidities and the functional limitations that typically occur with age, we will be facing some real challenges. As the informal care sector disappears because of smaller family sizes and more families spread out geographically, and with more women in the full-time workforce, keeping in mind the fact that women have done over 75 percent of informal caregiving in the past, the country will become increasingly and acutely aware of the weaknesses in the ways we currently finance, deliver, and coordinate care.

So again, it is an honor to be here, and without further adieu I want to introduce our first speaker, Mr. Rich Bringewatt, one of the Nation's leading experts on chronic care. Mr. Bringewatt is the president and CEO of the National Chronic Care Consortium. The consortium is a national non-profit organization comprised of 34 of the Nation's leading health care providers who are collaborating to develop innovative models for integrating care.

Mr. Bringewatt developed the chronic care network strategy that is central to the consortium's work and was the leader in developing the National Chronic Care Consortium. Prior to his role there he worked extensively with the spectrum of acute and long term care providers.

Mr. Bringewatt.

STATEMENT OF RICHARD BRINGEWATT, PRESIDENT AND CEO, NATIONAL CHRONIC CARE CONSORTIUM, BLOOMINGTON, MN

Mr. BRINGEWATT. Good morning. The purpose of my presentation today is to substantiate the need for a strong health care agenda focused on people with chronic conditions. Managed care financing has been the most influential force in our current health care reform efforts. By establishing fixed dollar limits for a defined benefit package, to be received by Plan beneficiaries, public and private payers really have fundamentally changed health care. Managed care financing has squeezed out costs of provider operations and expedited consolidation among providers and payers.

In some cases, these arrangements have limited consumer access, have created real disincentives for serving high risk populations, and in some cases, have discouraged coordination and continuity of care. Further containment of health care costs and improved quality will not occur without fundamentally changing the way we finance, administer, and deliver care.

Next stage reform will only succeed, if we recognize that chronic conditions are the number one health care problem and substantially change existing infrastructure accordingly. Next stage reform must include two additional major components; one, integration, and two, long term care.

To succeed, we must move beyond consolidation of balance sheets and boards and evolve towards integration of care information and financing. It is important for us to not equate consolidation with integration. Integration requires care to be coordinated across provider settings, for networks to collect common data across provider settings and over time, for network providers to share risk rather than separately receive capitated and discounted payments, and for network providers to have the flexibility to offer whatever combination of care is most clinically and cost effective in addressing a person's condition.

Second, we must recognize that long term care is an integral and cost effective component of health networks. Currently, long term care is not integrated in many of our Nation's health networks. While the term chronic care often is used interchangeably with long term care, chronic care includes the entire spectrum of primary, acute, and long term care services. Ellective care requires dynamic interchange of these major segments of the health care industry. Chronic conditions are progressive and have no known cure.

Over 100 million people have one or more chronic conditions. Nearly 40 percent of the elderly not living in institutions are limited by chronic conditions, and in the next 25 years the number of persons with chronic conditions will increase by over one-third. As the population ages and new drugs and medical technologies extend life, the importance of chronic care will only become more pronounced.

Approximately 40 percent of Americans with chronic conditions have more than one chronic condition. The number of elderly with multiple conditions is even higher, 70 percent.

Multiple conditions means increased prevalence of limitation, mobility, sensory capability, and intellect. As the demographic im-

perative facing our Nation grows, it will have significant implication for how we structure the ongoing management of care within our health care delivery systems.

The economic implication of this growth in chronic conditions is staggering, in light of pressures to contain expenditures under Medicare and Medicaid. In 1990, 70 percent of all personal health care expenditures can be attributed to care of people with chronic conditions. These figures include skilled nursing home care, but they exclude the cost of long term care, program administration, research, and other components of a health care budget. Therefore, the 70 percent figure actually underestimates the total amount of overall spending on care for the chronically ill. With per capita costs for an individual with multiple conditions six times greater than an individual with acute conditions, the growth in chronic care problems has a multiplying effect on health care expenditures.

While policymakers often equate chronic care with long term care, almost two-thirds of the chronic health care dollars are spent on hospital and physician services. Excluding nursing home expenditures, chronic care costs were more than three times the cost of care for acute conditions in 1987. That is within our traditional medical care system. Over 40 percent of the total cost for chronic conditions was paid by Federal and State Governments, compared to only 19 percent of the cost of acute conditions, making chronic care a significant public issue.

Chronic care is the number one publicly financed health care expenditure, and costs span the full range of primary, acute and long term care.

To resolve the chronic care challenge we believe it is critical that Congress shift the focus of policy from short term cost containment achieved through ratcheting down payments to specific provider segments, e.g., hospitals, nursing homes, home health agencies, and physicians, to focus more on the problems of people. Public officials, like in the private sector, will increasingly find it necessary to become more person-centered and less focused on simply being "consumer friendly."

At its simplest level, problems of chronic disease and disabilities are marked by five key characteristics. They are multidimensional, meaning they affect more than one body system and/or dimension of well being. They are interdependent, meaning that the interrelationship among the multiple problems of a person's condition makes care extremely complex. They are ongoing, meaning the problems do not go away after a person leaves a physician's office or is discharged from a hospital. They are disabling, meaning they can significantly affect a person's ability to carry out the most basic activities of daily living. They are interpersonal, meaning the problems of people with chronic conditions affect and are affected by families and friends.

To achieve long term cost savings and quality—and we think those are compatible objectives—we believe that all administrative, financing and delivery systems must correspond to the characteristics of chronic illness.

Perhaps, the most important factor in improving the quality of care for people with chronic conditions and reducing cost is to understand the cumulative effect of care interventions. For example,

any person with a chronic condition, who receives care, as an example for a hip fracture or stroke, receives care from multiple service providers, often using separate and unrelated care interventions. These conditions are invariably preceded by other chronic conditions, such as hypertension, osteoporosis, or other biological conditions, which in turn are preceded by genetic or environmental or social behaviors that increase the probability of the presence of seniors and high cost conditions at a later date. The probability of having a hip fracture or a stroke is directly related to some of those preceding conditions. As a persons condition evolves many trigger the need for a lifelong series of long term care interventions.

So depending upon how we address the presence of chronic conditions as a condition evolves over time, the level and prevalence of disability, and the cost of health care goes up or goes down.

It is also important to note that providers receive financing for chronic care services from many different funding sources resulting in significant fragmentation of care. Each payer has its own rules, regulations, who is eligible for what benefits, who should provide what care, how should it be provided, et cetera. Differences in administrative requirements among payers makes it extremely complicated and expensive to manage care within one program setting, let alone across programs, which is key to achieving cumulative cost and quality objectives in chronic care management.

Ellective national policy requires that we must eliminate needless administrative duplication, reduce cost shifting between Medicare and Medicaid, and offer providers who serve the same person, incentives to establish common clinical and financial goals across the network as opposed to within each provider setting.

The solution to the chronic care dilemma requires system transformation. If we look at care through the lenses of the people who have chronic conditions we see care requirements that are very different. Health care today is a highly specialized industry. Yet, if we look through the lenses of people with chronic conditions, it requires us to move from an industry focused on specialized providers to care by interdisciplinary care teams. To move from independent action by individual providers to managing care across settings under coordinated care plans.

To move from a disease orientation to a disability prevention orientation as that trajectory of disability progresses for any given person. To move from an institutional-based to a home and community-based approach. To move from a reactive crisis orientation, whether that is within acute care or long term care, to proactively pursuing long range, aggregate cost and care objectives.

We are nearly 500 days away from the 21st century. While there are many health care issues of importance to the American people and to Congress, there is no issue more important than transforming care for people with chronic diseases and disabilities. The Balanced Budget Act of 1997 included a number of measures that will enhance care and reduce cost for those with chronic conditions.

The demographic and financial imperatives surrounding chronic conditions, however, requires Congress to lay the foundation for a new wave of health care reform. We must restructure rules and regulations to promote person-centered care for chronically ill people, and where greater collaboration exists among Federal pro-

grams, among Federal and State programs, between public and private sectors who pay for the same set of care, and among purchasers, payers, or providers of service in addressing the spectrum of chronic care concerns.

The Chronic Care Act, soon to be introduced by Senators Grassley and Wyden, offers the kind of leadership necessary for next stage health system transformation. The legislation would establish a chronic care commission, which among other things would outline a national policy agenda in chronic care for the 21st century. It would establish quantitative goals for reducing disease prevalence and cumulative health costs over time. It would direct the Secretary to identify legislative and regulatory barriers, risk factors associated with chronic conditions, and disability-based outcomes measures focused on function as well as medical indicators.

It would direct MedPAC to identify financial incentives for health plans and provider networks to target high cost, high risk populations. It would establish a national clearinghouse on chronic care to educate the public about chronic care issues, health care professionals about best practices in chronic care. It would develop chronic care prototypes through a partnership between HHS and the VA.

If you have any further questions or comments I would be pleased to respond during the question and answer period.

[The prepared statement of Richard Bringewatt follows:]

The Chronic Care Challenge: Preparing for the 21st Century

The NCCC Vision for Transforming Healthcare

Written Statement Prepared for
Senate Special Committee on
Aging

Senator Chuck Grassley, Iowa, Chairman
Senator John Breaux, Louisiana, Ranking Member

"Transforming Health Care Systems for the 21st Century:
Issues and Opportunities for Improving Health Care
for the Chronically Ill"

Wednesday, May 13, 1998, Room 902 Hart

Richard J. Bringewatt
President and CEO
National Chronic Care Consortium

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Introduction

The healthcare industry in the United States is in the midst of profound change. Virtually every dimension of healthcare's approach to administration, financing, and delivery is being questioned. Healthcare reform is at the forefront of critical issues on our national agenda.

Most reform today is driven by two sources: government and employers. Government, plagued by escalating costs to Medicare and Medicaid, has sought to finance care through pre-paid, per capita, fixed-rate financing structures that empower health plans to offer a pre-defined set of benefits to program beneficiaries living within defined service areas. Employers have pursued a similar strategy in seeking to reduce the cost of production and maintain or gain a price advantage over their competitors. Both have employed managed care financing methods to control costs, including HMOs who act on their behalf in contracting with providers and controlling service utilization.

In most cases, providers have responded by pooling their assets with like-minded organizations and establishing new administrative and marketing structures that enable them to successfully compete for limited contracting opportunities. These consolidation strategies have been driven primarily by large hospital systems, seeking to maintain or expand their market share and to stabilize their referral base with physicians. Increasingly, consolidation efforts are moving across state lines. More recently, leaders within the nursing home industry have created long-term care alliances to leverage contracting opportunities with HMOs, prepare for new pressures to contain cost, and develop new business opportunities. Consolidation has been pervasive within the home health industry as well. In most cases, however, these efforts have not fundamentally changed the nature of how care is provided.

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Last year as part of the Balanced Budget Act of 1997, Congress passed legislation that will expedite the consolidation effort, but still may not fundamentally change how care is provided. Integrated service systems will be able to "go at risk" for Medicare financing without HMOs functioning as third-party payers, and HCFA will soon move Medicare financing of home healthcare and nursing homes to prospective payment. States are also becoming more and more aggressive in moving Medicaid to capitated financing.

Almost all of these changes are focused on reducing the costs of care as provided by hospitals, physicians, home health agencies, and physicians. Providers serving the chronically ill and disabled will still function as separate and unrelated providers, although they may offer different aspects of care to the same person. And, while there is increased recognition of and support for continuity of care for the chronically ill, most cost reduction and consolidation efforts will maintain if not further reinforce unit hospital and long-term care structures, without regard for the cumulative cost and care effects of addressing problems that cross primary, acute, and long-term care service sectors. The focus of reform is still more on the problems of payers and providers than on the problems of people served. It is still more on achieving efficiencies in the operation of existing programs than on containing costs through better care methods, regardless of who provides it.

The National Chronic Care Consortium advocates for a next-stage reform strategy that is rooted in principles of care critical to serving people who have chronic diseases and disabilities. People with chronic diseases and disabilities are the fastest-growing, highest-cost, most complex user segment in healthcare. Almost 100 million Americans have one or more chronic conditions. Chronic conditions account for about 80 percent of all deaths and 90 percent of all morbidity. Seventy percent of all medical costs relate to people with chronic conditions. One half trillion dollars a year is spent on

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problems of chronic illness. If we are going to adequately address the cost containment problems of the future, if we are going to maintain quality care over the long term, it is absolutely vital that we give more attention to the problems of chronic disease and disability.

Since 1990, the NCCC, comprised of 34 of the nation's leading health systems, has focused on establishing chronic care networks (CCNs), or person-centered, community-based, systems-oriented methods for people afflicted with problems of chronic disease and disability. The focus has been on changing the infrastructure of health systems operation to prevent, delay, or minimize the progression of disability associated with chronic conditions. New methods of operation are being established to manage care across time, place, and profession and to provide whatever combination of care is most efficient and effective in achieving cumulative cost and quality objectives.

NCCC members believe that the success of cost containment and the health and well being of Americans requires that we move beyond containing costs and consolidating authority within the confines of existing institutions and establish new methods that are more in keeping with the fundamental nature of problems that are most prevalent today and that will dominate health care well into the 21st century. It requires that we come to grips with the fact that healthcare is changing from an acute to a chronic care business, and that a fragmented, crisis-oriented delivery structure can have adverse effects on the quality of life for people with chronic conditions. It requires that we view what we do through the lenses of people who will be the primary users of healthcare for the next 30 years and transform operations to be more in keeping with the prevailing characteristics of chronic disease and disability.

It is increasingly important that we think about healthcare reform in waves, with an eye toward current and next stage marketplace conditions and that we recognize change as constant rather than transitional.

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We can think about the current wave of reform driven primarily by managed care financing and marketplace competition. The tenets of managed "care" are yet to be fully realized. The primary purpose of those who purchase care has been to reduce the flow of money to providers of care in order to achieve greater efficiencies in care delivery. To date, these pressures have been sufficiently strong that most providers have been forced to downsize without fundamentally changing the mix of program operations. Hospitals, physicians, nursing homes, home health agencies, and other care providers continue to function as unrelated businesses. Providers have responded to a change in payment methods, but not to a change in the nature of presenting problems.

While in the midst of the current healthcare reform wave, we need to begin thinking about the second wave, one that will be far more important to meeting the healthcare needs of the 21st century. Over the next five years we are likely to experience pressures to contain the costs associated with problems of chronic disease and disability. We are likely to experience pressure to move reform from the executive and accounting offices and board rooms to the infrastructures for managing money, information, and care. We are likely to be asked to fundamentally transform our responses to the problems of chronic disease and disability among people living within defined communities, with a focus on cost containment through methods that reduce cost and improve care. Providers are likely to feel pressure to redirect their attention to improving care outcomes for those served and to maintaining customer satisfaction without increasing costs. As a result, a whole new wave of reform is likely to emerge with the focus on the highest cost and fastest growing user group in healthcare, namely people with serious and disabling chronic conditions.

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In addition, long-term care, public health, home care, and alternative therapies are likely to become more mainstream. The foundation of care is likely to move from hospitals and nursing homes to the home and to community care centers which empower people to define and manage their own care through the use of new self-care technologies, reinforced by institutions that blend the expertise of public health, primary, acute, and long-term care. Cost containment is likely to become more focused on the accumulation of costs across settings and over the long term, with interventions targeted more toward issues of prevention and with dollars flowing to whatever combination of care is most cost effective in achieving predefined outcomes.

As we prepare for this second wave of reform, we need to do more than consolidate assets. We must not become complacent with the structures of managed care financing. We must find ways to do more with less. Our goal must be to fundamentally change the nature of how we do business, with sensitivity to improving how we care for our most vulnerable citizens.

We must build upon the progress that currently exists without becoming trapped by the needs of new and more powerful mega-institutions with old-line service structures at their core. We must move out of our boxes of component-based management, specialized medicine, and facility-based planning and into more of a collaborative model of care where seemingly disparate programs function as a single system. We must seize the moment and establish a new methods of operation that are more in keeping with what we know will be the primary healthcare business of the 21st century—problems of chronic disease and disability. We must see through new lenses, learn a new language, develop new skills, and transform the nature of our business to build and preserve healthy communities through more person-centered, systemic approaches to care.

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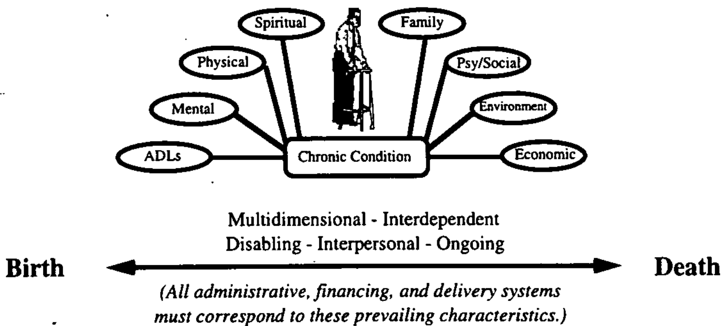
The Nature of Chronic Diseases and Disabilities

The starting point for system transformation is understanding that the needs of people with chronic conditions are fundamentally different from those of other individuals. Chronic diseases are multidimensional, interdependent, disabling, interpersonal, and ongoing. Unfortunately, our current healthcare environment defies the logic of these characteristics. We are not multidimensional; we are highly specialized. We are not interdependent; we are highly fragmented. We focus more on disease than we do on disability. We frequently ignore the benefits of interpersonal relations. And we respond to the crisis of the moment, not to the ongoing nature of chronic conditions.

If we are going to fundamentally transform healthcare to improve quality of life and at the same time to save costs over the long term for those who are being served, we must take into account these characteristics of chronic illness. Chronic care is a systems problem and requires a systems solution.

Person-centered Chronic Care



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Multidimensional

In considering healthcare, we make an arbitrary distinction between acute care and long-term care. People think about acute care in terms of hospitals and primary care physicians and about long-term care in terms of nursing homes and home care organizations. People who have chronic diseases and disabilities require the full array of services as their conditions evolve and their needs change. The body, mind, and soul are all affected by and affect problems of chronic disease. Where and how people live are part of the problem and solution. We need to think about and prepare for the multidimensional nature of chronic conditions and not think the problems of chronic illness can be solved with a single pill or any single care intervention.

Interdependent

In healthcare today we tend to organize, finance, and deliver care around three factors: healthcare setting, profession, or funding source. Each place, profession, or funding source has its own system for managing quality and cost. Each uses its own approach to defining the problem, providing care, planning and managing care, and monitoring and reporting costs and results. Each assumes responsibility for chronically impaired people, many times for the same person, yet each functions as if all were unrelated healthcare domains. The fact is, people with chronic diseases and disabilities require the full array of settings, working together to achieve a common care outcome. People with chronic conditions need the full array of healthcare professionals to see themselves are part of the same care team.

Consider a person with a hip fracture—something that is clearly part of the acute care environment but is also a chronic condition that evolves over time. After a person fractures her hip, she probably arrives in an emergency room where she is assessed and is moved into a hospital setting. In the hospital setting, professionals develop and implement a care plan and,

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increasingly, shorten the length of stay. They move this person to another environment, such as a subacute care facility, where other professionals create and implement another assessment and another set of interventions, and where, increasingly, they shorten the length of stay. The person is discharged from that setting to a nursing home setting, where there is another array of providers who do an assessment and a care plan and who, increasingly, shorten the length of stay to discharge the patient to a home care setting. In home care, there is another assessment, another care plan, and another healthcare professional. In many cases these settings are different organizations, paid by different payer systems that involve different governance structures and different providers. Yet this is the same person with the same problem, simply at a different stage of the condition.

It makes no sense to organize healthcare around these silos of provider operation and not look at the management of care in relation to the evolution of the condition. We are not going to contain cumulative costs and improve overall quality until everyone involved in the care of people with chronic conditions, regardless of training or place of employment, sees themselves as a part of the same team and works together to manage care through a natural care episode.

Disabling

As healthcare professionals, we are trained to respond to healthcare problems in relation to a specific event. Society's cure-oriented, crisis approach to care planning and treatment has resulted in remarkable improvements in acute care and our overall quality of life. However, it has also caused us to wait for problems to occur before we intervene. Preventing, delaying, or minimizing the progression of disability is a critical function of cost and quality — and must be maintained as a compatible concept. It is critical to achieving long-term cost savings through quality care interventions.

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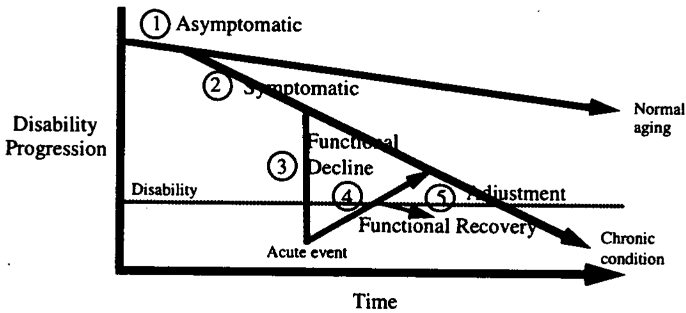
In their article, "Preventing Frail Health", Buchner and Wagner (1992) identify the normal aging process as a general decline of functional ability, with certain events pointing a person on a path toward significant, long-term functional dependence. Disability prevention interventions involve preventing the onset of disabling events, retarding the progression toward further dependence once an acute event has occurred, and precluding recurrence and/or optimizing functional recovery. Healthcare interventions at key points in time can minimize high-risk/high-cost events, even though they may be unable to prevent the natural, ongoing decline of functioning which is the result of normal aging. When we think of proactive disability intervention rather than reactive medicine, we are preventing, delaying, or minimizing the progression of disability over an extended period of time.



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Personal/Interpersonal

We think about individuals and families in terms of patients who are recipients of our care, rather than as active participants, if not primary managers, in the ongoing care process. When we think about self-help strategies, we think about individuals doing for themselves what healthcare professionals might normally do rather than of empowering individuals to maintain an ongoing, quality, healthy lifestyle, regardless of their stage of disability. As we move into the coming phases of healthcare reform, it is vital that we take into account the fact that chronic diseases and disabilities involve, affect, and are affected by the values and priorities each of us holds, and the relationships we have with spouses, family members, friends, and neighbors. These factors affect the outcomes as well as the problems that a person has at any given time. We need to integrate care with the values, norms, and conditions of those we serve, as well as their family and community of residence.

Ongoing

The last characteristic—and maybe the most significant—of chronic disease and disability is the ongoing nature of chronic illness. It is important that we organize financing, administration, and service delivery around the assumptions that these problems are ongoing, not isolated events. The focus is on what transpires over *a period of time* rather than on what happens at *any point in time.* This defocusing on how we view the problem has significant implications for how we manage our time and resources.

As we consider transforming healthcare, we need—at all levels of public policy, administration, financing, and delivery—to understand that the majority of our problems today are not about evil motives or incompetence. The healthcare industry is filled with honorable, bright people, people who want to do what is right. The problem of our current healthcare environment relates more to governance, programs, financing, and

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information systems that do not respond to the critical dimensions of chronic care. They do not enable us manage care in relation to the trajectory of chronic disease, to reduce the accumulation of cost over time, and to optimize the health and well being of individuals throughout the evolution of any disease or disability.

Unless we address the ongoing nature of chronic conditions and integrate care over time, we are not going to solve our healthcare problems.

A Trinocular View

Once we understand the nature of chronic diseases and disabilities, the first action we must take is to change the lenses we use for viewing our healthcare environment. The mental lenses that we look through guide our decisions; how we define the problem has as much to do with our training, our perspective on life, and our values, as it does with the nature of the presenting problem.

Within the provider community, there are three main professional groups that will shape how chronic care is practiced: these are people trained in acute care, managed care, and long-term care. While each of these groups is responsible for shaping the delivery of care for chronically impaired people as we enter the 21st century, each sees care through different lenses.

Acute care professionals tend to view chronic care problems in terms of illness and solutions in terms of cure. They are very high-tech in service orientation and organize care in very short-term, episodic approaches. Providers deliver care primarily through highly trained professionals with specialized, one-dimensional views, generally without regard for how one problem is linked with another.

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Long-term care professionals, on the other hand, tend to view chronic care problems in terms of function and solutions in terms of care. They are very high-touch in service orientation and organize care over an extended period of time. They assume the problem is ongoing and multidimensional with most of the care requirements coming from paraprofessionals and family.

Managed care professionals, the newest professional group in the United States, tend to view chronic care problems in terms of optimizing health solutions into levels of primary, secondary, and tertiary prevention. They are highly aware in service orientation and emphasize a continuous process of educating people about how life events, such as smoking, diet, exercise and stress, affect health and well-being over the long term.

While we have people involved in healthcare in all of these arenas, the fact is all of these people are serving the same person. And when you look at a person with a chronic disease and think "illness" you are going to respond one way, while if you look at the same person and think "function" you are going to respond in another way.

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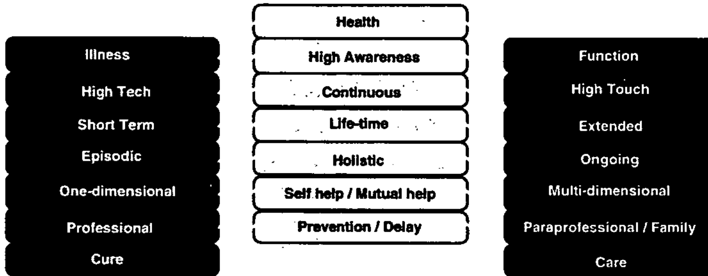
The future of chronic care depends upon a trinocular view; all three perspectives are critical to minimizing the accumulation of costs over time and across settings and in attaining quality outcomes.

A Trinocular View of Care



Chronic Care Networks

Once we adopt this trinocular view, it is important to begin to evolve what the NCCC calls "Chronic Care Networks" (CCNs). A CCN is a person-centered, community-based, systems-oriented alliance among providers who serve a common group of people with serious and persistent chronic conditions. Problems like Alzheimer's, heart disease, diabetes, arthritis, and chronic obstructive pulmonary disease become our primary concern, with roles, responsibilities, and authorities redefined to offer whatever combination of care is most cost effective to prevent, delay, or minimize the progression of disability through a condition's natural evolution. The focus

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is on managing care across time, place and profession rather than within predefined institutional structures. Relationships among care components are integrated to maintain a simple, seamless continuum of quality care.

CCNs are not necessarily independent, self-standing organizations, but are hospitals, physicians, nursing homes, home care providers who serve the same people in a defined community and who have a shared vision, common leadership, and integrated procedures. One might think about CCNs as PSOs with special care capabilities or specialized PSOs. They may also be special care networks used by HMOs, CMPs, and other third-party payers. They may operate under a single governance structure or they may not. Their primary focus is on how people function, rather than on issues of ownership. The major issue is how people work together across settings to achieve a common set of care objectives focused on problems of chronic disease or disability.

CCNs actually transform the nature of how we provide care in response to the natural evolution of chronic conditions instead of in response to a crisis event or simply a presenting problem that shows up at the front door. CCNs track the progression of conditions as they evolve over time, from pre-symptomatic issues such as smoking and stress, to disease manifestation such as high blood pressure and diabetes, to problems of diabetes, high blood pressure, and COPD, to the multidimensional and interdependent problems commonly seen among the frail elderly. If someone has an ongoing condition, CCNs continually ask: "Do we know where that person is in relation to the condition's evolution? Do we know what intervention is most effective to minimize that person's disability progression?

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Critical Components for Transforming Healthcare

To meet the healthcare needs of the next millennium, we need to focus on integrating the following critical organizational components that guide and support organizational behavior.

Integrated Governance/Management

Integrated governance links key executives, leadership, and network personnel in support of a common mission. People in healthcare today find themselves increasingly encumbered by governing boards who function out of old paradigms. Many who sit on board have become experts in managing a hospital or a nursing home, component parts of our healthcare system. As a result, they frequently think in terms of buildings instead of problems. Their decision making is bounded by the place they govern rather than the start point and end point of the problem to be addressed.

If we are going to change the nature of healthcare over time, it is imperative that we re-define governance structures to reflect a new vision, where everyone who is important to solving the problem sits at the table. We need to ensure that those who serve on these boards are conversant not only with the medical components of healthcare, including hospitals and physician services, but also with home healthcare, nursing home care, and the spectrum of home and community-based services. We must become more conversant with the problems of Alzheimer's, arthritis, and heart disease as well as with those of business, financing, and facilities. We need to have staff whose roles and responsibilities extend beyond simply managing programs and functions within predefined places. We need health leadership that cuts across settings to enable continuity of care throughout a condition's natural evolution. We need training and education for our healthcare professionals

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across settings that builds a sense of team, focused on the problems of people served.

Until we change governance structures, until we change how we organize, staff, and manage, we are not going to achieve the kind of outcomes we need.

Integrated Care Management

The goal of integrated care management is for care provided in different settings at different times and by different professionals in the network all to support common client and system goals. To do this, we need to establish seamless continuums of care, including the full spectrum of primary, acute, and long-term care services. In most cases healthcare professionals define continuum of care in the context of place, for example, establishing a continuum from home to nursing home or from hospital to home. In chronic care the continuum must follow the person. It is important to define the concept of continuum in relation to how a given set of conditions evolves over time. All the major pieces must be in place, but their relationship to one another must respond to the changing dynamics of the person being served.

We must get away from simply connecting the different places. We must avoid thinking about admissions and discharges between staff who serve the same person and start thinking about helping people make a transition from place to place as their needs evolve across time and setting. We need to develop single plans of care whereby all staff who serve the same person adopt common approaches that prevent, delay, or minimize disability progression, regardless of who provides the care.

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We must develop what we call extended care pathways (ECPs). ECPs are not simply care approaches within a setting. ECPs facilitate integrated care by applying a single approach to care throughout the entire course of a condition's evolution. The starting point for care planning is risk factors associated with next-stage disability progression, not admission to a given facility or program. The ending point is death or problem resolution, not discharge. Extended care pathways enable providers to be more than a patchwork of admissions and discharges—to be a team of providers addressing a common set of problems in pursuing a common set of cost and quality objectives. Chronic disease defies the logic of facility-based planning, and we must establish care planning accordingly.

Integrated Information

To prepare for the needs of the 21st century, it is critical that we improve our use of information technology. We need to establish communication systems that allow providers in all settings to share information about clients, costs, and operations. Integrated care requires information systems to be integrated so that people responsible for making administration, finance and care decisions for a common clientele can see the whole picture of what is being done for whom, in addressing what conditions, at what cost, and to what effect.

The capacity of existing information system technology is far beyond how we use it today. Our current uses are too bounded by outmoded structures. No one can tell us the true cost of any chronic disease or disability today. We make assumptions about the costs of care. We aggregate costs. We organize our information systems around settings so we know the costs of pieces of care, but have only a peripheral sense of the cumulative cost of care for a person as that person's condition evolves over time. We organize information systems around functions and setting, using them to maximize billing, simplify record-keeping, and track outcomes-specific institutions and

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programs. We need to find new and creative ways of linking our independent information systems across all settings and care providers who serve the same person, either at the same time or sequentially.

If we don't connect cost, quality, and patient information across settings and over time—and, in most cases, we don't—we cannot make reasonable judgments about what combination of care is most effective. We can determine what is most cost-effective for a place, a treatment, an episode, or an event, but we don't know what is most efficient or effective in providing care over an extended period of time. We simply must develop new approaches that empower us to bring disparate organizations and information together to make quality decisions.

Integrated Financing

Building effective health systems for people with chronic illnesses requires changing the financing incentives and infrastructure for managing care. Current healthcare reform is mired in simply ratcheting down costs, leaving our current provider structures in place. If we simply lower costs in each healthcare setting, we think we will save money over the long term. The truth is we have no sense of what this ratcheting of costs does cumulatively; it may be that as we shrink costs in one place, we increase costs in another, or delay costs for another time. Care needs may even require a whole new provider structure, one that is more person-centered and less institutional, one that is more community-friendly and less bureaucratic.

The goal of integrated financing is that all components of network financial management support integrated, appropriate, and cost-effective care delivery across time, place and profession, regardless of who provides the care. Key elements of integrated financing include pooled, primary, acute, and long-term care financing; network contracting with provider flexibility to move dollars to whatever combination of care is most cost effective for community-

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based networks or teams; capitated, risk-based financing; outcome-based accountability; and integrated cost accounting strategies that track costs across settings and over time.

If we are going to redesign our service delivery environment, if we are going to reengineer care in keeping with problems of the 21st century, it is vital that the purchasers—federal and state governments and other private insurance carriers—and the payers—whether HMOs or insurance companies acting as third party payers on behalf of purchasers or PSOs with providers sharing risk under direct Medicare risk financing—all see themselves as part of the same team. We must realign incentives to enable collective action to prevent, delay, or minimize disability progression, regardless of the legal basis for how we govern.

Integrated Policy

In addition to transforming our service delivery environment, it is important that we also reengineer the public administration of healthcare programs in light of future rather than historical needs. While the delivery of care is local, the financing of care is national. Whether we like it or not, the majority of healthcare is financed by government. For most of us, the majority of our care, near the end of life, will be financed by Medicare or Medicaid. And, while most Americans believe in private institutions, we rely on government to insure equity and quality and to help us fill the gaps in our private insurance, particularly if we are no longer able to finance the significant ongoing cost of long term care. We also rely on government to stage the debate of healthcare reform.

The emergence of chronic disease and disability as America's number one healthcare problem sounds a clarion call for national leadership, to create a sense of understanding and urgency regarding the need for systems

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transformation in the care of people with serious and disabling chronic conditions.

Currently, the administration, financing, and oversight of government-sponsored programs locks in place a fragmented, institutionally-biased, reactive, and cure-oriented approach to care. Policies and procedures for Medicare, Medicaid, the Veterans Administration, and a host of other programs available to people at various stages of disability, frequently provide incentives to third-party payers and providers to maintain antiquated operations. Rules and regulations provide disincentives for serving people with chronic conditions and for using collaborative disability prevention methods. They restrict innovation and retard the evolution of a person-centered, community-based, systems-oriented approach. They encourage cost shifting between programs, federal and state governments, and service providers. Again, it is not because of people with evil motives or incompetence; it is simply that we work within outmoded operating structures.

Effective care of the chronically ill requires that we become more cognizant of the future prevalence rates for major chronic conditions and the projected costs associated with various disease and disability trends. It requires that we create a national agenda to reduce the projected incidence and prevalence of chronic conditions through better care intervention. We must shift from an emphasis on reducing costs for defined programs to exploring what incentives and oversight functions can enable people in the private sector, working within defined communities, to establish a new generation of care in keeping with the nature of chronic illness.

Legislation passed in the Balanced Budget Act of 1997 created a foundation for reform, but if we are to meet the healthcare challenge of the next millennium, we must do more. In order to effectively address problems of

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the 21st century, public policy must focus more on the problems of people than on payment to third-party payers and providers, more on defining incentives for achieving predefined outcomes than on maintaining predefined structures and procedures through rules and regulations which are rooted in outmoded methods of operation. In particular, we must focus on problems of chronic disease and disability.

We are not going to meet the healthcare challenges of the year 2000 and beyond until we standardize Medicare, Medicaid, and other public programs for the chronically ill. We are not going to improve healthcare and make it truly cost-effective until we streamline rules and regulations so that providers do not have to respond to multiple and different requirements in serving the same people over time. We are not going to achieve long-term cost savings and improve quality outcomes until we move out of component-based policymaking for hospitals, physicians, nursing homes, and other provider groups, and create incentives and oversight structures that enable providers to offer whatever combination of care is the most cost effective. We are not going to preserve the Medicare Trust Fund and preserve the trust with those it serves until we zero in on problems of chronic disease and disability, reduce the swell of prevalence rates, and adopt more person-centered, community-based, disability prevention-oriented approaches to care.

To meet the future chronic care challenge, we must align roles and responsibilities for States and federal agencies who administer Medicare and Medicaid to stop cost shifting, reduce administrative burden, and enable collective decision making in support of common care objectives. We need to redefine public administration in relation to the ongoing, interdependent, disabling, interpersonal, and multidimensional problems of chronic disease and disability. We need policies that cross time, place, and profession with aggregate results, not results tied to specific places and circumstances. We

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must establish a national chronic care agenda for the 21st century that seeks to contain costs through better care intervention, that seeks to reduce cost by reducing demand, that seeks to do whatever is needed to bring quality and cost containment into common alignment, with support for whatever proves to be most cost effective for improving the overall health and well being of our citizens, regardless of how it impacts institutions of historical precedence.

Reengineering Managed Care

To transform healthcare in preparation for the needs of the next millennium, we must also reengineer managed care. Managed care financing can work positively for people with chronic diseases and disabilities. Yet there is evidence that current managed care financing arrangements may actually hinder the care of people with chronic diseases and disabilities. The problem is not managed care as a concept. The problem is managed care as it is currently practiced.

Managed care involves paying for a defined set of benefits for individuals who enroll in a defined health plan and living within a defined community. The assumption is that in risk based financing there is a fixed dollar amount that can be used to respond to a full array of problems, with the flexibility to send dollars to whatever combination of care that is most cost effective. There are built-in incentives for pursuing a disability prevention strategy, for transforming our healthcare environment to achieve better outcomes on behalf of government and employers as well as the people served. There is the potential for enabling compatibility between cost containment and quality of care objectives.

Unfortunately, our obsession with managed care financing has blinded us to the power of managed care to contain costs through use of new and improved care methods. In far too many cases under current managed care financing

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arrangements, managed care organizations function simply as a third party payer. Prevailing managed care companies, functioning as third-party payers, take 15 to 20 percent of revenues received off the top of a particular allocation to cover their own predefined administrative costs. Then they write a series of contracts with hospitals, nursing homes, and home health agencies under separate agreements, using a variety of arrangements that produce disincentives to coordinate care or to pursue prevention strategies. There are frequently disincentives for targeting care for the seriously ill and virtually no incentives for collaboration. The incentives are for a provider to batten down the hatches, close the door on collaboration, and do whatever is most beneficial for their own bottom line, without regard for or even awareness of the cumulative effects of independent decision-making.

Until we focus on the fundamentals of managing care through evidence-based decision-making, as well as leveraging use of capitated financing to reduce cost, we are not going to achieve the cost and quality goals we all desire. We need to refocus financing to support integrated delivery networks and abandon blind reinforcement of component-based management. We need to provide incentives for groups of providers targeting chronic conditions of major concern. We need to align financial incentives among providers functioning in the same care network so that financing can shift from one program to another, with all providers in the network functioning in favor of whatever produces the greatest collective good, whatever reduces costs and achieves better care outcomes over the long term.

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Preparing for the Next Millennium

A new care reality is not going to happen over night or by itself. Change, particularly system change, is an ongoing process. It requires people throughout the healthcare industry—policymakers, insurance companies, health systems administrators, physicians, nurses, social workers, and consumers and consumer advocates—to put on new lenses, with a commitment to work together under a new paradigm. It requires people to think outside of the mental constructs within which we work and refocus their attention on problems of chronic disease and disability. It requires everyone in healthcare to feel a sense of urgency about doing something different to increase our level of professional understanding of what is most critical for people to live a life of health and well being, not only for as long as possible, but with as much meaning as possible, throughout all phases of our life process.

Five tasks are crucial to moving this reform process forward:

1. **Think systems.**

   Problems of chronic disease and disability are multidimensional, interdependent, and ongoing. Chronic care is a systems problem and requires a systems solution. While we must preserve the pieces of healthcare, our success, over the long term, is dependent upon our ability to make whole cloth out of disparate parts. It is not only about perfecting the pieces; it is about perfecting how the pieces fit together.

   In a time of increased competition it is easy to become defensive, to build fences around what we know, to strengthen the fortresses of hospitals and nursing homes. "Do what we do now but better. Stay out of relationships; relationships are messy." Yet in the long run we do not succeed by

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standing alone or by pairing up with others just like us. Our success comes in establishing relationships with those who complement our skills.

It is important to remember that in chronic care the best way to compete is to cooperate. Success is dependent upon knowing how to work within disparate structures, how to celebrate diversity. It is not about building larger and larger hospital systems, larger and larger nursing home systems, larger and larger systems of primary care clinics. It is about bringing together the pieces of healthcare to serve a common population, with an eye to integrating care as chronic conditions evolve across time, place, and profession.

2. **Focus our energy on the future.**
These are very scary times. The current pace of change is faster than at any time in history. Change is more pervasive than at any time in history. The environment today is very unstable, and in times of instability it is easy to feel out of control, to find comfort in doing more of what we know.

The truth is the future is ours to define. We have, in part, already defined our own future by what we have done to date. Our bodies, our social institutions, our technologies are all a product of our collective invention. They have a life of their own. We can choose to ride the wave we have set in motion. We can try to stop it; reverse the course of history. Or, we can build on the strengths and weaknesses of our lot and create something new. We must establish clarity about the kind of world we want to live in and act on that vision of care, or it will be defined for us.

In many ways, healthcare today is like driving a car full of active people. Under these circumstances we have three primary options for where we focus our attention. We can focus on what we see in the rear view mirror,

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we can focus on the ruckus inside the car, or we can focus on the road ahead. If our symbolic car is healthcare, our view in the rear view mirror is defined by component-based healthcare, by specialized medicine, by actuarial tables, by rules and regulations of the past. Our view inside is one of chaos, pressure to produce more with less, to generate revenue, to increase market share, to define life by new technology. The road ahead is less clear. Most know it will not be like the past, but until the fog clears, we are unsure. We are preoccupied by the ruckus in the car. We try to read the future, but given the fog, we look in the rear view mirror for guidance.

If we move forward with blinders, stay the course, perfect our current ships of state as they are, we may simply be polishing the Titanic. If we obsess over the present or peer too much into the past, we may drive off a cliff, for the trajectory of our actions is moving us in new directions. We can increase our chances for success only by recognizing that we are in control of our own destiny and by establishing clarity about where we want to go.

The assumption of NCCC members is that the goal of healthcare is to maximize the health and well being of those it serves, to enable the emergence of healthy communities. For the NCCC, the primary focus is on people who are at risk of affliction from problems associated with chronic disease and disability.

For NCCC members, as non-profit organizations, profit margin, authority, image, market share, and technological advancement are important but secondary. They are means to an end, not the end themselves. They are useful only if they help us get where we want to go. Our primary focus is on bringing meaning to the lives of people we serve by preventing the onset of chronic conditions, by minimizing their impact, if and when they

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become a problem, and by helping people find meaning, if and when the disabling effects of chronic disease and disability become pervasive in a person's life or the life of a loved one.

3. **Bridge the boundaries of social institutions.**

The starting point for this task is to stop throwing stones at others. The starting point is not to get government off our backs. The starting point is not to get management out of our face. The starting point is not to control how doctors and other care providers make decisions. The starting point is not to have clients become more responsible. The starting point is not about "them." It is about us.

It may seem that much of what is required lies outside our control. So we ask, "What can I do to preserve my autonomy"? or, "What can I do to retain control over the pieces I already own"? However, in chronic care, the most important issues are not about control, but about how the pieces of healthcare function in relation to one another. It is not about buying and selling. It is about building relationships in service of people with chronic disease and disability.

We are not going to solve problems of chronic disease and disability until we understand that our future success requires us to celebrate unity amidst diversity. Policymakers, insurance specialists, health systems executives, and program managers, direct service providers, patients, and family caregivers are all in this together. Physicians, nurses, social workers, and other healthcare professionals are all on the same team. We are only going to achieve our vision of healthy communities by coming to grips with the fact that this is a team effort, a community effort, a national effort. As healthcare professionals we have a collective responsibility to find solutions together.

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Once we view this as a team effort, we can assess the readiness of our institutions to become the institutions of health and wellness for all people, with special skills in preventing, delaying, or minimizing the impact of chronic disease and disability as people seek to find meaning in their lives. We can look at the structures and procedures for how we make decisions, how we function, and change them to be more effective in pursuit of our social mission.

4. **Build a new infrastructure for decision making.**

   Again, the problems of today are not about incompetent people. They are about ineffective systems. They are about how our organizational structures and procedures, our new technologies, strengthen or impede our ability to address problems of chronic disease and disability. Where they impede our progress, we must change them. Where they enable our progress, we must strengthen them. We must change the structures and procedures for administering, financing, and delivering services for the chronically ill commensurate with the nature of chronic conditions. We must put on the lenses of a multidimensional, interdependent, disabling, interpersonal, and ongoing problem and establish a new infrastructure for managing money, information, and care.

   In assessing the infrastructure of our social institutions we must view them from both a vertical and a horizontal perspective. From a vertical perspective, it is important to assess the effectiveness of relationships that exist between federal and state government, between government and third-party payers, between third-party payers and providers, between providers serving the same community, and between providers and recipients of care. All elements of the healthcare industry are involved in making decisions about problems of chronic disease and disability. Success requires that the structures and procedures used by the spectrum of

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healthcare institutions be properly aligned around a common set of assumptions about what is most important for enabling our health and well being, given our focus on problems of chronic disease and disability.

Within each community we need to assess how providers, who serve many of the same people either at the same time or over a period of time, enable or impede one another in achieving a new vision of care. How is it that hospitals, physicians, nursing homes, home care providers, community-based programs, assisted living providers, public health officials, enable or impede one another to strengthen the health and well being of those served?

In this analysis, it is particularly important to pay attention to how we:

- identify people at risk for problems of chronic disease and disability
- define what services we will make available and at what time
- collect, share, analyze, and communicate information
- choose financial incentives, structures, and procedures
- delegate or retain authority
- define roles and responsibilities for decision-making.

The final task is to act, to get on with it. How people proceed will vary from one organization to another. However, regardless of the setting, it is critical that everyone:

- maintain some commonalty of vision
- empower internal champions to assume a leadership role in charting a course of action
- ensure that the necessary commitment exists, from the top, with senior executives in charge who possess skills in managing complex relationships
- align themselves with others, vertically and horizontally, to build relationships of importance to chronic care integration

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- create financial incentives and investment for systems transformation
- maintain a sense of mutual respect and understanding
- develop a blueprint for change
- commit to getting on with the task at hand, with tenacity and purpose for establishing the culture, tools, and technology for effective action.

Chronic disease and disability is the number one problem in healthcare. More money goes to caring for problems caused by chronic conditions than to any other problem. This will be true well into the 21st century, and the pervasiveness of the problem will only become more pronounced. We need to refocus our attention on the problem at hand and get on with the process of change.

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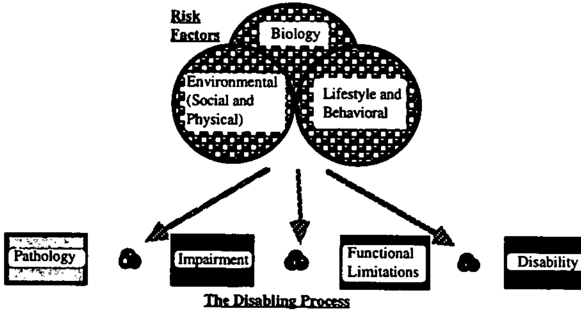
THE DISABILITY PREVENTION PROCESS



This is a representation of a model of care that was developed through the Institute of Medicine and published in *Disability in America*.

The stages of disability, as defined by the Institute of Medicine (1991), are:

Pathology: The interruption of or interference with normal bodily processes or structures as a result of cellular and tissue changes caused by disease, infection, trauma, congenital conditions, or other agents.

Impairment: A discrete loss and/or abnormality of mental, emotional, physiological, or anatomical structure or function, including all losses or abnormalities caused by all forms of pathology, not just those attributable to active pathology. Also includes pain.

Functional Limitations: Restriction or lack of ability to perform an action, or limitations on activity in the manner or within the range considered normal. All functional limitations result from impairments, but not all impairments lead to functional limitation.

Disability: The inability or limitation in performing socially defined roles and tasks expected of individuals within a social and physical environment.

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Important Definitions

The major driving factors in our healthcare reform effort are managed care and integrated delivery systems. People frequently mix these concepts and the terms connected with them. The NCCC uses the following definitions.

Serious and Disabling Chronic Conditions
A serious and disabling chronic condition is one or more biological or physical conditions which are likely to last for an unspecified period of time, or for the duration of a person's life, for which there is no known cure, and which may affect an individual's ability to carry out basic activities of daily living and/or instrumental activities of daily living. Such conditions may include, but are not limited to: Alzheimer's disease and related disorders, arthritis, cancer, cerebrovascular disease, depression, diabetes, emphysema and bronchitis, chronic obstructive pulmonary disease, hip and other fractures, hypertension, ischemic heart disease, multiple sclerosis, Parkinson's disease, peripheral vascular disease, renal disease, and other related conditions.

Chronic Care
Chronic care includes the entire spectrum of services required by people with serious and disabling chronic conditions, including primary prevention, primary care, acute care, long term care, pharmaceutical care, community care, supportive housing, alternative therapies, and other interventions that prevent, delay, or minimize disability progression associated with the multidimensional, interdependent, disabling, interpersonal, and ongoing nature of chronic conditions.

Managed Care Financing
A healthcare financing strategy that requires providers to function under a fixed dollar amount, in providing services to a defined population enrolled in a defined health plan. Medical care is provided through staff, group, or independent practice associations. Financing options include capitated and global budgeting with providers reimbursed through discounted rates, per diem rates, per case rates, specialty, bundled, or comprehensive pooled financing arrangements.

If you have seen one managed care organization, you have seen one managed care organization; managed care organizations can be extremely diverse. What is important about the NCCC approach to managed care is to think about managed care financing as strategies *within a fixed dollar amount, providing care to a defined population enrolled in a defined health plan.* This is contrary to a fee-for-service strategy where money is paid to a particular providers for specific care. Managed care provides, in advance, money for a specific group of people to pay for a specific set of benefits.

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Integrated Delivery Systems
A group of providers working together under a common governance arrangement in serving a defined population. Integrated health networks may include the full array of prevention, primary care, acute care, transitional care, and long-term care services. IDSs increasingly function under managed care financing arrangements and may include direct administration, a health plan and financial administration.

Integrated delivery systems (IDSs) focus on care. IDSs have resulted, primarily, from managed care financing initiatives and are, significantly, driven by managed care financing initiatives. Organizational environments are beginning to blur the boundaries between financing and healthcare delivery

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Ms. GERSTENBERGER. Thank you, Mr. Bringewatt.

Our next speaker is Meryl Weinberg, who has a long history of working to improve the delivery of health care and other services for persons with chronic conditions. She currently serves as president of the National Health Council, an umbrella organization made up of more than 100 national organizations. Membership includes voluntary health agencies, patient groups, professional organizations, and business groups. For 77 years, the council has served as a neutral forum where all parties can discuss concerns and form coalitions around issues of common interest.

Ms. Weinberg also serves currently on an Institute of Medicine committee that is responsible for assessing how research priorities are established at the National Institutes of Health.

Ms. Weinberg.

STATEMENT OF MERYL WEINBERG, PRESIDENT, NATIONAL HEALTH COUNSEL, WASHINGTON, DC

Ms. WEINBERG. Good morning. I wanted to add just a couple of things about the Council to put my remarks in context. Our core constituency are those groups that are patient-based organizations. So therefore, we represent approximately 100 million people with chronic diseases and/or disabilities. I think it is also important to note that we have within our membership the health care provider organizations. We have organizations like AARP representing the elderly. We have organizations like the National Hospice Organization and the National Family Caregivers Association.

The reason I wanted to point that out is that we really have within our membership all of the stakeholders regarding the issues that we are discussing today. The good thing is that when we can agree on a course, then almost no one can stop us. The challenge is having us all agree.

The Council has three goals. We work to improve quality health care for all people. We work to promote the importance of medical research. We work to promote the role of voluntary health agencies, or those patient-based groups within the United States.

Today, because of time I have selected four issues that are some of the primary concerns people with chronic diseases or disabilities have when they interact with today's health care system. First, as we all know, there really is no system of health care for people with chronic diseases or disabilities, people whose health care needs are multidimensional and who require multiple services from different providers. According to Webster's Dictionary—I actually looked it up—a system is an established, orderly way of doing something.

What patients face is a confusing, often chaotic array of service delivery, and reimbursement and coverage mechanisms. Now I also attached a chart which is attachment A to my statement and is one that Rich has already shared with you. But I felt like it is one of the best that actually provides a visual representation of the complex relationships among and between various health funding streams on the one hand and health related services on the other.

Trying to figure out who pays for what services and where to go to obtain needed services is an absolutely overwhelming task, and I am sure you all know it, whether or not you have a chronic dis-

ease or disability. There is no overall coordination of health care programs, coverage provisions, and service delivery. There is no such thing as one-stop shopping when it comes to putting together the package of health care services one needs.

As much as we hear about care management or case management services these days, very few persons are provided a care coordinator to assess their health care needs and service options, to determine which payment source pays for which service, to develop a single plan of care that will be followed by all health professionals interacting with the patient, to arrange the services once elected, and to monitor the effectiveness of the care plan developed.

In short, to perform the basic services needed by persons with serious and disabling chronic conditions.

Second, there are significant problems associated with how and how often health care providers ask for information from individual patients. A person seeking services from a health care provider often is asked for the same information repeatedly, literally five, six, or more times within a single day. We know of examples where this has happened when an individual finds it necessary to go to the emergency room and subsequently is admitted on an inpatient basis.

In addition, to make things worse, if a person who checks out of a hospital in the morning finds it necessary to return later the same day, he or she often finds it necessary to begin this process all over again.

The problems associated with obtaining needed patient information and sharing it appropriately within one health care provider setting are only magnified when one looks across health care services and provider settings.

Now I want to be clear that this is much more than just a nuisance for the patient and a waste of time and resources for the health care provider. It is striking evidence of the lack of coordination between providers who are caring for the same person; providers that should be sharing information and coordinating care to providing the best outcome for the whole person. We need to develop systems that will make this happen.

Third, and as you know, only the poor are eligible for Government funding for long term care services. There simply is no coverage for the millions of people who may need some form of long term care for an indefinite period of time. They must either find a way to pay for it themselves, spend down so that they are eligible for Medicaid, or literally do without. Currently, it is estimated that only between 10 percent and 20 percent of older adults can even afford to purchase long term care insurance.

It is also very important to be aware that when we talk about long term care for people with chronic diseases or disabilities, we are talking about a broad array of home and community-based services, not just the traditional institutional model.

Health care services should be provided in a manner that allows a person with a chronic disease or disability to live as healthy and productive a life as possible for as long as possible. Most often this is best accomplished through an appropriate, individualized set of home and community services and support.

There are many issues, and you will hear about quite a few today, you have heard from Rich already, that are associated with the financing, coordination, and delivery of long term care services. Attachment B, the other attachment to my statement, is a few pages from the Alzheimer's Association publication "1998 National Public Policy Program to Conquer Alzheimer's Disease." This document eloquently and succinctly describes several of the most important long term care issues and provides other recommendations related to Medicare and Medicaid as these programs seek to appropriately meet the needs of those with chronic diseases.

A fourth and final issue that I want to highlight relates to the role of the informal caregivers and personal assistants. For many people, their long term care is provided by a family member with or without the help of paid assistance. These individuals are rarely viewed and treated as respected, integral members of the health care team. Yet often, other than the person with the disease or disability, they have the most intimate knowledge of the individual's health status, home environment, and response to medical treatments.

In addition, they are often expected to personally provide medical treatments and services, but rarely are provided the education and training to do so. Unfortunately, these caregivers themselves are at great risk of developing health problems as a result of their caregiving responsibilities, thus adding to the already overloaded health care needs of this country.

In addition to the four issues I have identified there are other serious problems with our health care system, especially as it relates to the needs of people with chronic diseases or disabilities. For example, Medicare is biased toward acute institutional care and coverage is lacking for critical benefits such as drugs, eyeglasses, hearing aids, and supportive services.

While I do not have time today to address these and other areas of concern, I do want to offer a few specific recommendations for improving the health care system as it relates to the four items that I did discuss. I am just going to list these because of time.

First, establish integrated, coordinate, person-centered health care across provider services and settings.

Second, establish common core data sets that are shared appropriately within and across providers and settings.

Ensure that patients are provided concise, easily understood information about their coverage. We at the Council have a set of patients' rights and responsibilities and believe that this is one of the most important things that we must do is provide information to people so that they clearly understand and then can take action related to their own health care.

Create coverage policies and financial incentives to make long term care services more readily available and affordable for those who need them.

Fifth, provide recognition and reimbursement for informal caregivers as an integral part of the health care team. This should include appropriate education and training related to the medical services and treatment delivered by these caregivers.

Sixth, provide respite care coverage for informal caregivers.

Last, expand Medicare coverage to include coverage for drugs, eyeglasses, hearing aids, supportive services, and other non-traditional services necessary for the care of persons with chronic diseases or disabilities.

Before closing I want to note that the National Health Council and many of our member organizations believe that there are some new and very real advantages and opportunities associated with certain aspects of our current health care system. Just to have things a little bit more balanced I wanted to provide at least one example of this.

There is an increased ability to collect and analyze data on an individual and aggregate basis across components of care within many managed care settings today. This data enables us to better measure the actual health outcomes and costs associated with specific treatment regimens.

I want to thank you again for the opportunity to present some of the concerns and recommendations, and I hope that we will all work together to make these a reality. Thank you.

[The prepared statement of Myrl Weinberg follows:]

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE

"Transforming Health Care Systems for the 21st Century: Issues and Opportunities for Improving Health Care for the Chronically Ill"

STATEMENT

MYRL WEINBERG, PRESIDENT

NATIONAL HEALTH COUNCIL

May 13, 1998

Transforming Health Care Systems for the 21st Century: Issues and Opportunities for Improving Health Care for the Chronically Ill

Good morning. I want to thank you for this opportunity to provide information about a few of the concerns people with chronic diseases and/or disabilities have with today's health care system.

In order to put my remarks in context, I'd like to tell you a little about the National Health Council. The Council is a nonprofit, umbrella organization whose members are more than 100 national organizations with an interest in health. Our core constituency is our patient-based groups, like the American Cancer Society, Alzheimer's Association, Arthritis Foundation, American Diabetes Association and the National Osteoporosis Foundation. The Council has over 40 of these patient organizations in its membership, representing approximately 100 million people with chronic diseases and/or disabilities. Our membership also includes health care provider groups and other organizations with an interest in health, for example, the American Association of Retired Persons, the National Hospice Organization, and the National Family Caregivers Association.

The Council has three goals:

To promote quality health care for all people;

To promote the importance of medical research; and,

To promote the role of voluntary health agencies, or patient-based organizations.

Issues

Today, I want to share with you four of the primary concerns people with chronic diseases and/or disabilities have when they interact with the health care system.

First, as we all know, there really is no "system" of health care for people with chronic diseases and/or disabilities, whose health care needs are multidimensional and who require multiple services from different health care professionals and providers. According to *Webster's Dictionary*, a system is an "established, orderly way of doing something." What patients face is a confusing, and often chaotic, array of service delivery and reimbursement and coverage mechanisms. The chart (Attachment A) attached to my remarks provides a visual representation of the complex relationships among and between various funding streams and health-related services. Trying to figure out who pays for what services and where to go to obtain needed services is an absolutely overwhelming task. There is no overall coordination of health care programs, coverage provisions, and service delivery. There is no such thing as "one-stop shopping" when it comes to putting together the package of health care services one needs.

As much as we hear about care management or case management services these days, very few persons are provided a care coordinator to assess their health care needs and service options; to determine which payment source pays for which service; to develop a single plan of care that will be followed by all health professionals interacting with the patient; to arrange the services, once elected; and, to monitor the effectiveness of the care plan developed - in short, to perform the basic services needed by persons with serious and disabling chronic conditions.

Second, there are significant problems associated with how, and how often, health care providers ask for information from individual patients. A person seeking services from a health care provider often is asked for the same information repeatedly, literally five, six, or more times, within a day. We know of examples where this has happened when an individual finds it necessary to go to the emergency room and is subsequently admitted on an inpatient basis. In addition, if a person who checks out of a hospital in the morning finds it necessary to return later the same day, he/she often finds it necessary to begin this process all over again.

The problems associated with obtaining needed patient information and sharing it appropriately within one health care setting are only magnified when one looks across health care services and provider settings.

I want to be clear that this is much more than just a nuisance for the patient and a waste of time and resources for the health care provider. It is striking evidence of the lack of coordination between providers who are caring for the same person – providers that should be sharing information and coordinating care to provide the best outcome for the whole person. We need to develop the systems to make this happen.

Third, as you know, only the poor are eligible for government funding for long-term care services. There simply is no coverage for the millions of people who may need some form of long-term care for an indefinite period of time. They must either find a way to pay for it themselves, spend down to be eligible for Medicaid, or do without. Currently, it is estimated that only between 10 and 20 percent of older adults can afford to purchase long-term care insurance.

It is also important to be aware that when we talk about long-term care for people with chronic diseases and /or disabilities, we are talking about a broad array of home and community-based services, not just the traditional institutional model. Health care services should be provided in a manner that allows a person with a chronic disease and/or disability to live as healthy and productive a life as possible, for as long as possible. Most often, this is best accomplished through an appropriate, individualized set of home and community services and support.

There are many issues associated with the financing, coordination and delivery of long-term care services. Attachment B, which is a few pages from the Alzheimer's Association's publication, *1998 National Public Policy Program to Conquer Alzheimer's Disease*, eloquently and succinctly describes several of the most important long-term care issues and provides other recommendations related to Medicare and Medicaid as these programs seek to appropriately meet the needs of those with chronic diseases.

A fourth issue that I want to highlight relates to the role of informal caregivers and personal assistants. For many people, their long-term care is provided by a family member with or without the help of paid assistants. These individuals are rarely viewed and treated as respected, integral members of the health care team. Yet, other than the person with the disease or disability, they often have the most intimate knowledge about the individual's health status, home environment and response to medical treatments. In addition, they often are expected to personally provide medical treatments and services, but rarely are provided the education or training to do so.

And, unfortunately, these caregivers are themselves at great risk of developing health problems as a result of their caregiving responsibilities, thus adding to the already overloaded health care needs of this country.

In addition to the four issues I have identified above, there are other serious problems with our health care system, especially as it relates to the needs of people with chronic diseases and/or disabilities. For example, Medicare is biased toward acute, institutional care and coverage is lacking for critical benefits such as drugs, eyeglasses, hearing aides, and supportive services. While I do not have time today to address these and other areas of concern, I do want to offer a few specific recommendations for improving the health care system as it relates to the issues I have raised.

Opportunities and Recommendations

1. Establish integrated, coordinated, person-centered health care across providers, services and settings.

2. Establish common, core data sets that are shared appropriately within and across providers and settings.

3. Ensure that patients are provided concise, easily understood information about their coverage.

4. Create coverage policies and financial incentives to make long-term care services more readily available and affordable for those who need them.

5. Provide recognition and reimbursement for informal caregivers as an integral part of the health care team. This should include appropriate education and training related to the medical services and treatments delivered by caregivers.

6. Provide respite care coverage for informal caregivers.

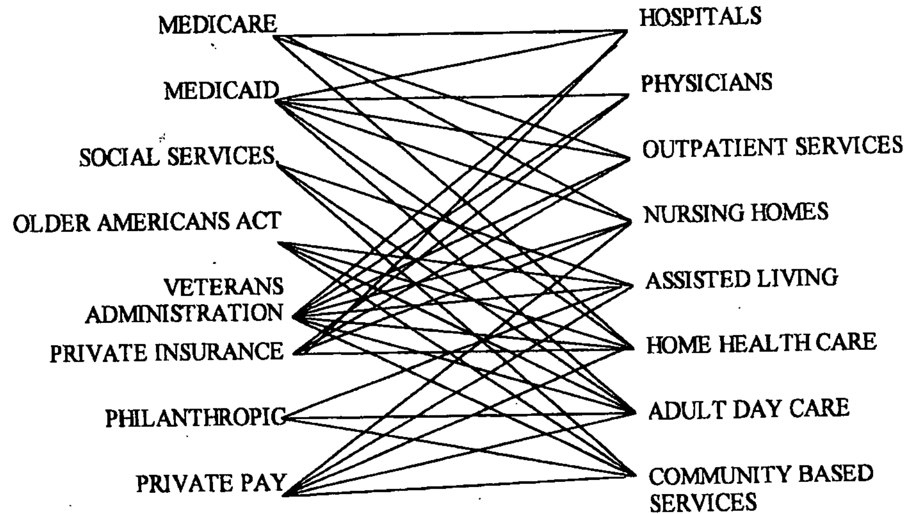
7. Expand Medicare coverage to include coverage for drugs, eyeglasses, hearing aides and supportive and other non-traditional services necessary for the care of persons with chronic diseases and/or disabilities.

Before closing, I want to note that the National Health Council and many of its member organizations believe there are some new, and very real, advantages and opportunities associated with certain aspects of the current health care system. Let me give you one

example -- there is an increased ability to collect and analyze data, on an individual and aggregate basis, across components of care within many managed care organizations. This data enables us to better measure the actual health outcomes and costs associated with specific treatment regimens.

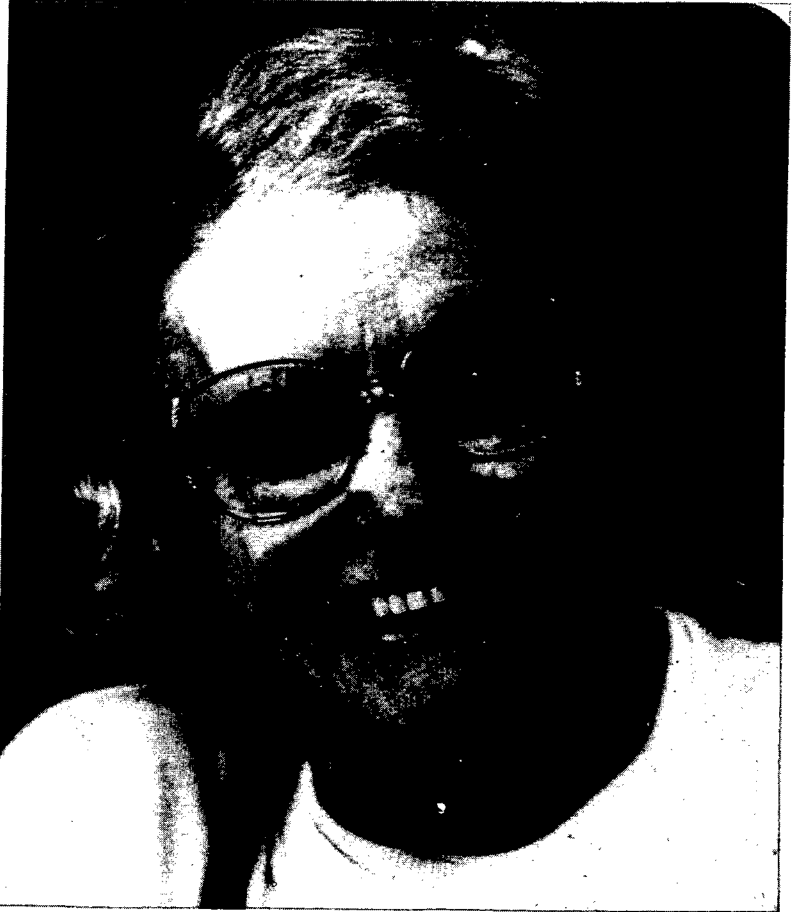
Thank you again for this opportunity to present some of the concerns and recommendations related to the health care system and its impact on the health of those with chronic diseases and/or disabilities.

FINANCING



ATTACHMENT A

ATTACHMENT B



ALZHEIMER'S® ASSOCIATION

1998 NATIONAL PUBLIC POLICY PROGRAM
TO CONQUER ALZHEIMER'S DISEASE

MEDICARE: CHRONIC CARE—THE BIGGEST CHALLENGE

If Congress and the Bipartisan Commission on the Future of Medicare are to save Medicare for future generations, they must confront directly the issue of Alzheimer's disease. Most people who get Alzheimer's are Medicare beneficiaries, but the program is poorly structured to meet their health care needs. The basic benefit package, designed in 1965 is badly outdated, particularly for the growing proportion of beneficiaries with chronic illness and disability. For people with dementia, this results in unmet need, preventable medical crises, and avoidable institutionalization. Medicare ends up spending more money, and costs are shifted to families, to Medicaid, and to the states.

ALZHEIMER'S DISEASE—A COSTLY MEDICARE PROBLEM

Alzheimer's disease and related dementias cost Medicare a lot of money, even though the program does not pay for most of the long term care a person with dementia needs.

> Per capita expenditures in 1995 for beneficiaries with Alzheimer's were $7,682, compared with $4,524 for beneficiaries with no reported cognitive impairment.

> Patients with dementia suffer complex, lengthy, and expensive hospitalizations—75% more costly than admissions of elderly patients without dementia.

> A study of a managed care organization in 23 states found that enrollees with Alzheimer's disease used more than twice as many resources as others their age and sex, for emergency room care, inpatient admissions, physician visits, and other professional services.

Part of the high cost of health care for people with dementia comes because the confusion caused by Alzheimer's disease confounds the common health problems of aging and adds to the time and complexity of treating them. One study of hospital utilization found that patients with dementia had an actual length of stay that was more than four times as long as predicted for the specific health care problem for which they were admitted.

But much of the cost comes from preventable health care crises—falls, injuries, infections, incontinence, malnutrition, medication mismanagement—that are the direct result of the person's impaired memory, judgement, and capacity for self care.

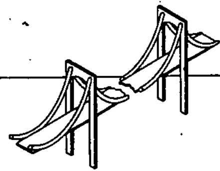
> People with Alzheimer's disease living in the community have twice the rate of fractures of others in their age group.

> They are at greater risk of non-fall related injury. Lacerations, sprains, hypothermia, and burns are common injuries that require medical attention.

> Changes in eating, continence and mobility caused by the dementia break down defenses against infection. Malnutrition is the leading cause of secondary immunodeficiency in persons with Alzheimer's disease.

> People with dementia get sicker because they cannot follow medication orders or nutritional advice and do not recognize or misinterpret signs of illness and infection.

Caregivers of people with dementia—one-third of whom are Medicare beneficiaries themselves—also face more health problems, adding further to costs associated with the disease. They report 46% more physician visits, use 70% more prescription drugs, and are more likely to be hospitalized. An estimated 12% become physically ill or injured as a direct result of caregiving. Depression among caregivers is three times the norm for persons in their age group.



Most people who get Alzheimer's are Medicare beneficiaries, but the program is poorly structured to meet their health care needs.

MEDICARE—PART OF THE PROBLEM

Medicare, as the primary health insurer for people with Alzheimer's disease, pays most of their health care bills. But it is not doing a good job of meeting their health care needs. In fact, it may be contributing to health care crises and adding to medical bills by failing to address needs in ways that could prevent the crises in the first place.

> Physician reimbursement systems do not pay for the time it takes to do a full assessment and diagnosis of Alzheimer's disease, or for ongoing disease management.

> The benefit structure relies on outdated concepts of treatment for persons with chronic illness. For example, in some jurisdictions, home health benefits are denied persons who use adult day care (at their own expense), even though adult day services can be a critical intervention for persons with dementia and their caregivers.

10

> Medicare arbitrarily denies payment for services that have proven effective in treating dementia, including occupational and speech therapy to maintain mobility and self-feeding, and mental health services for managing behavioral symptoms.

> Little if any reimbursement is available for caregiver training, support and respite, although even modest caregiver interventions have improved health outcomes, delayed nursing home placement, and achieved substantial savings in the cost of paid care.

> New interim payment policies enacted in the Balanced Budget Act of 1997 have created incentives for home health agencies to di charge or deny services to persons with Alzheimer's and other chronic needs because the cost of services exceeds the new per capita cap on agency expenditures.

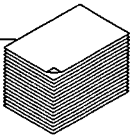
THE DUAL ELIGIBLES

Almost half (49%) of Medicare beneficiaries who have Alzheimer's disease also receive Medicaid. Most have exhausted their own financial resources paying for long term care and have had to turn to Medicaid for help in paying those bills.

These "dual eligibles" are the most expensive participants for both Medicare and Medicaid, in part because they have high health and long term care needs. But those costs are driven up unnecessarily by the lack of coordination between the two programs and the inherent incentives to shift costs, often to the most expensive and frequently less effective setting of care. The lack of coordination between the two programs not only discourages cost-effective quality care; it leaves both programs vulnerable to fraud and abuse.

Demonstrations like PACE (the Program of All-Inclusive Care for the Elderly) prove that integrated delivery systems can bring quality care to very frail elderly people with dementia, with positive health and quality of life outcomes for the individual and overall savings to Medicare and Medicaid. The challenge is to find ways to extend such models to a larger group of beneficiaries and to extend the lessons to fee-for-service as well as managed care.

Congress and the Health Care Financing Administration cannot fix Medicare by cutting or denying benefits to persons with dementia. Alzheimer's disease will not go away because Medicare stops paying the bills. Costs will simply shift, either to more expensive Medicare hospital care or to nursing homes and Medicaid. If Congress is to guarantee the future of Medicare, control Medicare and Medicaid spending, and protect the health security of the elderly and persons with disabilities, then Medicare must be redesigned to address chronic health care needs. And Medicare, Medicaid, and private financing must be brought together to put an end to the cost shifting that results in excess cost and inappropriate care.



Medicare may be contributing to health care crises and adding to medical bills by failing to address needs in ways that could prevent the crises from occuring in the first place.

MEDICARE RECOMMENDATIONS

> Medicare must be modernized to meet chronic health care needs of beneficiaries in ways that are cost-effective and affordable for both the beneficiary and the taxpayer.

To measure fairly the budget impact of any change in Medicare or Medicaid policy, the Congressional Budget Office and the Office of Management and Budget must calculate the total cost or savings of such changes for both programs as well as the impact on tax expenditures.

The Bipartisan Commission on the Future of Medicare must, as a matter of the highest priority, develop specific recommendations for addressing chronic health care needs of beneficiaries.

HCFA should develop and demonstrate a model of chronic disease management of dementia in Medicare fee-for-service, with a goal of implementing the model in the regular Medicare program as soon as its effectiveness is demonstrated.

Congress and HCFA should develop financial incentives to encourage the coordination and integration of Medicare with public and private systems for financing long term care. This includes but is not limited to integration of Medicare and Medicaid for the dual eligibles.

Congress should introduce flexibility to the Medicare benefit package for persons with chronic health care needs, including the use of independent home care providers and the substitution of adult day care when that results in more cost-effective health care for the beneficiary.

> Medicare policies in both fee-for-service and managed care must recognize the special health care needs of beneficiaries with dementia.

(11)

Payment systems, including prospective payment systems for home health care and capitation rates for managed care, must recognize the added cost of care for a person with dementia and provide appropriate risk and case-mix adjustments.

Payments to physicians must reflect the time it takes to do a full assessment and diagnosis of Alzheimer's disease for patients presenting symptoms, for family consultation and caregiver education, and for ongoing disease management.

The Health Care Financing Administration (HCFA) must put an end to policies and practices that deny Medicare benefits to persons with Alzheimer's disease solely on the basis of their diagnosis.

Respite care for family caregivers should be recognized and reimbursed as an essential component of Alzheimer treatment.

> HCFA, in cooperation with the National Institute on Aging and the Administration on Aging, should undertake research on cost-effectiveness of new treatments, especially nondrug treatments of Alzheimer's disease. Such research should measure the impact of interventions like adult day care and caregiver education on the health of both patient and caregiver. Particular attention must be given to developing appropriate outcome measures for Alzheimer care and treatment including preventive, acute, and long term care.

Ms. GERSTENBERGER. Thank you.

Our next panelist is Dr. Susan Denman. Dr. Denman has a long history of working to improve health care delivery for frail elderly patients, particularly nursing home residents. Currently, she is senior vice president for medical affairs at the Philadelphia Geriatric Center, chief of geriatric medicine, and associate professor of medicine at the Temple University Hospital and School of Medicine.

She has an impressive career history, including extensive involvement in a number of medical and health care organizations. She served as past president of the Pennsylvania Medical Directors Association, and as a member of the American Geriatric Society, the Gerontological Society of America, and the American Medical Directors Association. She is also a fellow of the American College of Physicians.

Dr. Denman.

STATEMENT OF SUSAN DENMAN, M.D., VICE PRESIDENT FOR MEDICAL AFFAIRS, PHILADELPHIA GERIATRIC CENTER AND TEMPLE UNIVERSITY HEALTH SYSTEM, PHILADELPHIA, PA

Dr. DENMAN. Thank you and good morning.

Persons with chronic illness compose a heterogeneous group with varying degrees of disability and reliance on others for their care. Over the course of their chronic illness they may experience decline in function and bouts of superimposed acute illnesses, and their changing care needs require a variety of health care settings and a variety of services including inpatient and outpatient arrangements.

The challenge to health care providers is to ensure that their patients are being treated in the right setting, with the right services in place, and that there is a system to make sure that these settings and services will be flexible and can be changed quickly when clinical needs change. This coordination of care over time and across settings is usually the responsibility of the primary health care provider.

So what are some of the regulatory barriers that interfere with this process of optimal care delivery? I think one of the most important ones is the lack of provision of case management services. Most people with chronic illnesses would benefit from some degree of case management services, and most do not receive them. These services are not provided by traditional fee-for-service Medicare.

Medicare does provide reimbursement for physician care plan oversight for patients receiving home care services, but this oversight code is only in effect when Medicare eligible home care services are in place. It covers communication with other professional staff involved with patient care in the home care setting, but it does not cover any case management function following the discontinuation of home care.

Case management is covered more extensively by managed care plans. Plans may offer case management for certain disease states or for plan members who are identified as being high risk. However, this service is not universally available for persons with chronic illness and coverage varies from plan to plan.

Another barrier is that the setting of care can sometimes dictate what services are covered. In a Medicare fee-for-service plan, a specific treatment may be covered in one health care setting such as the hospital, but not in another such as at home or in a nursing home.

An example of this would be intravenous antibiotic therapy. Some intravenous medications are extremely expensive. The cost of the drugs are usually covered if a patient is in the hospital or in a skilled nursing setting. In the home, however, Medicare does not cover the cost of the medication, and although the IV administration and the necessary nursing supervision is provided, the cost of the drug is charged to the recipient.

These financial considerations may play a greater role in determining the site of care delivery than clinical considerations. Most managed care plans allow more flexibility. However, sometimes it is difficult to arrange appropriate care because of the lack of effective case management. As I said, case management is not universally available, even for managed care recipients. Recipients of care are often left with the perception, or maybe the reality, that finances and reimbursement are dictating the services that they receive, and the health care settings in which the services are delivered.

Another barrier is the existence of a limit to the number of physician visits in long term care facilities, which might encourage unnecessary hospitalizations under the Medicare system. Nursing home residents with acute medical problems may need to be seen frequently by a physician but might not otherwise require hospital care. This is primarily a problem for fee-for-service Medicare recipients.

However, nursing home residents that are covered by managed care health plans may be subject to different financial incentives during acute episodes of illness. For example, when laboratory or other diagnostic testing services are necessary, they may require a burdensome transfer of a patient to a capitated site where a diagnostic test can be performed.

Another barrier is that requirements for payment in one setting may require prior treatment in another setting. The classic example of this is the Medicare three-day rule. Medicare recipients must be hospitalized for three days prior to being eligible for skilled care benefits in a nursing facility. Although managed care recipients may receive skilled services without prior hospitalization, it is sometimes difficult to put these services into play promptly.

I have mentioned a few of the barriers. Physicians in most primary care practices care simultaneously for fee-for-service Medicare patients as well as managed care Medicare patients and must constantly deal with different financial incentives. They usually identify care needs for their patients and try to work within existing benefit packages and community services that they know about to meet those needs.

Some practices are more successful than others in figuring this out as they go along. What I mean by this is that a primary care office that is most successful in managing persons with chronic illness is one that has a system in place that includes not only effective assessment of an individual patient's need, but also an excel-

lent working knowledge of benefits covered by a variety of health plans, on how to access services in the most effective way, and knowledge of the patient's personal resources and existing community resources so they might also be utilized.

Practices that do this effectively have generally committed a great deal of time and energy, which is usually uncompensated, into the goal of improving the overall care provided to their patients while maintaining financial viability. This is a cost of doing business and it has increased dramatically in recent years. Many busy practices have had to hire a full-time HMO person to help them accomplish this.

There is a genuine limit to altruism, however, and the reality for most practices is that uncovered services are undelivered services.

Let me give you a few examples of some of these barriers in action. I have three cases that sort of illustrate some of the problems that we face.

The first case is an 82-year-old woman who was admitted to our nursing home with a history of chronic heart disease and stroke. She was confined to a wheelchair and had mild cognitive impairment. She complained to her physician she was having more trouble with her breathing and intermittent chest pain. The doctor's examination did not clarify the cause of her symptoms but he was concerned that they might be related to her heart condition and it might be deteriorating.

The physician wanted to obtain a chest x-ray and an electrocardiogram. The patient's insurance coverage was through a Medicare managed care plan. Although the nursing home had portable radiology services available, her managed care radiology services were provided off-site at an area several miles away. Additionally, EKG services were covered only at a site that was a 20-minute drive away.

The physician attempted to arrange coverage for on-site EKG and chest x-ray and played voice mail tag with the HMO for several hours. The physician did not want to transport the resident outside of the facility because he thought this would be too burdensome for her. He had to decide whether or not he could make a treatment decision without the benefit of these diagnostic studies or if he should send the patient to an emergency room at higher cost to have these tests performed.

This case in this example is not uncommon in long term settings where capitated laboratory and radiology services are not always available on-site. In this regard, fee-for-service Medicare provides better service for elderly client. The plan inflexibility and the difficulty accessing the powers-that-be at the insurance company also represent a problem for clinicians who are trying to coordinate care for their patients.

In this case, the doctor decided that she was not acutely ill enough to warrant moving her to an emergency room. The nursing facility performed the EKG without reimbursement, and he decided not to get the x-ray. Fortunately, her symptoms did resolve with adjustment of the treatment with her chronic medications.

The second case is a 78-year-old woman living in the community with diabetes and visual impairment. Although she was legally

blind, she was still able to live by herself and had limited mobility using a cane.

Her primary care physician wanted her to receive preventive podiatry services, which are certainly covered by her managed care Medicare insurer. Unfortunately, the only capitated podiatrist was 10 miles away from her home and was not on a public transportation line. She could not afford other transportation and insisted on cutting her own toenails, which in a blind diabetic is a recipe for disaster. Diabetics often have circulatory problems in their feet and even a small cut is at risk to develop a serious infection that can eventually result in gangrene and amputation.

This physician did not contact the managed care company to ask for another podiatry option or to see if transportation services might be arranged, but instead asked her to get her family to help her out. Perhaps a case management system, if readily available to the patient and the physician, there would have been negotiated a more flexible and appropriate outcome for this person.

The third case is a 79-year-old man with Alzheimer's disease who was being cared for by his daughter in her home. He had been living with her for approximately one year and the daughter was developing progressive stress, exacerbated by his poor sleeping habits and difficult behaviors. The primary care physician ordered medication to treat the agitation which was intermittently successful.

The daughter was referred to the Alzheimer's Association for support group and education, but was unable to take advantage of any services provided by the Alzheimer's Association because she could not afford respite care to be with her father while she was away.

Her father had fee-for-service Medicare coverage. The daughter was unable to manage her situation successfully and finally decided to put her father in a nursing home. He did not have enough funds to pay for private nursing home care and the daughter then applied for Medicaid.

There were no Medicaid nursing facility beds available immediately, so she kept him at home and several weeks later her father's agitation became so severe that she brought him to an emergency room. He did not have a serious medical problem, but the daughter refused to take him back home and he was hospitalized with a diagnosis of possible urinary tract infection.

Doctors often refer to this kind of admission as a "social admission." What I mean by that is that medical problems alone would not have mandated hospitalization if there was an adequate community support system.

During his hospitalization he declined further. He was restrained to keep from pulling out his IV. He developed a pressure sore or bedsore which became infected, and he stopped eating. A nursing home referral was made from the acute hospital and he was now eligible for Medicare coverage for short term nursing home care. He was now no longer ambulatory, was more confused, and now had a serious medical problem, the infected bedsore. The daughter was very dissatisfied and felt very guilty about her failure to manage her father at home.

This man's doctor had tried to connect his caregiver with helpful supports that may have enabled her to keep him home for a longer

period of time. But without the means to access respite services, the daughter was unable to take advantage of an existing resource. Flexibility, case management, and respite care benefits might have helped enable her to keep him out of the hospital and living at home longer.

How can we better manage these and other similar scenarios? The three cases would all have benefited from an effective system of coordinated case management that could evaluate the need for a variety of clinical services, evaluate the need for a change in setting, and provide ongoing, longitudinal monitoring and adaptation. Physicians are not trained to provide case management, and even those who have figured it out do not have the tools to optimally manage and they are not usually compensated to provide this service.

Case management systems have worked effectively in many managed care environments to decrease recurrent hospitalization and functional decline. However, not every individual with chronic illness is eligible for these services. The Chronic Care Act of 1998 describes criteria for an effective policy to manage persons with chronic illnesses over time that include a care coordination and care management component for persons with chronic illness.

The act recognizes that care management must empower consumers to maximize their own responsibility regarding their care, to avoid creating unnecessary dependencies on caregivers or case managers. However, without a case management system with flexibility regarding access to service and coverage of service, it is impossible to imagine how we can improve the overall management of individuals with chronic illnesses.

Such a program would focus on disability prevention, not crisis intervention. Such a program could deal with inflexibility of existing coverage benefits and arrange coverage when it makes sense, so people with chronic illnesses could improve their long term functional independence, and their overall health care outcomes.

Thank you.

[The prepared statement of Susan Denman follows:]

WRITTEN TESTIMONY
SENATE SPECIAL COMMITTEE ON AGING
FORUM ON CHRONIC CARE

"Transforming Health Care Systems for the 21st Century: Issues and Opportunities for Improving Health Care for the Chronically Ill"

May 13, 1998
A Clinical Perspective on Chronic Care
Susan J. Denman, M.D.
Philadelphia Geriatric Center/Temple University Health System

I. INTRODUCTION.

I am the Medical Director of the Philadelphia Geriatric Center and Chief of the Section of Geriatric Medicine at Temple University Hospital and School of Medicine. Philadelphia Geriatric Center and Temple are members of the National Chronic Care Consortium and I am very pleased to represent the NCCC today. Philadelphia Geriatric Center is a not for profit organization that provides housing and health care services for elderly Jewish clients across continuum of health care settings. These include: Long Term Care services, inpatient and outpatient rehabilitation services, congregate housing, medical hospitalization, Adult Day Care and community based geriatrics clinical practices. At Temple University Hospital, I am the Medical Director of the Acute Care Geriatric Unit. I have the fortune of being positioned to provide a leadership role in geriatrics for both acute care and long term care settings. I see the challenges that geriatricians face that as they help their patients negotiate the health care system on a daily basis.

II. CHALLENGE TO HEALTH CARE PROVIDERS.

Persons with chronic illness compose a heterogeneous group with varying degrees of disability and reliance on others for care. Over the course of their chronic illness, they may decline in function and experience bouts of superimposed acute illnesses. Their changing care needs require a variety of health care settings including inpatient and outpatient arrangements. At times they may need home health care services or hospice services. The professional services that persons with chronic illnesses may utilize include not only primary medical care and subspeciality medical care, but also nursing and rehabilitation services as well as psychology and social work services. Most people with chronic illness would benefit from some degree of case management services and most do not receive them. In the course of a chronic illness, a range of equipment and treatment needs are utilized and diagnostic testing services including laboratory and radiology are frequently necessary.

The challenge to health care providers is to ensure that their patients are being treated in

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the right setting with the right services and that there is a system in place to make sure that these settings and services will be flexible and can be changed as needs change. This coordination of care over time and across settings is usually the responsibility of the primary health care provider.

III. INGREDIENTS FOR SUCCESS.

- Shared vision between clinical and administrative leadership in all health care settings.
- Quality health care settings and quality health care services.
- Access to these settings and services.
- Effective information management.
- Longitudinal follow up with reassessment.
- Evaluation of health care outcomes, functional outcomes, patient satisfaction and total costs to achieve these outcomes

IV. ROLE OF PRIMARY CARE PHYSICIAN PRACTICES.

Physicians in most primary care practices, care simultaneously for Fee For Service Medicare patients as well as managed care Medicare patients. They constantly deal with different financial incentives that can create barriers to good care and fragment service delivery. They usually identify care and service needs for their patients and try to work with existing benefit packages and community services (they know about) to meet those needs. Some practices are more successful than others in committing resources and energy to "figuring it out as they go along." What I mean by this, is that a primary care office that is most successful in managing persons with chronic illness is one that has a system in place that includes not only effective assessment of an individual patient's need, but also an excellent working knowledge of benefits covered by a variety of health care plans, how to access services in the most effective way, and knowledge of a patient's own resources and community resources that also might be utilized. Practices that do this effectively have generally committed a great deal of time and energy (uncompensated) with the goal of improving the overall care provided to their patients while maintaining financially viability. This "cost of doing business" has increased dramatically in recent years. Many busy practices have had to hire a full time "HMO" person to enable them to accomplish this. Practices that are particularly successful at managing patients with chronic illnesses might be considered "best practice" examples. I do not mean to suggest that these practices that are capable of working within the existing fragmented health care system are gaming the system, but merely that they have been able to provide coordinated services and remain financially sound. There is a genuine limit to altruism, however, and the reality for most practices is that uncovered services are undelivered services.

IV. CASE EXAMPLES.

Case 1: An 82 year old woman was admitted to our nursing home with a history of

chronic heart disease and stroke. She was confined to a wheelchair and had mild cognitive impairment. She complained to her physician that she was having more trouble with her breathing and intermittent chest pain. The physician wanted to obtain a chest x-ray and an electrocardiogram. The patient's insurance coverage was through a Medicare managed care program. Although the nursing home had portable radiology available, her managed care radiology services were provided off site at an area several miles away. Additionally, EKG services were covered only at a site that was a twenty minute drive away. The physician attempted to arrange coverage for onsite EKG and chest x-ray and played voicemail tag with the HMO for several hours. The physician did not want to transport the resident outside of the facility because he thought this would be to burdensome. He had to decide whether he could make a treatment decision without the benefit of these diagnostic studies or if he should send the patient to an emergency room (at higher cost) to have these tests performed. This case is an example which is not uncommon in long term care settings where capitated laboratory and radiology services are not always available on site. In this regard, Fee For Service Medicare provides better service for elderly clients. The plan inflexibility and the difficulty accessing the powers-that-be at the insurance company also represent a problem for clinicians who are trying to coordinate care for their patients.

Case 2: A 78 year old woman living in the community had diabetes and visual impairment. Although she was legally blind, she was still able to live by herself and had limited mobility using a cane. Her primary care physician wanted her to receive preventive podiatry services (which were certainly covered by her Medicare managed care insurer). Unfortunately, the only capitated podiatrist was ten miles away from her home and was not on a public transportation line. She could not afford other transportation and insisted on cutting her own toenails, which in a blind diabetic, is a recipe for disaster. This physician did not decide to pursue the problem with the managed care company to arrange for another podiatry option or to see if transportation services might be arranged. Perhaps a case management system could have negotiated a more flexible and appropriate outcome.

Case 3: A 79 year old man with Alzhiemers Disease was being cared for by his daughter in her home. He had been living with her for approximately one year and the daughter was developing progressive stress, exacerbated by his poor sleeping habits and difficult behaviors. The primary care physician ordered medication to treat the agitation which was intermittently successful. The daughter was referred to the Alzhiemers Association for support group and education, but was unable to take advantage of any services provided by the Alzhiemers Association because she was unable to afford respite care. The father had traditional Fee For Service Medicare coverage. The daughter was unable to manage the situation successfully and decided to put her father in a nursing home. He did not have enough funds to pay for nursing home care privately and the daughter applied for Medicaid. There were not beds available immediately. Several weeks later her father's agitation became so severe that she brought him to an emergency room. Although he did not have a serious medical illness, the daughter refused to take him back home and he was hospitalized with a diagnosis of possible urinary infection. During his hospitalization he declined further. He was restrained, developed a pressure sore and,

stopped eating. A nursing home referral was made from the acute hospital and he was now eligible for Medicare coverage for short term SNFcare. The daughter felt dissatisfied and very guilty about not be able to manage her father at home.

This man's doctor tried to connect his caregiver with helpful supports that may have enabled him to continue living at home for a longer time. Unfortunately, without any means to access respite services, the daughter was unable to take advantage of an existing resource. Flexibility, case management and respite care benefits would have helped.

How can we better manage these and other similar scenarios? The three cases would all have benefited from an effective system of case management that could evaluate the need for a variety of clinical services, evaluate the need for a change in setting and provide ongoing longitudinal monitoring and adaptation. Physicians are not trained to provide case management and even those who have "figured it out" do not have the tools to manage optimally and are not usually compensated to provide this service. Case management and care management systems have worked effectively in many managed care environments. Some HMO's provide disease management systems that are effective in decreasing recurrent hospitalization and functional decline. However, not every individual with chronic illness is eligible for these services. The Chronic Care Act of 1998 describes criteria for an effective policy to manage persons with chronic illnesses over time that include a care coordination and care management component for every delivery system for chronically ill individuals. The act recognizes that a health care system for persons with chronic illness must use care management to empower consumers to maximize their own responsibility regarding their care to avoid creating unnecessary dependencies on caregivers or case managers. However, without an effective care management system with flexibility regarding access to services and coverage of services, it is impossible to imagine how we can improve the overall management of individuals with chronic illnesses. Such a program could focus on disability prevention, not crisis intervention. Such a program could deal with the inflexibility of existing coverage benefits and arrange coverage when it makes sense for an individual to improve their long term function and health care. Thank you for your attention.

EXAMPLES OF CHRONIC ILLNESSES WHICH MAY LEAD TO DISABILITY AND CARE DEPENDENCY

- Arthritis
- Chronic Lung Disease
- Congestive Heart Failure
- Dementia
- Depression
- Diabetes
- Hip Fractures
- Parkinson's Disease
- Renal Failure
- Stroke

HEALTH CARE SETTINGS AND SERVICES FOR PERSONS WITH CHRONIC ILLNESSES AND DISABHLIITIES

HEALTH CARE SETTINGS

Acute Hospital
Inpatient Rehabilitation
Subacute Rehabilitation
*Nursing Facility
Adult Day Care
*Senior Centers
*Assisted Living

COMMUNITY HEALTH SERVICE PROGRAMS

Home Health Services
Hospice Care
PACE Programs

PROFESSIONAL SERVICES

Medical
Nursing
Rehabilitation
*Psychology
*Social Work
*Case Management
*Spiritual
*Support Groups

DIAGNOSTIC SERVICES

Laboratory
Radiology

EQUIPMENT /TREATMENTS

Wound Care Supplies
Tube Feedings
*Medications
Durable Medical Equipment
*Hearing Aids
*Eyeglasses

*Not covered or incompletely covered by FFS; sometimes covered by Managed Care

Susan J. Denman, M.D.

BIOSKETCH

Dr. Susan Denman is the Senior Vice President for Medical Affairs at the Philadelphia Geriatric Center, Chief of the Section of Geriatric Medicine and Associate Professor of Medicine at the Temple University Hospital and School of Medicine. Dr. Denman is Medical Director of the Temple Geriatrics Acute Care Unit. Her postgraduate residency training program in Internal Medicine was completed at the Johns Hopkins Bayview Medical Center in Baltimore, Maryland. Dr. Denman is Board Certified in Internal Medicine and Geriatric Medicine. Prior to her current position, she was the Medical Director of the Johns Hopkins Geriatrics Center in Baltimore and Associate Professor of Medicine at the Johns Hopkins School of Medicine. Dr. Denman is past President of the Pennsylvania Medical Directors Association and a member of the American Geriatrics Society, the Gerontological Society of America and the American Medical Directors Association. She is a fellow of the American College of Physicians. Her interests include the delivery of quality care for nursing facility residents regarding management of infections, pressure ulcers and restraint reduction, and the implementation of Extended Care Pathways to improve healthcare delivery for frail elderly patients across a variety of clinical settings.

Ms. GERSTENBERGER. Thank you.

Our next speaker is Dr. Gerard Anderson, who is a professor at Johns Hopkins University, professor of health policy and management, also of international health, and also of medicine. He is associate chair of the division of health policy and management, director of the center for hospital, finance, and management, and director of the program for medical practice and technology assessment.

He has published two books and over 130 articles. He is currently conducting research on managed care in the chronically ill, comparative health insurance systems, technology assessment, and health care finance. He has done research on managed care in the chronically ill that has been funded by the Commonwealth Fund, the Kaiser Family Foundation, Packard Foundation, HCFA, the assistant secretary for planning and evaluation, and the Maternal and Child Health Bureau. He is also the person who talked me into staying in graduate school.

STATEMENT OF GERARD ANDERSON, PROFESSOR, JOHNS HOPKINS UNIVERSITY, BALTIMORE, MD

Mr. ANDERSON. Thank you.

Doing research is a lot of fun, but students like Andy are even better. As I get older and older and my research productivity goes down, I look to Andy and a number of other students who have been with me and around the room today for a lot of guidance and a lot of support.

My role on the committee today is to present data on the cost of the chronically ill, the delivery system which they utilize, and then try and explain how these higher costs and their unique delivery systems could influence the access to care that they receive and the quality of care which they receive.

I am going to focus today on managed care because it is going to be the delivery system that they are going to receive, at least for the medical care they will receive at the beginning of the 21st century, which is sort of the title of this topic.

The first point is that the chronically ill are much more expensive than other Americans. As we heard in Senator Grassley's and Andy's and Rich's opening statements, the chronically ill are much more expensive. What our research has done is to focus on what are those specific illnesses which are very expensive for people with chronic illness?

We have looked at both seniors and looked at children. When we look at children, what we see is that they are anywhere from 2.3 to about 50 times more expensive than the typical child. Now the data we have presented up here is from the Medicaid program in Washington State, but we have done it in a number of other Medicaid programs. We have done it for Blue Cross. We have done it for managed care organizations. The ratios pretty much hold up. We generally see that children with chronic illnesses are much more expensive than the typical child.

We also look at the Medicare program. When you look at that we see slightly different ratios. The ratios vary from about 1.3 to about 4.

We were sort of puzzled by this for a while, in trying to understand why these ratios were so different. Once we figured it out,

it was sort of obvious to us. People with chronic illness are very expensive, both children and seniors have about the same level of expenditures when they are chronically ill. Children, if they do not have chronic illnesses, are relatively inexpensive, whereas seniors that do not have chronic illnesses still have fairly high level of expenditures.

So the dollars for the chronically ill are about the same for children and for seniors, but the ratios look very different.

The second point that I want to make is that the Medicare payment rates to HMOs and to capitated physicians need to reflect the higher expected costs of the chronically ill. Think of two girls, each 5 years old. One has muscular dystrophy, the second one is perfectly healthy. What you can see up there, on the chart on children, was that the child with muscular dystrophy is about 18 times more expensive than the child who is generally healthy.

Now if you are a managed care organization which child would you rather have if the payment rates were exactly the same for that child with muscular dystrophy and the perfectly healthy child? Well, clearly, you would want to try and enroll that perfectly healthy child.

If you are a pediatrician and you have got responsibility for taking care of them and you are paid on a capitated basis, and your payment rate does not vary based upon the amount of services that child receives, which child would you want to receive? You would want to enroll that healthy child. You have to do a lot less work and you are going to get paid the same amount of money.

We see now is that about half of the physicians in the United States receive at least a portion of their revenues from capitation. So there is the concern about the chronically ill child, same set of concerns about the chronically ill senior.

Now what we have been doing at Johns Hopkins and has been going on in a number of other academic institutions, is trying to develop risk adjusters or payment systems. What the chart on the left, next to Jill, suggests is that the payment system that the Medicare system currently uses is inadequate for people with chronic illnesses.

What I have done is taken three women, all aged 65 to 69, and said how much would they get paid under the current Medicare system does not adjust the payment rate based upon the health status of that woman. So she would get the same amount, not varying on the basis of her health status.

On the other hand, what we see in a payment system that we have developed at Johns Hopkins that will be used as part of Medicare+Choice and is also in some of the payment systems that are being used by Medicaid as well is a system which does vary the payment rate based upon the health status of the individual.

The measure that we are using for health status is utilization of specific services in the previous year. So a woman who did not have any prior utilization in the previous year would get about $1,300. A woman who had some prior utilization but was totally ambulatory would get about $3,400. A woman who had a lot of prior utilization, had a series of chronic illnesses which brought her into the hospital, would have a payment associated with her of $14,000.

You can see just looking at this, if you believe our numbers are at all close, why managed care organizations want to attract healthy people and why they want to stay away from the chronically ill. What risk adjusters do is give a financial incentive for managed care organizations to try and enroll the chronically ill.

Now one of the questions I frequently get asked is is our payment system perfect? Do we have it worked out? Or do any of the payment systems have it worked out? The answer I think we would all give you is no, we do not have it completely worked out.

Is it substantially better than the current system that Medicare uses or most States use, which are totally based on demographic information? The answer I think we would all give you is absolutely yes.

Should we wait for the perfect system? Will it ever arrive? The answer is probably not. So should we move ahead? At least most of us agree that we should in fact move ahead in trying to make some adjustments in to the payment system, really to protect the chronically ill.

The third point is that the chronically ill use a very different bundle of services than most other Americans. What these two charts show is that the chronically ill are very heavily dependent on certain medical services.

If you look across the chart on children, what you see—and if you look at cystic fibrosis, for example is that children with cystic fibrosis use about 45 times the number of prescription drugs as the typical child. They use 66 times the amount of durable medical equipment. They use 77 times the amount of home health services.

These are areas where access to the services for the chronically ill are particularly critical. This is where Dr. Denman was talking about, in terms of where access for certain of her cases was impaired. If not, it is clear why certain managed care organizations have targeted certain services.

We have presented this data in a number of settings. The managed care organizations are using it for financial planning. They are trying to figure out how much should they allocate for home health? How much should they allocate for durable medical equipment.

The managed care organizations are also using it for quality monitoring, trying to make sure that on a capitated basis that they are, in fact, allocating the appropriate amount of money and that that money is getting utilized appropriately.

The regulators are using this kind of information for quality monitoring, making sure that there is access to care in a number of areas.

My fourth point, and sort of the policy conclusion of all this financial activity, is that policymakers have a choice. What they can do is they can implement payment rates that reflect the expected costs of the chronically ill. Or they can enact a lot more regulation and much of that regulation is likely to fail.

The current payment system is very problematic. The chronically ill are much more expensive. The payment rates do not reflect higher costs. The chronically ill use a very different bundle of services. Those bundle of services are very easy to identify.

We know that every State has passed laws trying to govern managed care. Congress is debating this issue. We know that the most vulnerable group is the chronically ill. We have been slow to include them into managed care because we do not have the payment systems right, we do not have the regulatory systems right.

If we do not get the payment systems right, we know we are going to have to do a lot more regulation. So again, the bottom line for me is policymakers, you have got a choice, getting the payment system right or spending a lot of time writing regulations which are likely to fail.

Thank you.

[The prepared statement of Gerard Anderson follows:]

Statement of Gerard Anderson, Ph.D.

Professor
Johns Hopkins University

to the

United States Senate Special Committee on Aging Forum:

"Transforming Health Care Systems for the 21st Century:
Issues and Opportunities for Improving Health Care for the Chronically Ill"

May 13, 1998

Mr. Chairman, members of the Committee, fellow presenters and assembled guests, I am pleased to be part of this Committee forum. My name is Gerard Anderson, Ph.D. and I am Director of the Johns Hopkins Center for Hospital Finance and Management and Professor of Health Policy and Management, International Health, and Medicine at Johns Hopkins University.

I have been working for the past fifteen years on issues related to the chronically ill and managed care. First, I helped develop payment systems that will pay managed care organizations the higher expected costs of treating the chronically ill. Versions of these payment systems are now being implemented by the Medicare program, some Medicaid programs, and managed care organizations. More work needs to be done to refine these payment systems before they truly reflect the high expected costs associated with specific chronic illnesses although keeping the current systems in place until the "perfect" system is developed should not be an option.

Second, I have tried to educate managed care organizations and providers about the costs and utilization patterns of the chronically ill. Surprisingly little is known about how the chronically ill receive their care over the course of a year. It is only in the last few years that clinicians have have begun to recognize the multitude of providers that care for a chronically ill person. In addition, we have learned that it is not simply the medical system, but also educational services, social services, transportation services that many chronically ill persons require. Frequently they are confronted with multiple care coordinators.

Finally, I have tried to educate policymakers about the various ways to monitor the managed care industry. State legislatures began to pass legislation regulating the managed care industry in the mid-1990s and now every state has passed legislation monitoring some aspect of the managed care industry. Congress is now beginning to debate this very important issue. One key point that I have tried to stress with state legislatures and Medicaid directors is that there is a choice between more sophisticated payment systems and more regulation. If the payment system does not recognize the higher expected cost of care for the chronically ill, then more regulation will be necessary. Managed care organizations and capitated physicians will not be able to provide appropriate care if they do not receive sufficient funds to care for the chronically ill. This is a special problem for providers who specialize in caring for the chronically ill. Capitation rates have to reflect the higher expected costs of the chronically ill.

My testimony today has three main themes.

First, persons with chronic illness have much higher expected costs than other individuals. This is shown in charts 1 and 2. Children with chronic illness have expected costs that are 2.3 to almost 50 times more expensive than the average child. Medicare beneficiaries have expected costs that are 1.3 to almost 4.0 times greater than the "typical" Medicare beneficiary. This suggests that risk adjusters are necessary to protect the chronically ill. Demographic risk adjusters, such as the Adjusted Average Per Capita Cost (AAPCC) which is currently used by Medicare, are simply not adequate. They do not recognize the higher cost of the chronically ill.

Second, persons with chronic illness use a different group of providers than other individuals. The chronically ill are especially dependent on home health care, durable medical equipment, and certain clinical specialties. This is shown in charts 3 and 4. Children with cystic fibrosis, for example, use almost 80 times the level of home health services as the typical child. By selecting certain providers, managed care organizations are able to influence what individuals will join their plan, since the chronically ill are very aware of what providers they currently use and will need in the future. The chronically ill must be assured access to a broad range of providers. Much of the managed care legislation at the state level is to assure appropriate access to these providers for the chronically ill.

Third, policymakers have a choice -- implement payment systems that reflect the expected cost of caring for individuals with chronic illnesses or spend time writing regulations preventing a few managed care plans from taking actions which would jeopardize their access to managed care and their quality of care if they enroll. My final chart illustrates how one of the payment systems would operate. It compares a payment system that includes clinical information to the current Medicare model for three women aged 65-69 with very different levels of illness. Under the current Medicare model, the capitation rate would be the same for each woman. However, under the proposed model, capitation rates would be lower for a relatively healthy woman and would increase as the illness burden of the woman increased.

I have attached a series of charts which explain these three main points in greater detail.

I appreciate the opportunity to present this information to the Committee today.

Individuals with Chronic Illness:

- Are more expensive on a per capita basis
  -- especially children
- Have a skewed distribution of expenditures
- Often have comorbidities /complications that contribute to higher expenditures

Higher Cost of Seniors with Selected Chronic Conditions

Condition	Ratio of Average Payment per Senior with Condition to All Seniors
Lung Cancer	3.7
Colon Cancer	3.5
Congestive Heart Failure	3.0
Stroke	2.9
COPD	2.8
Ischemic Heart Disease	2.1
Alzheimer's	2.0
Diabetes	1.6
Arthritis	1.4
Breast Cancer	1.3
All Seniors	1.0

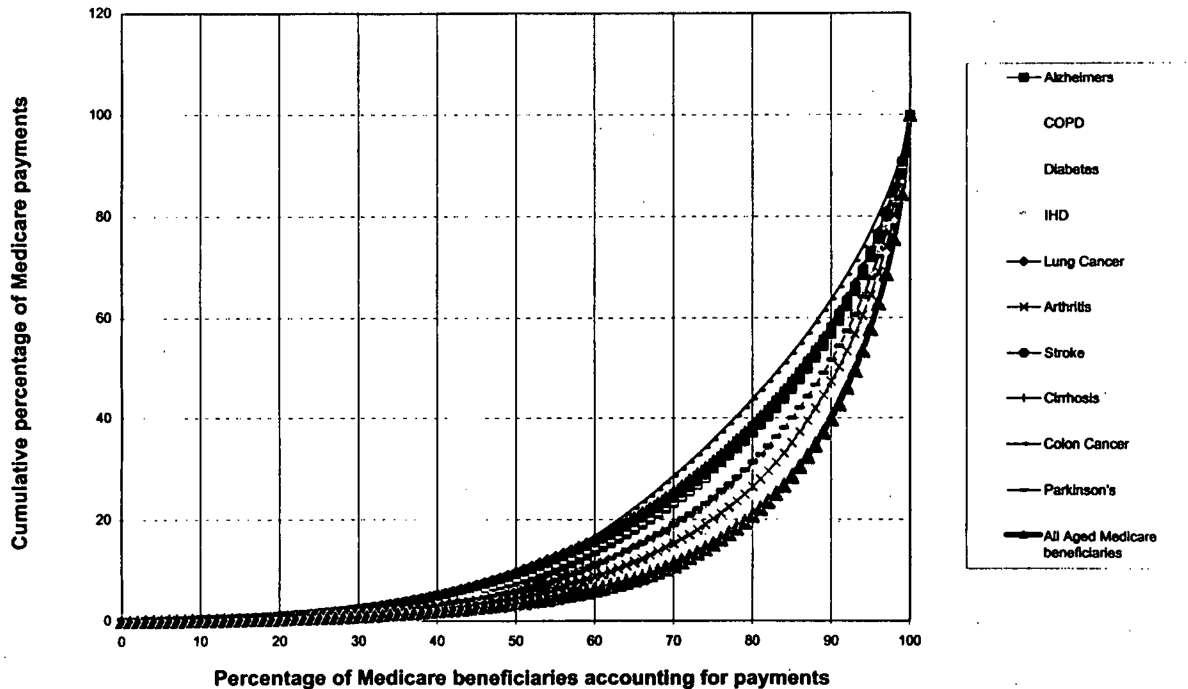
Source: Medicare, FY1994

Higher Cost of Children with Selected Chronic Conditions

Condition	Ratio of Average Payment for Child with Condition to All Children
Chronic Respiratory Disease	48.7
Muscular Dystrophy	18.0
Cystic Fibrosis	13.2
Malignant Neoplasms	12.7
Spina Bifida	11.4
Cerebral Palsy	9.2
Diabetes	2.7
Asthma	2.3
All Children	1.0

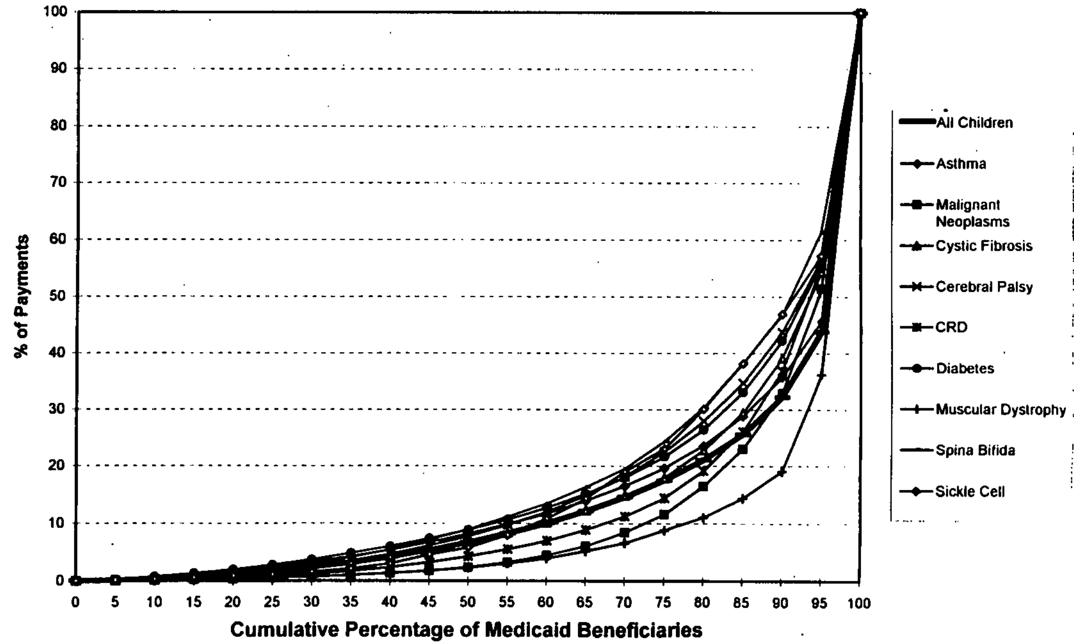
Source: Washington State Medicaid Program FY93, children <18

Spending Distribution
For Selected Chronic Conditions in Medicare Beneficiaries



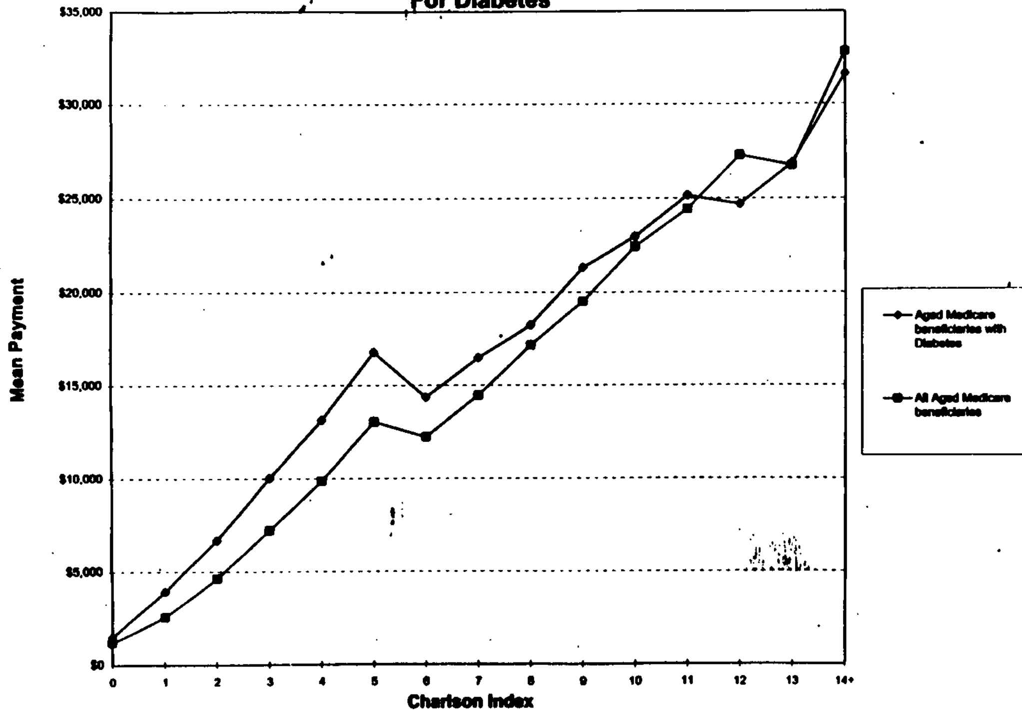
Source: CY 1992 Medicare

Spending Distribution
For Selected Chronic Conditions in Children



Source: FY 1993, Washington State Medicaid Claims

Mean Payments By Charlson Index For Diabetes



Source: FY 1992 Medicare Claims

Ratio of Average payment per Aged Medicare Beneficiary with Chronic Condition to All Medicare Beneficiaries, by Type of Service

Chronic Condition	All Services	Inpatient	Outpatient	Part B	Skilled Nursing Facilities	Home Health
Lung Cancer	3.7	3.9	3.7	3.2	2.4	14.6
Colon Cancer	3.5	3.9	2.6	2.9	2.5	6.4
Congestive Heart Failure	3.0	3.5	1.7	2.2	3.7	2.1
Stroke	2.9	3.2	2.1	2.2	4.9	1.6
Chronic Obstructive Pulmonary Disease	2.8	3.2	1.7	2.3	2.6	2.4
Ischemic Heart Disease	2.1	2.4	1.6	1.9	1.9	1.0
Alzheimer's	2.0	2.0	1.8	1.5	5.5	2.5
Diabetes	1.6	1.6	1.3	1.4	1.7	.9
Arthritis	1.4	1.4	1.3	1.4	1.7	.6
Breast Cancer	1.3	1.1	2.0	1.6	1.0	2.8
All Aged Medicare Beneficiaries	1.0	1.0	1.0	1.0	1.0	1.0

Source: 1994 Medicare Standard Analytic File

Ratio of Average Payment for Child with Chronic Condition to all Children, by Type of Service

Chronic Condition	All Services	Inpatient	Outpatient	Physician	Prescription Drugs	DME	Home Health	Other[1]
Asthma	2.3	2.4	2.3	2.1	3.7	3.2	4.9	2.0
Malignant Neoplasms	12.7	24.9	11.1	6.9	12.8	15.0	13.5	3.1
Cystic Fibrosis	13.2	12.5	5.7	4.5	45.3	66.4	77.6	10.1
Cerebral Palsy	9.2	9.2	4.6	3.7	5.7	106.3	68.3	7.2
Chronic Respiratory Disease	48.7	110.8	3.7	8.8	8.5	36.4	116.1	28.5
Diabetes	2.7	3.6	1.9	2.4	4.1	1.7	4.4	1.8
Muscular Dystrophy	18.0	17.6	5.4	4.7	9.3	89.1	108.9	27.1
Spina Bifida	11.4	17.4	6.3	5.8	6.1	64.7	25.7	6.9
All Children	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0

1 Other includes: EPSDT, eye care, dental services, laboratory services, chiropractic and podiatric services

Source: Washington State Medicaid, FY93. Children under 18

Policy Implications

- Need risk adjustment methods that account for:

  -- the higher costs of care for the chronically ill

  -- cost variations within similar chronic conditions

- Need to monitor and ensure access to appropriate services and providers for chronically ill enrolled in managed care

Risk Adjustment Mechanisms

- Reduce the effects of risk selection when individuals have a choice among health plans

- Risk adjustment mechanisms can protect:

  -- Medicaid programs
  -- chronically ill individuals
  -- managed care organizations
  -- providers

Components of Risk Adjustment Systems

- Reinsurance
  - -- protection against very high cost individuals
- Carve-outs
  - -- separate payment and/or delivery system for individuals with specific medical conditions or for specific services
- Prospective risk adjusters
  - -- adjusts payments to reflect the expected costs of a group of individuals

Possible Reinsurance Thresholds

- $5,000
- $25,000
- $50,000
- $75,000
- $100,000

Reinsurance Issues

- Lower thresholds → more money set aside for reinsurance
- May minimally protect the chronically ill

Condition Carve Outs

- Clinical conditions where more than 50 percent of cases have expected costs greater than $25,000

- Clinical conditions where mean costs are greater than $25,000

- Clinical conditions with minimal discretion involving diagnosis and coding

Sample Pediatric Carve-Out Conditions

Condition	Average Per Capita Expenditures
Muscular dystrophy x tracheostomy	$182,740
Liver transplantation	$162,672
Acute renal failure	$59,284
Low birthweight (<1000g)	$46,263
Neoplasms x chemotherapy	$42,756

Source: Andrews JA, et al: Pediatric Carve Outs: The Use of Disease-Specific Conditions as Risk Adjusters in Capitated Payment Systems. *Archives of Pediatrics and Adolescents.* 1997;151:236-242.

Carve Out Issues

- More carve outs → more dollars carved out
- Cost variation within carve out conditions

Prospective Risk Adjusters

- Use characteristics of all individuals in a group to predict future needs for medical services and their expected costs

Criteria for Evaluating Risk Adjusters

- Predictive accuracy
- Incentives for appropriate care
- Susceptibility to manipulation
- Administrative feasibility
- Patient confidentiality

Possible Risk Adjusters

- Demographics
- Self-reported health status
- Functional health status
- Prior utilization
- Clinical indicators

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Clinical Indicator Models

- ACG
- HCC
- DPS
- NACHRI Model

Determining Capitation Rates for Three Individuals Using Two Different Capitation Adjustment Measures

Individual	ADG-MDC Model	Current Medicare Model
Individual 1 No health system encounters in previous year	$1,212	$2,625
Individual 2 Ambulatory treatment in prior year for: Depression (ADG 23) Gastric Ulcer (ADG 7) Coronary Artherosclerosis (ADG 11)	$3,480	$2,625
Individual 3 Ambulatory treatment in prior year for: Depression (ADG 23) Gastric Ulcer (ADG 7) Coronary Artherosclerosis (ADG 11) Diabetes (ADG 9) 2 Hospital admissions in prior year for circulatory problems (MDC 5) 2 Hospital admissions in prior year for respiratory problems (MDC 3)	$14,713	$2,625

Conclusions

- Payment systems
  - -- existing risk adjustment may not protect chronically ill
  - -- risk adjustment not widely used

- Provider networks
  - -- broad network needed
  - -- certain services heavily used by chronically ill
  - -- clinical and non-clinical services needed

Conclusions

- Treatment protocols / quality measures
  - -- difficult to generalize across conditions

Ms. GERSTENBERGER. Thanks. Before I introduce our final panelist, I want to remind people to please fill out the question cards if you have questions, and the committee staff will be coming around during Dr. Meiners' presentation to collect them.

Our final panelist is Dr. Mark Meiners. He is nationally recognized as a leading figure in the area of long-term care. He is an expert on financing and program development and his groundbreaking research on long-term care insurance has been a major catalyst to the current policy debate.

Dr. Meiners has written numerous publications in the areas of aging and health, with an emphasis on financing and reimbursement issues. His extensive knowledge is well utilized in his current position as associate professor and director of the University of Maryland Center on Aging. He is also the Director of the Robert Wood Johnson Foundation Medicare/Medicaid Integration Program and Director of that Foundation's Partnership for Long-Term Care Insurance. Dr. Meiners.

STATEMENT OF MARK MEINERS, Ph.D., DIRECTOR, ROBERT WOOD JOHNSON FOUNDATION MEDICARE/MEDICAID INTEGRATION PROGRAM, COLLEGE PARK, MD

Mr. MEINERS. Thank you, Andy. It is a pleasure to be here today. I know we are short on time, but I want to get the audience involved. If you go to the last page of my testimony and fill in the words acute and long-term care to finish off my last sentence, I would really appreciate it.

I have been advised to involve the audience and this was my meager approach to do it. Actually, I am trying to land on my feet because I discovered a typo.

My part of this program is to talk about programmatic issues from the perspective as the director of the Robert Wood Johnson Foundation Medicare/Medicaid Integration Program. This program makes grants and provides technical assistance to States to help them develop managed care programs that integrate acute and long-term care.

The Medicare/Medicaid link is the one you have heard about today, the notion that Medicare is fundamentally a primary and acute care payer. Certainly for seniors Medicaid is a significant long-term care payer. Those are important facts that we need to build on, and that is the theme of my talk today.

I actually had brought overheads along. We have all done our thing at media, and I could hold them up, but I do not think I will do that.

Well, maybe I will. I have this one here that I thought by now would be presented. It makes what I think is a relatively simple case for the importance of dual eligibility for Medicare and Medicaid

First, nearly all Medicaid seniors are eligible for Medicare. So that is part of the link. Then one-third of the Medicaid disabled are eligible for Medicare. So you have significant populations.

More importantly, you have these figures that get bantered around, and I do not think anybody gave them today, so I have the chance to give them, and I think they are extremely compelling: 17 percent of the Medicaid population is eligible for Medicare and 16

percent of the Medicare population is eligible for Medicaid. Now that is striking itself, because I think those are pretty significant numbers, ones that you would not want to work on and worry about.

But even more striking is the fact that those Medicaid folks account for 35 percent, those 17 percent account for 35 percent of the Medicaid costs. On the Medicaid side that 16 percent account for 30 percent of the Medicare costs. It is a huge expenditure and Government is on line to pay those bills.

So if we can come up with a better way to do it, a more efficient way to take care of all the problems you have heard about with these very special and needy populations, we could perhaps do better and save some money at the same time.

I think that is a major theme of why I am involved in this work on the dual eligibles. When I would show my next slide is why are we interested in that? In fact, the one that is right at the top is the important public financing considerations which I have just touched on.

But it is an opportunity, I think, for us to do better with limited resources. I think those of us who have studied it, and those of you in the audience who have studied it, know that when you have two systems that really are fundamentally focused on different types of populations and different parts of the problem, they develop their own sets of rules. The unintended consequences that you heard Dr. Denman and others talk about are there. So not only are we spending a lot of money, but we probably are not spending as well as we could, and certainly as well as we would like to.

We know that there is cost shifting in both directions. You have these programs not only struggling to do what they do well, but also realizing that part of—if they are in a cost containment mode, if they can cost shift one to the other, they are going to be doing a little better. So you have this conflict.

Finally, a compelling reason for why we should care about the dual eligibles has to do with the fact that we are entering the world of capitated managed care when we talk about Medicare and Medicaid. Both of those programs are significantly and recently getting into the managed care field.

I think that that is something that while it is scary, it is also important and it is inevitable that I think we are going in that direction. It is scary because it is new and it is different and under developed and undeveloped, and we need to work on that. But it is extremely important for those of us who worry about better health care systems for seniors and the disabled because there is a real opportunity reflected by the chance to take that pool of resources and really do something different, downward substitute, get more long-term care, chronic care benefits available. Not at the expense of the acute care benefits but in a way that really makes the acute care benefits more consumer friendly so that they are really getting a better system of care.

That is the importance of it. It is inevitable and I think maybe we will overcome some of the barriers to it, because most of us in the audience who have health insurance have come into the world of managed care. It is called a lot of different things, PPO's, what-

ever. But basically roughly, 80 percent of the working population get their health care through managed care systems.

So it is going to happen and it is not too much of a surprise that Government is looking at the private sector and the working age population sort of says gee, maybe we can use some of those same managed care principles and make them work for us. I think we need to sort of grasp that with more of a can do than a cannot do mindset.

That gets me into this program of working with states because, to a large extent, doing the dual eligible programs, working with the States to try to integrate acute and long-term care, it has been a real struggle. I am here to tell you that this is not a brand new out of the box, struggle so that when we talk about new demonstrations, there have been programs that have been out there demonstrating over the years. I touch on some of that in my written testimony. There are an awful lot of lessons that we have learned, and so let us not ignore those lessons.

Unfortunately, I would suggest to you that a lot of the lessons we have learned are just to get programs started. I mean, how do you get the waivers to get dual eligible managed care programs off the ground? I can go through some of that, and I will touch on that a little bit today, to share with you the struggles.

But let us face it, those are not the real lessons we need to learn, to make everybody feel comfortable. It is kind of how do you do integrated care, and how do you do it well, and what does that mean? Some of the materials that we have left for you out on the table are designed to try to help push us in that direction. That is part of the technical assistance that we are working on in this initiative.

But I am here to tell you, in part, that I am very disturbed and distressed because it is so onerous and difficult to get these programs started. That is not necessarily because you have the Health Care Financing Administration not wanting to do this, because that is really not the case. In fact, I think the Health Care Financing Administration has been a key and active, positive partner in a lot of this, but is also operating in a political environment and a tough environment, which creates an environment that not everybody agrees on.

For example, the notion of Medicare choice, that people have Medicare choice is at the heart of the Medicare law. When you move to a managed care system, you need to think in terms of giving up choice. How do you rationalize that? Well, that is some of what has gotten in the way of progress, in terms of getting these programs off the ground.

As I say in my little bullets here, one other thing is the waiver hopes and hoops because there are tremendous hoops that we have to jump through. I think HCFA is struggling with, on the one hand, demonstration waivers that are designed to learn and, on the other hand program waivers which are designed to get programs off the ground.

It is struggling with, on the one hand, the notion of not quite knowing how to move because there is no precedence as to how to move. On the other hand, fearing that whatever they decide to do will indeed set a precedence and unless you are sure that that is

acceptable to everybody and covers all the bases, that creates a stalemate. So it is a difficult process.

BBA, Bubba as I guess it is referred to in some circles, really did, I think, a number of things that should help us do dual eligible integrated care programs. It allows for provider service networks to enter the arena. In other words, broaden the array of choices, Medicare+Choices, and create some lock-in features that I think will allow people to deal with their clients for more than a short period of time. If you worry about chronic care and long-term care, that is critical. You want to reap the benefits of your preventive interventions.

Got rid of some of the proxies for quality, the 50/50 rule that was brought to the Senate's attention last year. Indeed, as Gerry's talked about, BBA has introduced the demand for a new risk adjustment system for Medicare.

So there is a lot of good in BBA that over time will have a positive effect.

The downside, of course, are several. First of all, with respect to doing dual eligible programs, there is still a need to go through, do the waiver process. That has not been eliminated, and so much of what I have been worrying about, and what the States have been struggling about with respect to that, you still have to go through. That has not been taken away.

When it comes to the risk adjustment approaches that are being talked about, I am afraid that the data and the concepts underlying them are still very much oriented to acute care mindset. The notion of functional dependencies is not there. As a result, some of the necessary adjustments that we think will entice providers to be involved in this market are not going to be made.

In the future, we will still be faced with needing to come up with new reimbursement systems that tack on adjustments for functional dependencies that people are not entirely comfortable with.

As compelling as those substantive comments is the fact that BBA is a big agenda for the Health Care Financing Administration and for those of us who are going to them for help to do integrated care programs. They have a lot on their plates. To get HCFA's attention to some of these issues that really are the cutting edge issues to lead us into the 21st century, it is sometimes hard to get the help you need when HCFA needs to create a reimbursement system for all the TEFRA HMO's.

These are very real world issues. I bring them to you not to say that they cannot be solved, but I think that we probably need to, when it comes to the dual eligibles, begin to think in terms of them as being a terrific group of folks that can indeed lead us in the direction of the health care systems we want in the future. We need to begin to think about them as a special group and get the kind of help that is needed to help States get off the ground, to test how to work with managed care organizations who can specialize in acute and long-term care, and begin to learn some of the real lessons of how you do integrated care.

There are many issues regarding the contracting rules of Medicare and Medicaid that are not the same that need to be worked on. There are issues related to quality assurance and getting con-

sumers involved that need to be worked on. These are all very substantive areas.

But they will not be worked on, frankly, unless States and providers are allowed to get their programs off the ground. I think that is the compelling argument I would make today. We have learned a lot, but what we really need to learn is still yet to come and the States need a chance to experiment with systems of care for dual eligibles.

So I encourage us to discuss and think about some of the creative ways we can do that, get us out of some of the more rigid review process that we have been in, be it budget neutrality considerations or waiver considerations.

Just to step back one point, budget neutrality is something that both the Health Care Financing Administration and OMB struggle with and force the States to struggle with. I would suggest to you that while I understand that, that the benefits of working in this area and maybe thinking in terms of more creative budget neutral arguments, are very significant for the simple reason that the technology to do good integrated acute and long-term care is not sitting on the shelf someplace just to be pulled off and plugged in once somebody says go. It has to be developed.

You know what they say, you get what you pay for. Unless we pay for those developmental costs and help development happen, it will not happen in a way that makes us feel good about what we have tried to do. That would really be a mistake.

So we need to be careful with these budget neutrality assumptions or think about them in a different way, so that we recognize that the technology, while it is important to develop, is not there sitting on the shelf. The notion that you can do these in a cost saving fashion, I think, is true but it needs that technology to be developed.

I think, in the interest of time, and to give the audience a chance to participate, I will close and say I appreciate being here today. For all I have to say, you are probably better referring to my written testimony. That is where I think a little bit more clearly.

Ms. GERSTENBERGER. It seems pretty clear to me.

The questions that we have gotten sort of cluster around five areas. I am just going to list them all so that you will know what is coming, and then I will refer individual ones if the request was referred to a particular person.

The first one concerns care management and the difference between, if there is a difference between, care management and case management and the cost effectiveness of care management, what the evidence is.

The next concerns quality and fraud problems within nursing homes and home health and hospice, and what we can do about that, and how that may impede the goals of the chronic care consortium and others.

Another has to do with reinsurance and carve-outs as they relate to risk adjustment.

Another had to do with MSAs, medical savings accounts.

The last one, if you could make one recommendation to the Commission to Reform Medicare and how can we change Medicare to

pay for whatever your recommendation would be, or the changes that are needed.

So we will begin with the care management and cost effectiveness of care management question, which was addressed to you, Dr. Denman.

Dr. DENMAN. OK. I tend to use care management and case management interchangeably. I think that more often, however, care management refers to the management of a specific disease or illness, like congestive heart failure or diabetes or the management of a specific problem like a hip fracture. Care management or disease management programs often put in place by managed care organizations, to deal with those specific diseases or illnesses.

I think of case management in a broader sense. In my opinion, case management, is a more holistic approach to caring for someone with multiple chronic illnesses and who needs not just coordination of their medical care needs, but of all the other things that if not attended to can sabotage the best medical plan in the world.

These include the psychosocial supports, and other support services in the community, spiritual, I mean all kinds of many different areas need attention to ensure that a treatment plan will be successful.

A case manager would make sure that these areas were addressed.

Now in terms of the second part of the question, about the evidence for the cost effectiveness, unfortunately of case management there is not a lot of evidence. Hopefully this area will grow. There is some data that care management programs have been effective in reducing rehospitalization for persons with congestive heart failure in managed care settings.

It seems to me that when effectiveness is demonstrated it is not just because there is a program in place, but it is very dependent on the quality of the people who are in the roles in that program. So what I am talking about is if we demonstrate that perhaps an interdisciplinary team can be effective in one setting, it may be that you do not just need a nurse, a social worker, access to a therapist, and access to a physician. You need to have access to those professional services that are quality services. Those disciplines need excellent training in their areas in order to be effective.

Professional caregivers in all disciplines must receive excellent education and training about assessment, about what interventions are most effective. I think that—and I certainly hope—that the effectiveness will be demonstrated but it will be dependent not just on a model of care delivery but on the quality of the components of that model.

Mr. ANDERSON. If I can just answer this in a slightly different way, what Dr. Denman has talked about it is cost effectiveness is in a fee-for-service model predominantly, and does it save money in a fee-for-service model.

We also are dealing increasingly with a managed care model where the physician is capitated. Now the concern flips almost 180 degrees. Is too little service being provided to the patient when the physician is fully capitated? This makes the cost effectiveness calculation very different.

Most of the work that we have done, and it is still in its infancy, is in the fee-for-service model. Very little of the work we have done is in a managed care model. Yet you are seeing a large portion of the elderly, and increasingly the chronically ill elderly, involved in this situation.

Mr. MEINERS. I might as well throw in a different take on it. That is just when you think of care management, think of what you want when you are in a health care system. You basically want a buddy, somebody who can help you think through these problems. It does not mean you do not need teams that help you with your medical conditions, but you want to have somebody who kind of knows how to speak their language and who can see you from one component of the health care system to another.

That is what I think care management would truly be. Whether it will be cost effective or not, I think for sure it will ring the bell on satisfaction measures, which is the other piece of the equation. You are going to get clients, if you do things that your clients like.

So I think that is where care management will win the day, when you kind of feel like you can transverse the various systems of care that you are dealing with and have it feel like one rather than a bunch of different systems.

Mr. BRINGEWATT. Care management is critical for managing services for people who have complex needs. One of the biggest dangers of care management is that becomes an excuse to not change the system. Sometimes we can have care management simply help us help people get through the maze, and not do anything to change the maze.

So if care management is going to be effective over the long term, it really needs to have the authority, care managers, care teams, physician, nurse, social workers need to have the authority to use whatever combination of care is most cost effective, not simply serve as the vehicle for referring them as serve as a transfer vehicle, for enabling people to get through the maze more easily.

I think it is also important that we—and I think the common myth that sometimes prevails in Washington is that managed care somehow equals service delivery systems as integrated. Physicians who work, or other people who work within provider organizations, need to respond to many different payers, even though there may be many different integrated—we talked about managed care organizations but those managed care organizations are really made up of many different providers who respond to multiple managed care organizations and multiple payer structures.

So care management, to be effective, has to kind of move beyond simply sorting out which payment method is going to work and referring them to what option may be available to actually being able to do, be able to provide and manage the care that is needed, and where the dollars flow to the plan as opposed to the plan flows to where the dollars are.

Ms. GERSTENBERGER. I have just been given word that they are having a luncheon in here and we need to move it along. So I am going to invite people to speak, and I am hoping that our speakers can stay for a few minutes. A lot of these were directed at individual people.

I think in the time remaining, it would be interesting to go one by one and answer this question. If you could make one recommendation to the Bipartisan Commission to Reform Medicare, which would improve Medicare's ability to meet the needs of the chronically ill, what would that recommendation be?

I do not know if someone wants to volunteer or if I should just——

Ms. WEINBERG. I will tell you, that is extremely difficult, as you can imagine.

One of the things that strike me, at least one of the top priorities would be to deal with informal caregivers. I just really feel that we have a disaster waiting to happen with so much care being provided, probably billions of dollars of care actually being provided by family caregivers or other caregivers in an informal way who then become part of the health care problem in the country.

If we do not resolve that in some way, I am really not sure where the major breakdown is going to happen. But I think Medicare is the best place to start in providing the education, training, recognition, reimbursement, and just respecting the system so that better information—especially for a patient that has a condition like Alzheimer's—better information gets to the health care provider so that, in fact, better care is delivered.

Mr. ANDERSON. I do not think you will find mine surprising. Essentially, we need to reallocate the dollars that are spent in the Medicare program so that more and more care dollars go to the chronically ill, and that there is an incentive for managed care organizations to try to enroll the chronically ill.

I think there is a lot of potential benefit from coordinated care for the chronically ill in managed care. Right now they do not have a financial incentive to try to enroll the chronically ill. So I think if they were given the appropriate financial incentive there would be a tremendous benefit to them.

Mr. BRINGEWATT. If I was limited to only one recommendation for reducing medical costs through better care interventions I would suggest the Federal Government establish national targets for reducing incidence rates and reducing the need for care also reduces the need for Medicare expenditures.

One of the biggest problems under Medicare right now is we tend to organize policy around provider settings, hospitals, nursing homes, home health agencies, physicians, medical equipment, whatever, and ratchet down costs in relation to each one of those.

If we could move our national policy to a higher level and look at establishing national targets for addressing problems, where the focus is on dealing with conditions where care requirements evolve across different settings, and over time then other things will follow in terms of establishing different payment incentives. Establishing a different kind of oversight structures that enables us to look at outcomes in relation to ongoing management of conditions, and related cost and care requirements as opposed to management of care in relation to place, by setting without any sense of the cumulative effect that our fragmented approach to care has on government expenditures and those being served.

Dr. DENMAN. I think the top priority should be that all persons with chronic illness would have access to case management serv-

ices, and that a case manager would have some flexibility in determining how benefits might be utilized.

Acute hospitalizations could be avoided by putting services that might not be covered now in place. Case managers would require extensive knowledge of existing services in the communities. But I do think that case management services would improve coordination of care for people with chronic illness, and ultimately reduce overall health care expenditures.

Mr. MEINERS. I like all of those and it is hard to decide what would be the single most solid recommendation. Given where Medicare is coming from, I really think consumer education is an important thing. I think we have to 'fess up to the fact that Medicare is not and was not designed for long-term care. But it certainly covers nursing home care, home health care and hospice care.

How it does those things, I think, can get confusing to people and where you draw the lines can be controversial. I think if we could sort through that controversy and draw the lines more clearly, then it would help people also step up and understand what their responsibilities were on the long-term care and chronic care pieces.

Those distinctions, I think, will help us over time develop the kinds of products and delineations that we need. Right now it is a very confusing environment and I think it gets in the way of progress, and we debate cost shifting and that sort of thing in a way that is not particularly productive but very real, depending on which side of the cost shift you are on.

Ms. GERSTENBERGER. It turns out I have a little more time than I thought, so I will give a couple of these questions.

To Dr. Anderson regarding Dr. Meiners' point that current risk adjustment methods seem to focus on acute care problems rather than chronic care problems. Another question, would you please discuss the issues of reinsurance and condition carve-outs as they relate to risk adjustment.

Mr. ANDERSON. One of the things I said is that we do not have the perfect risk adjuster. What I think we have is a risk adjuster which is better than the current AAPCC which Medicare uses.

We could get a better risk adjuster, which incorporates both long-term care and acute care, and that is likely to take us another 3, 4, 5 years to develop. Then we have got to test the risk adjuster. So we are talking the year 2005 before that happens.

Over that next 7 or 8 years, what is going to happen is that people with chronic illness are going to have increasing difficulty in managed care. So we need to do something which is not perfect.

I think all of us would admit that we would like to have something that involves functional limitations. The problem with functional limitations, however, is that it is a self-reported, activity. That makes it suspect to manipulation by the provider community. So the concern is an implementation issue, a feasibility issue. But you could, if you wanted to, test that out to see how bad it is.

The question in risk adjusters, carve-outs, and reinsurance is a little bit more of a sophisticated question, so somebody clearly knows the answer that they are interested in getting, so let me try to do it.

What I proposed up there is a risk adjustment system. What that does is it takes everybody in the Medicare program and assigns a dollar value to them based upon their health status.

A shorter term and easier thing to do is just reinsurance. Most of the managed care organizations have purchased reinsurance. Many of the capitated physicians have purchased reinsurance. What that does is set a dollar threshold, say $25,000. Above that dollar threshold of $25,000 a reinsurer picks up the bill.

So it protects, to some extent, the expensive chronically ill person. But if you have got too many of those, you are going to spend $25,000—the first amount of money up until $25,000—and lose money on those people because you are only getting paid $4,000 or $5,000 for taking care of them. So you lose $20,000 on a person.

Plus you have got to buy a reinsurance package. It is quite expensive, and does not really protect the chronically ill.

A second thing is carve-outs. There are disease specific carve-outs, people with liver transplants or certain chronic illnesses. There are service carve-outs, things like mental health. There are population based carve-outs, like the SSI population in Medicaid. All of those will work, but do any of them really protect the chronically ill, except for maybe the SSI carve-outs when you do not have the chronically ill involved in the program.

So what we have done is taken a look at what is really, from a financial perspective, going to protect the chronically ill. The simple one that is the carve-outs helps a little bit but not very much. Reinsurance helps a little bit, carve-outs help a little bit more but not a lot. Really what you need is a combination of these three, reinsurance, carve-outs and risk adjusters, to really protect the chronically ill, at least from a financial perspective.

Ms. GERSTENBERGER. Thank you.

We are running out of time. What I have been told we can do is give the remaining questions to the panelists. They can supply written answers which will be included in the record, the written record of this forum.

I am also asked to tell you that copies of the written record will be provided to the Medicare Commission, as well.

I will just close by very quickly saying it has been exciting to be here with the innovators and the people who have the new vision of how a system could be constructed, and those that are developing the practical tools and doing the nitty-gritty work at the State Government level.

I encourage those here who develop policy and legislation, and those who are influencing the policy process, to continue pushing to allow demonstrations, evaluation of those demonstrations, and make those long-term investments that lead to the tools that can change the system that we currently have for the better.

Thank you very much.

[Whereupon, at 11:12 a.m., the forum was adjourned.]

APPENDIX

QUESTIONS AND ANSWERS

RESPONSES FROM DR. ANDERSON TO THE QUESTIONS RAISED AT THE FORUM

Question. Would you discuss the issues of reinsurance and condition carve-outs. (Are these like "Outliers" as they relate to risk adjustment for chronic illness?)

Answer. Reinsurance and condition carve-outs are two approaches for limiting financial risk to capitated health plans and providers. Reinsurance is primarily designed to protect against large, unpredictable or random variations in health expenses. Under the most common form of reinsurance, individual stop-loss coverage, providers are responsible for the health care costs of individuals up to a certain dollar threshold, for a given time period. The reinsurer is either partially or totally responsible for costs incurred beyond this amount.

Condition carve-outs are another method for reducing financial risk under capitation. Certain consistently high cost conditions can be "carved out" (i.e., removed) from the capitation payment and be reimbursed separately by establishing a separate payment amount or through a modified fee-for-service arrangement.

Reinsurance and carve-outs either alone or in combination may offer only limited protection for the chronically ill. Reinsurance, for example, may afford some protection for chronically ill persons who have very high health costs in a single year. However, research shows that although most persons with chronic conditions have above average health care costs over a single year, only a small portion of those persons incur very high costs. Reinsurance alone, therefore, would not eliminate incentives for capitated health to avoid or under-treat chronically ill persons whose health care costs are above average, but below the threshold.

Condition carve-outs may preserve access to care for chronically ill persons with certain specific conditions. They may also be useful for providers who may have a higher proportion of patients with certain conditions or who specialize in one type of illness. However, because there is likely to be wide variation in the costs of treating persons with carve-out conditions there may still be a financial incentive for identify and attract the least severe/expensive individuals within the carve-out condition. Moreover, carve-out conditions have only be applied to a narrow range of medical conditions. Currently, the trend in both the public and private sectors is to limit the number of conditions that are carved out of the capitation payment.

Question. Would you please comment on Dr. Meiner's point that current risk adjustment methods seem to be focused on acute care problems rather than chronic care problems.

Answer. Prospective risk adjustment methods use enrollee characteristics to explain differences in expected costs across groups of individuals and to adjust capitation rates accordingly. The goal is to reduce incentives for risk selection and preserve access to care by setting capitation rates closer to expected costs. Enrollee characteristics that can be used to adjust capitation rates include demographic factors, functional health status, self-reported health status, prior utilization, and clinical indicators. However, researchers have focused most of their efforts on developing risk adjusted capitation models that used diagnostic information on the individual to establish capitation rates. These models typically use diagnoses obtained from claims or encounter data to predict cost and utilization in the subsequent year.

Although, clinical indicator models usually incorporate both acute and chronic diagnoses, diagnosis alone may not adequately reflect the variations in health status within a given diagnosis, particularly chronic diagnoses. Also, some clinical indicator models may omit several chronic conditions. An alternative approach is to use functional health status (i.e., ability to perform activities of daily living) or self-reported health status information to adjust payment rates. However, the information to implement such models is usually not routinely collected by plans or providers and would, therefore, require a considerable amount of primary data collection to imple-

ment and maintain. These models are less developed than clinical indicator models and have been used primarily for demonstration purposes. They have not been widely adopted by health plans or physicians.

While continuing to explore risk adjustment models based on functional and self-reported health status is important, particularly in addressing the needs of the chronically ill, there are a number of reasons for implementing clinical indicator models now. First, although these existing models are not "perfect" they are better than not adjusting capitation rates and may perform as well as models that rely on more sophisticated functional health status measures.[1] Second, the information required for these models is often readily available through administrative data and therefore could be implemented fairly easily in the short-term. This is a particularly important consideration for Medicare managed care plans. The Balanced Budget Act of 1997 requires payments to these plans to be risk adjusted starting January 1, 2000. Plans are also required to submit inpatient hospital data (from 1997 onward) on enrollees and information on other services (from 1998 onward). Most Medicare managed care plans would not be able to provide information on functional or self-reported health status in this short time frame.

Question. Please comment on the impact that Medical Savings Accounts (MSA's) would have on the overall payment system.

Answer. There are several different approaches for structuring MSA's. Typically, high deductible/catastrophic health insurance is combined with "tax-advantaged" savings accounts. Individuals or families would contribute to their MSA and use savings to pay for health care until their deductible is met. Contributions to the MSA would be tax deductible and withdrawals to pay for medical bills would be tax free. Accounts would be taxed on annual interest and penalties would be imposed for non-medical withdrawals. Under a common alternative approach, employers or public programs (e.g., Medicare) would periodically contribute to the MSA, usually the difference between the cost of catastrophic insurance and more comprehensive coverage.[2]

The goal of MSA/catastrophic insurance is to make the consumer more cost conscious and to lower spending on health care for which the marginal benefit is less than the marginal cost.

Evaluation of the impact that MSA's would have on the payment system are mixed. Proponents of MSA's argue that overall health care spending will decline as people switch from comprehensive health plans to catastrophic/MSA plans. Because people in these plans will be paying an amount closer to the full cost of care, spending on "low valued" medical care will be reduced.

However, major concerns with MSA's have been expressed. MSA's may potentially further fragment the insured population and result in higher premiums (especially for the chronically ill) and larger public expenditures on health care. It is likely that healthier individuals, with relatively low annual health care expenditures will be more likely to enroll in these types of plans. In contrast, persons with chronic conditions or others in need of frequent medical care will likely elect to retain comprehensive health coverage. This could result in higher premiums for sicker persons.

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[1] Fowles JB, Weiner JP, Knutson D, Fowler E, Tucker AM, Ireland M. Taking Health Status into Account When Setting Capitation Rates: A Comparison of Risk Adjustment Methods. *JAMA*. 1996;276(16):1316–1321.

[2] Ozanne, L. How Will Medical Savings Accounts Affect Medical Spending. *Inquiry*. 1996;33 225–236.

University of Maryland Center on Aging

Medicare/Medicaid Integration Program

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Integration of Acute and Long-Term Care for Dually Eligible Beneficiaries through Managed Care

A Technical Assistance Paper of
The Robert Wood Johnson Foundation
Medicare/Medicaid Integration Program.
An initiative directed by the
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Prepared by

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MMIP Technical Assistance Paper No. 1

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The Medicare/Medicaid Integration Program

The purpose of the Robert Wood Johnson Foundation Medicare/Medicaid Integration Program, (MMIP) is to end the fragmentation of financing, case management, and service delivery that currently exists between Medicare and Medicaid. States will be provided with grant support and technical assistance in their efforts to restructure the way in which they finance and deliver acute and long-term care. Technical assistance will focus on those states that have been awarded grants, but not be limited to grantees. It is recognized that other states and initiatives can benefit from this help. This paper represents one such effort.

The Foundation staff responsible for the program are: Nancy Barrand, Senior Program Officer; James Knickman, PhD, Vice President For Research and Evaluation; and, Diane Montagne, Program Assistant. The National Program Office (NPO) for the program is based at the University of Maryland Center on Aging under the direction of Mark R. Meiners, Ph.D. The NPO will provide technical assistance and direction for the initiative. Hunter McKay is the Deputy Director for the program.

The MMIP Application Kit contains a complete set of budget and narrative guidelines. Requests for application materials and information about the MMIP can be obtained from the following locations:
Web Site: http://www.inform.umd.edu/aging
Phone/Fax: 301-405-2471 (phone) -- 301-314-2025 (fax)

ALERT TO READERS!!!

Congress was poised to pass the Balanced Budget Act of 1997 as this paper went to press. The Act makes significant changes in the managed care options under Medicare and Medicaid. The specific impact on state dual eligibility initiatives must await the drafting of regulations by HCFA. The major components of the Act include:

Medicare

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

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

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

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

Medicaid

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

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

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

These changes broaden the managed care options under Medicare which should make it easier for states to contract with MCOs eligible for Medicare contracts. The Medicare open enrollment period and the requirement that beneficiaries must remain in the plan for a calendar year is consistent with the 12 month "lock-in" provision under Medicaid.

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Executive Summary

Managed Care as Vehicle for Integration

This paper discusses technical aspects of acute and long term care integration for dually eligible beneficiaries through managed care. It is intended primarily to assist states considering managed care approaches for dually eligible beneficiaries. While other options are of interest to states and HCFA for this population, including fee-for-service based case management systems, managed care/fee-for-service hybrids, and consumer directed systems, the purpose of this paper is not to provide comparative analysis of multiple approaches to serving dually eligible beneficiaries. Rather, the focus is on the use of managed care for the population, and the multiple forms managed care can assume.

What is Integration?

Though many state and federal policy makers and program designers are intrigued by the notion of integration, we are still without a broadly accepted definition. This paper joins the struggle for definition by breaking integration into component parts, including integrated benefit packages, delivery systems, quality mechanisms and financing, and discussing the technical challenges of integration within each component.

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

Integration v. Coordination

Full integration requires integration of many program components. Whether a state can or wishes to meet all the conditions of full integration at the outset of its program will depend on the state's infrastructure, market conditions, political considerations and implementation schedule.

As a trail blazer in this area, the Minnesota Senior Health Options (MSHO) program has received well-deserved attention, but states should not automatically move to replicate MSHO without careful consideration of that State's somewhat unique circumstances. Before launching MSHO, Minnesota had considerable experience enrolling elderly people in risk-based managed care, and initially, MSHO is being implemented in an urban market with one of the highest managed care penetration rates in the country.

Some states may choose approaches that begin with program coordination or partial integration as a reasonable stepping stone to a fully integrated model. The danger of an incremental approach is that it may lose its focus and momentum over time, but if a state has established clear goals, they can serve as the touchstone for each successive step in program development.

Integration Building Blocks

When a state is designing an integrated program, integration may be broken into its component parts. Whether a state attempts them all at once or in increments, the following components may be viewed as building blocks toward integration:

- *Broad and Flexible Benefits.* In order to integrate care, a program should be able to offer a broad range of benefits, including primary, acute and long term care. The benefit package should be flexible and responsive to individual needs and not simply replicate fee-for-service Medicaid and Medicare benefits;

- *Far-Reaching Delivery Systems.* If a program is to include a broad range of acute and long term care services, the delivery system should have capacity and experience beyond what is offered by traditional Medicaid or Medicare HMOs. Community-based long term care, case management and a host of specialty providers should be included in the delivery system through capacity building or strategic partnerships;

- *Care Integration.* The program design should include mechanisms for actual integration of care at the beneficiary level, such as case management, interdisciplinary care teams and centralized member records. Otherwise, a program may do little more than recreate a fragmented array of services under an ineffective program umbrella;

- *Unified Program Administration.* Medicare and Medicaid enrollment, disenrollment, data collection, payment and other systems should be unified, at least through the eyes of the beneficiary. The beneficiary should be interacting with one system regarding all Medicaid and Medicare administrative issues;

- *Overarching Quality Systems.* A single point of accountability should be established, Medicare and Medicaid quality requirements should be unified, and a quality umbrella should be established that moves beyond the traditional quality systems based on individual provider performance; and

- *Integrated Financing.* Medicare and Medicaid funding should be flexible, and the incentives created by the two major payors should be aligned to eliminate cost shifting.

A Few Givens

States should be creative in designing new approaches to integration that will achieve their goals and fit their particular landscapes. However, indications are that the following conditions will be necessary to win HCFA's support:

- *Medicare Freedom of Choice*. Programs must ensure that a dually eligible beneficiary is able to exercise his or her statutory right to choose Medicare providers. HCFA's position on this stems from §1802 of the Social Security Act, which *may not be waived*:

  > Any individual entitled to insurance benefits under this title [XVIII] may obtain health services from any institution, agency or person qualified to participate under this title if such institution, agency or person undertakes to provide him such services;

- *Medicare Cost Sharing*. States must meet their obligation to pay Medicare cost sharing for dually eligible beneficiaries, regardless of where the beneficiary receives Medicare services. HCFA will not approve arrangements (as it has in the past), in which cost sharing is only available through designated managed care plans;

- *Lock-in to Plan*. Once a dually eligible beneficiary chooses a managed care plan, the beneficiary must be able to leave that plan for Medicare benefits on a month-to-month basis. While states may fashion longer lock-in periods for Medicaid, this is currently the longest permissible lock-in for Medicare. However, this is an area likely to change in the future. As of this writing, Medicare provisions in the federal Balanced Budget Act of 1997 included movement toward an annual open enrollment period for Medicare, beginning in 2002; and

- *Cost Neutrality*. Programs must be cost neutral. If both Medicaid and Medicare waivers are requested, the program must be cost neutral to *each* funding source *independently*. It is not sufficient to show overall cost neutrality for the two programs combined.

Managed Care Vehicles for Integration

Several vehicles have emerged around the country as suitable for integrating Medicare and Medicaid services. The one or more vehicles selected by a state will depend on program goals, purchasing philosophy and availability. Vehicles include:

- Medicare managed care contractors, which are currently limited almost exclusively to HMOs, but which will be expanded to include provider-sponsored organizations

(PSOs), preferred provider organizations (PPOs) and other forms of managed care under the federal Balanced Budget Act of 1997;

- National demonstration programs, including Medicare Choices, Social HMO II, PACE and EverCare. (PACE becomes a permanent option under the federal Balanced Budget Act of 1997); and

- Medicaid MCOs, including traditional Medicaid HMOs and community-based organizations that are willing and qualified to bear risk.

None of these vehicles will universally meet the needs of all states, nor is it necessary for a state to settle on a single approach. A state may want to use a combination of vehicles to reach distinct populations, cover certain geographic areas, or simply take full advantage of the existing market place.

Waiver Options

The waivers a state needs will depend on the program features and vehicle selected. There is no single combination of waivers required, and states have been creative with assistance from HCFA. Waiver requirements have been thrown into a state of flux by the Balanced Budget Act of 1997, but as of July, 1997, the following guidelines applied:

- *Medicaid Freedom of Choice.* As previously stated, *Medicare* participation must be voluntary, but a number of states have fashioned programs with *mandatory Medicaid* components. Currently, in order to do so, a state must have a §1915(b) or §1115 waiver. Although Medicaid waivers will not be required in as many situations under the Balanced Budget Act of 1997, it appears that most programs targeting dually eligible beneficiaries will still require Medicaid waivers;

- *Changes in Medicaid Services.* If the program will offer Medicaid benefits outside traditional Medicaid services, a state must have a §1115 waiver, unless the changes in services are limited to home- and community-based long term care, in which case a §1915(c) may suffice;

- *Changes in Composition.* If the desired contractor does not meet Medicaid's 75/25 membership composition rule, or Medicare's 50/50 rule, waivers are needed to engage in full risk contracting. Waiver of Medicaid composition requires a §1115 waiver; Medicare composition may be waived through §222. The federal Balanced Budget Act of 1997 will eventually replace the Medicare composition rule with enhanced quality and outcome measures; and

- *Medicare Payment Variations.* If a state chooses qualified Medicare risk contractors and is willing to accept the existing AAPCC payment methodology for

Medicare, no Medicare waiver is needed. However, if a state desires capitated Medicare payments to MCOs that are not Medicare risk contractors, or if any alteration to the AAPCC is desired (whether or not the contractor is a Medicare risk contractor), a Medicare §222 waiver is required.

The Next Generation

The Health Care Financing Administration and The Robert Wood Johnson Foundation are both sponsoring demonstration programs that focus on dually eligible beneficiaries, and are challenging states to think about the next generation. At this writing, bipartisan agreement had just been reached on the Balanced Budget Act of 1997, expanding Medicare managed care to include several new entities and products, and eliminating the need for waivers in certain Medicaid managed care programs.

This paper dissects integration of acute and long term care into component parts, encouraging states to think of integration not in terms of models, but as a set of building blocks that may be assembled in many different combinations.

A. Introduction

Background

As states have gained experience enrolling mothers and children in Medicaid managed care, they have become increasingly interested in expanding managed care to other Medicaid populations. Indeed, the period 1994-1996 witnessed a 67% increase in the number of state Medicaid programs enrolling aged, blind, and disabled beneficiaries. Unlike the population of mothers and children with whom states built their early managed care programs, however, these new populations require a broader array of services and rely not just on Medicaid but also on Medicare for substantial health care financing. Where Medicaid is the primary payer of most care provided to mothers and children, most aged, blind, and disabled beneficiaries receive from Medicaid long term care services and limited primary and acute care not otherwise covered by Medicare. Some persons with disabilities are not eligible for Medicare, but the majority of the aged, blind, and disabled now enrolling in Medicaid managed care are also eligible for Medicare. Thus states have a growing interest in initiatives to integrate acute and long term care and the two payment sources - Medicaid and Medicare - which cover these services. Because states share responsibility for dually eligible beneficiaries with the federal government, these initiatives require strong collaboration between states and HCFA.

Defining Goals: What Does a State Wish to Achieve By Integrating Acute and Long Term Care?

Three factors have influenced the movement of states to integrate acute and long term care:

- The desire to improve continuity of care across settings and to provide flexible benefits that prevent or reduce institutionalization;
- The need to control costs; and
- An interest in expanding managed care to all Medicaid beneficiaries and minimizing the administrative complexities of operating both fee for service and risk based systems.

Continuity of Care and Benefit Redesign

The National Long Term Care Channeling Demonstration of the 1970s and the growth of Home and Community Based Waivers of the 1980s, brought states the opportunity to coordinate acute and long term care for frail elderly and certain persons with disabilities through case management. Both programs were targeted at those who were likely to require institutional care and sought to arrange alternative home and community services. While states experienced considerable success in developing home care alternatives, both programs still had limits on the type, duration, and scope of

services provided and neither addressed the needs to prevent illness and disability. That is, beneficiaries presented at home care programs with levels of illness and disability that begged the question of whether sufficient primary and preventive care had been delivered under Medicare. Nor did case managers have the capacity or authority to truly integrate care. For example, a beneficiary of Medicaid waiver services could experience an episode of acute illness, requiring hospitalization. The Medicaid case manager would likely lose contact with the beneficiary once hospitalized under the Medicare program. At hospital discharge, the beneficiary may be placed in Medicare reimbursed home health or a skilled nursing facility, unknown to the Medicaid case manager. Such disruption in service, despite case management, is not uncommon in waiver programs. While case managers can have considerable impact on coordinating care, they lack authority over the entire Medicaid and Medicare scope of services. Waiver programs often expanded the types of services reimbursable but did not provide opportunity for significant benefit redesign nor were programs able to access or re-direct Medicare expenditures. Additionally, the Medicare program provides benefits designed to better manage the needs of those with chronic illness. Some of these benefits duplicate Medicaid benefits; often they are required to be provided by skilled medical personnel when case managers may believe less medical intervention is appropriate. These home care initiatives, then, led states to recognize the need to coordinate acute and long term care and identified the need to build more preventive care into the Medicare primary and acute care benefit to possibly forestall and better manage the impact of chronic illness and disability.

Control Costs

Waiver programs also created the opportunity and often the incentive to cost shift between programs. A Medicaid case manager can refer a beneficiary to Medicare reimbursed services prior to paying for those services under Medicaid. A Medicare home health provider can exhaust skilled nursing benefits then transfer the beneficiary for Medicaid reimbursement. Strong incentives to maximize reimbursement can displace beneficiary centered care planning, which integrates acute and long term care services.

State incentives to maximize Medicare reimbursement and reduce cost growth are strong as well. Since aged, blind, and disabled beneficiaries comprise only 27% of Medicaid enrollees but expend 59% of its resources, states grew intrigued with the question: Can Medicaid managed care for dually eligible beneficiaries make these costs more predictable and reduce cost growth, as had been their experience enrolling mothers and children? Most of Medicaid's expenditure growth for elderly and disabled populations has been in institutional services. Despite significant efforts to reduce reliance on nursing homes through home and community based waivers, states still struggled with what they perceived as a persistent and resilient institutional bias in the Medicaid program. The attraction of capitating a health plan for acute and long term care services promised an approach which might prove successful in reducing the costly reliance on nursing homes and provide beneficiaries with greater choice of service and

residential options.

Finally, states were motivated to address the cost concerns of a non-integrated acute and long term care system with passage of the Medicare Catastrophic Coverage Act of 1988. That law required state Medicaid programs to pay Medicare cost-sharing for certain low income beneficiaries who did not otherwise meet Medicaid eligibility requirements. For this new group, states became responsible for meeting Medicare cost sharing without any capacity to control what and how many services were provided.

Expand Managed Care to All Populations

Historically, most states excluded aged, blind, and disabled beneficiaries from Medieaid managed care, but as states gained managed care experience, interest has grown in developing managed care for all populations under Medicaid. While other vehicles exist to coordinate Medicare and Medicaid, states have become convinced that managed care is a useful vehicle to deliver cost effective, quality health care. But they have also been frustrated by the complexity of maintaining both fee-for-service and managed care programs. By enrolling all populations in managed care, states hope to streamline data, billing, reporting, quality and other administrative systems and no longer run a separate fee-for-service program. In certain states, the move to Medicaid managed care for dually eligible beneficiaries has also been stimulated by growth in enrollment in Medicare HMOs. While Medicare HMOs are still not available in all parts of all states, enrollment in Medicare HMOs has increased 60% since 1993. These developments have complicated service delivery and financing to dual eligible beneficiaries who can now be covered in four discrete ways:

- Medicaid fee-for-service/Medicare HMO;
- Medicaid managed care/Medicare HMO;
- Medicaid managed care/Medicare fee-for-service;
- Medicaid fee-for-service/Medicare fee-for-service.

This increasingly complex set of possible combinations complicates enrollment, eligibility, claims and payment processing, third party liability, and quality oversight activities. Medicaid and Medicare laws and rules establish different requirements in these areas which present barriers to fully integrating acute and long term care and create confusion about accountability. This confusion is exacerbated as more and more Medicare HMOs offer enhanced benefits to attract enrollment. When these enhanced benefits duplicate Medicaid covered benefits, such as out-patient drugs, for those dually eligible, Medicaid programs need to restructure Medicaid capitation rates to assure no double payment for the enhanced benefits and primary care providers need to carefully monitor how dually eligible beneficiaries are accessing and using services. The growth of point of service and preferred provider arrangements may present still more approaches to integrate Medicare and Medicaid.

To truly eliminate service delivery fragmentation and coordinate care for dually eligible beneficiaries requires a careful review of what states wish to and can realistically accomplish. Given the significant differences in Medicaid and Medicare, and the differences among states in penetration and sophistication of managed care plans, demographic and geographic characteristics, marketplace availability, and political realities, each state needs to carefully determine its objectives prior to launching efforts to integrate acute and long term care. Within the broad goal to integrate care, states need to establish priorities for what they wish to achieve. For example:

- Does the state wish to include preventive and primary care objectives in the initiative? Is a goal to prevent or forestall the impact of chronic illness and disability?

- Does the state wish to create a seamless system of service delivery for those requiring both acute and long term care?

- Does the state wish to expand home and community based alternatives?

- Does the state wish to maximize Medicare reimbursement for dually eligible beneficiaries?

- Does the state seek to build managed care capacity to serve the special needs of dual eligible beneficiaries?

- Does the state wish to craft a consumer centered system with strong beneficiary support?

Most state policy makers would answer each of these questions in the affirmative. Yet, state objectives for integrating acute and long term care can conflict with one another. For example, a fully integrated financing and delivery system between Medicaid and Medicare would likely eliminate much of the capacity to maximize Medicare payments and incentives to cost shift between two payers would be eliminated in a truly integrated plan. Expecting preventive care and a full array of long term care benefits may challenge the capacity of existing plans and providers, and building that capacity may increase costs. Expanding home and community care options may require contracting with organizations without sufficient capitalization, yet using established commercial managed care organizations (MCOs) may compromise long term care expertise. Building a strong consumer centered system could jeopardize MCO and provider support.

Target Population: Who Will You Serve?

In order to determine what it wishes to achieve in integrating acute and long term care, a state must decide for whom it wishes to achieve it. For example, many state initiatives target only those elderly or disabled who are in need of long term care

services. Such a decision would limit the capacity of an initiative to achieve some primary and preventive care goals. Other states target all dually eligible beneficiaries who present with a wide range of needs. Others limit programs to elderly or persons with disabilities only, while still others serve both elderly and persons with disabilities.

Determining the target population to be served is critical to program design. PACE, for example, is targeted to older people who are nursing facility-certified and provides a wide array of primary, acute and long term care services. Social HMOs, with their limited long term care benefit, are technically open to all dually eligible beneficiaries but have attracted mostly Medicare beneficiaries; Minnesota's Senior Health Options serves older dually eligible beneficiaries, while most of the New England states seek to serve both older and younger dually eligible beneficiaries

Dually eligible beneficiaries account for about 16-17% of enrollees in both Medicare and Medicaid programs and account for between 30-35% of each program's expenditures. The population tends to be in greater need of health services, with dually eligible beneficiaries more likely to have chronic or serious illnesses. Using the Medicare Current Beneficiary Survey, HCFA has developed a profile comparing dually eligible beneficiaries to Medicare-only beneficiaries. The following chart summarizes some key distinctions between the groups.

	Dually Eligible Beneficiary	Medicare-only
Female	66%	55%
Live Alone	34%	24%
Reside in Institutions	24%	2%
Self Report Poor Health	17%	8%
No regular source of call	30%	20%
Used emergency room last year	33%	18%

While these characteristics draw a sharp contrast between large groups, characteristics will further differ among the many sub-populations that comprise dually eligible beneficiaries, and states should examine closely the specific needs of the sub-populations they seek to serve.

System Design: How Will You Serve Dually Eligible Beneficiaries?

Once a state identifies its target population and determines its goals for integrating acute and long term care services, questions need to be addressed regarding how to structure the integration of finances and service delivery. Initially, states must grapple with the decision about whether Medicaid should allow voluntary enrollment or require dually eligible beneficiaries to enroll in managed care. Some states initiate programs on a voluntary basis to develop consumer and other support for the program and to allow time for needed infrastructure to develop. Other states begin their programs with

mandatory enrollment, fearing that voluntary programs would yield insufficient enrollment, making it difficult for the state or plans to invest sufficient resources needed to fully develop programs. Medicare's freedom of choice requirements make it possible for a beneficiary to choose any Medicare provider even if enrollment in Medicaid managed care is mandatory. This complicates the integration of financing and service delivery. However, if a beneficiary elects to receive services from a plan that is both Medicare and Medicaid authorized, integration of services may be more likely. Though freedom of choice issues are often the most difficult to make, many others are equally important. What will the range of services include? Will the program operate statewide?

States and site-based programs have taken varied approaches to these and other questions that ultimately determine the degree of integration that will be achieved. For purposes of discussion, we have chosen to focus the discussion in this paper on six states and one site-based program, all of which have achieved or hope to achieve some degree of Medicare/Medicaid integration. We have selected these programs because of the variety of approaches they represent, not because they are the only or necessarily the best examples of integration. They are described here and summarized on Table 1.

ALTCS (Arizona Long Term Care System)

ALTCS is a mandatory Medicaid managed care program targeted to people whose needs qualify them for long term care services. The program is administered by the Arizona Health Care Cost Containment System for elderly people and people with physical disabilities and through the Department of Economic Security for people with developmental disabilities. In ALTCS, Medicaid acute, long term care and behavioral health services are integrated, but Medicare is not explicitly included as part of the program design. However, the program achieves a degree of integration at the contractor level, because Medicare services are usually delivered through that contractor and reimbursed on a fee-for-service basis. Beneficiaries tend to receive all of their services from the Medicaid contractors, in part because Arizona's Medicaid waiver allows the State to deny Medicare cost sharing to providers who are not part of the ALTCS contractor's network. This creates an incentive for beneficiaries to remain in network for all services, but HCFA has stated that it will not approve such arrangements in the future because they restrict Medicare choice.

Colorado Integrated Care and Financing Project

Colorado received Medicaid and Medicare waivers on July 1, 1997 to enroll all Medicaid beneficiaries, including those who are dually eligible, in an integrated managed care plan in Mesa county. The State will contract with Rocky Mountain HMO, which has an existing Medicare contract with HCFA. This voluntary program will combine Medicare and Medicaid health and long term care services at the HMO level. Mental health services and services for developmentally disabled beneficiaries will not be included. The program is expected to enroll 7,800 Medicaid beneficiaries

(AFDC, SSI and categorically needy beneficiaries) including 1,200 who are dually eligible. Long term care services will be managed through a subcontract with the Mesa County Department of Social Services, a single entry point agency,[1] which is currently responsible for managing Medicaid community based waiver services and state funded long term care services.

MaineNET

MaineNet is being developed for three rural counties in Northern Maine, areas with very low levels of managed care penetration. The State will require Medicaid enrollees who are elderly and those who are younger and disabled to join an Integrated Service Network (ISNs) for all Medicaid funded acute and long term care services. ISNs may be HMOs or groups of providers organized for the purpose of bearing risk. The State has proposed in its waiver application that Medicare services be delivered through a primary care case management component. The same PCP would order both Medicaid and Medicare services, and the Medicare services would be reimbursed on a fee-for-service basis. As an incentive, dually eligible beneficiaries who agree to use the Medicare PCCM component of MaineNET would receive points monthly, redeemable for supplemental benefits not otherwise covered, such as eye glasses.

MSHO (Minnesota Senior Health Options)

Minnesota was the first State to receive Medicaid and Medicare waivers to explicitly integrate acute and long term care for dually eligible elderly people. In January 1997, the State implemented MSHO in seven counties in the Minneapolis - St. Paul area. The program offers an integrated package of Medicaid and Medicare acute and long term care services through a choice of three managed care plans. Enrollment is voluntary. MSHO is the only program approved to date by HCFA that provides for state management and oversight of both Medicaid and Medicare through a single contract. Plans are at risk and the State has developed two risk sharing arrangements. Plans are responsible for the first 180 days of nursing home costs. After 180 days, nursing homes are reimbursed fee for service and the plan continues to provide all services. MSHO has multiple rate cells to create incentives for plans to use residential and home and community based services over institutional services.

OHP (Oregon Health Plan)

Oregon began implementation of its statewide, mandatory Medicaid managed care program, the Oregon Health Plan, in 1994. In 1995, older people and people with disabilities were added to the program. In most cases, OHP covers all Medicaid

[1]The single entry point agency is a county agency responsible for nursing home preadmission screening function, and case management for the state's Medicaid home and community based services waiver program and state funded residential and in-home services.

primary and acute care services through a choice of capitated plans. Most long term care services are provided on a fee-for-service basis when needed, and OHP contractors are expected to coordinate their primary and acute services with those provided by the separate long term care system. Behavioral health services are provided either through OHP plans or through separate contractors, depending on the region. Oregon developed a special approach to dually eligible beneficiaries as part of the design of the OHP. Four of the six Medicare HMOs in Oregon have OHP contracts, enabling dually eligible beneficiaries who choose those plans to receive both Medicaid and Medicare services through a single company. Those choosing an OHP plan that is not a Medicare HMO receive their Medicare benefits on a fee-for-service basis through their Medicaid plans. Like Arizona, Oregon does not pay Medicare cost sharing if beneficiaries receive Medicare services outside of OHP networks.

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

PACE is the longest standing integration program, having begun with San Francisco's On Lok program in 1983. A national demonstration program was launched to replicate On Lok's approach, and the first site opened in 1990. PACE integrates acute and long term care services for older people who are nursing facility-eligible in small, provider-based sites. Day health centers provide the locus of care, which is highly integrated through the use of Interdisciplinary Teams. Each site negotiates a Medicaid capitation with its state and receives a Medicare capitation from HCFA. The program is voluntary. As of July, 1997, twenty-five fully or partially developed PACE sites had been implemented in fourteen states. The federal Balanced Budget Act of 1997 includes provisions to grant the program permanent status and expand the number of available sites.

Texas Star+Plus

The State has submitted its waiver application to implement Star+Plus, a pilot project in the Houston area that will enroll 60,000 aged, blind and disabled beneficiaries, including 31,000 dually eligible beneficiaries, into managed care plans with a combination of §1915(b) and (c) waivers. The State has selected three managed care organizations (MCOs), two of which have or will have established Medicare risk mechanisms. (One is a Medicare HMO and the other has been selected by HCFA as a Medicare Choices demonstration site.) Enrollment will be mandatory for Medicaid services and voluntary for Medicare services. Those choosing to include their Medicare services will choose one of the two Medicare risk MCOs. The benefit package includes the full range of Medicaid acute and long term care services. Under the current state Medicaid plan, prescription drugs are limited to three prescriptions per month. As an incentive, dually eligible members who include their Medicare services will receive an unlimited drug benefit.

New approaches beyond those taken by the seven programs highlighted here are likely to emerge in the next few years. With both The Robert Wood Johnson Foundation and

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HCFA sponsoring demonstrations in this area, this paper is intended to help states clarify their goals, break integration into its component parts, and develop innovative approaches to integration which meet the unique needs of their own states and the dually eligible beneficiaries they serve.

Table 1. Summary of Selected Programs Serving Dually Eligible Beneficiaries

	Target Population	Scope of Service	Voluntary or Mandatory	Medicare Approach	Statewide?	Status
Arizona Long Term Care System	Nursing facility eligible elderly, physical or developmentally disabled	Primary, acute and long term care	Mandatory for Medicaid	Usually coordinated on FFS basis	Yes	Operating since 1989
Colorado Int. Care and Financing	All Medicaid, including dually eligible	Primary, acute and long term care	Voluntary	Capitated through Medicare HMO	No	Waiver approved July 1997
MaineNET	Elderly and disabled, including dually eligible	Primary, acute and long term care	Mandatory for Medicaid	Primary Care Case Managed	No	Waiver recently submitted
Minnesota Senior Health Options	Elderly dually eligible	Primary, acute and long term care	Voluntary	Capitated through Medicare waiver	No	Operating since 1997
Oregon Health Plan	All Medicaid, including dually eligible	Primary and acute	Mandatory for Medicaid	Capitated through Medicare HMO; or FFS	Yes	Operating since 1994 (with dually eligible phased in 1995)
PACE	55+ years, nursing facility eligible	Primary, acute and long term care	Voluntary	Capitated through Medicare waiver	No	At On Lok since 1983; replication sites since 1990
Texas Star+Plus	Elderly and disabled, including dually eligible	Primary, acute and long term care	Mandatory for Medicaid	Capitated through Medicare HMO or Medicare Choices MCO; or FFS	No	Waivers submitted

B: Laying the Conceptual Framework

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

It may be useful to think about integration as an end point on a continuum, with the other end representing completely fragmented care. Along the continuum fall the various existing efforts to make Medicare and Medicaid work better for dually eligible beneficiaries.

Medicaid/Medicare Integration Continuum

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Fragmentation Coordination Partial Integration Full Integration

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

We have identified six dimensions of integration, each of which comes with a set of trade offs and technical challenges. Section C provides a detailed discussion of each dimension, described briefly here:

- **Scope and Flexibility of Benefits:** To what extent is the full range of Medicaid and Medicare services integrated into the program? Is long term care included in the package of services (as in MSHO) or is it coordinated through case managers (as in the Oregon Health Plan)? Are Medicare services included directly in the program (as in PACE sites) or are they coordinated through a Medicaid plan (as in the Arizona Long Term Care System)? Are any services (such as mental health) carved out to separate organizations? Does the integrated service package simply combine and replicate Medicaid and Medicare service arrays, or are services more flexible and able to meet individual needs?

- **Delivery System:** How integrated is the network of providers that makes up the service delivery system? Is the entire range of services represented within the system, including home and community-based, residential and social service providers? How are network services coordinated with those provided outside the network?

- **Care Integration:** Are Medicare and Medicaid services actually integrated at the level of clinical practice? Does a centralized patient record exist? Is case management or some other mechanism used to integrate multi-disciplinary services? Is a Primary Care Practitioner or team leader accountable for clinical outcomes?

- **Program Administration:** Has contract oversight been unified, or do systems contract with separate entities for Medicaid and Medicare? Have operating systems been integrated? For example, have Medicaid and Medicare enrollment processes been combined into one? To what extent is data collected and analyzed by a single entity?

- **Quality Management and Accountability:** Has a single entity been identified as accountable for beneficiary outcomes, or do quality efforts focus on the individual services offered by the various providers within the system? Have Medicaid and Medicare quality requirements been integrated into a single set?

- **Financing and Payment:** Does the manner in which Medicaid and Medicare payments are made maximize flexibility of benefits and minimize opportunities for cost shifting? To what extent are the state and HCFA acting as a single purchaser with common financial incentives?

As a practical matter, few if any states will be able to construct fully integrated programs from the outset. The dimensions described here and explored in greater detail in the next section become useful for prioritizing and organizing program development in any given state, either as part of a transition to integration, or as a decision to focus resources on the dimensions that most fully advance program goals, are manageable given public and private capacity, are possible within state and federal policy, are politically feasible and are achievable within a state's time table.

C. Key Dimensions of Integration

C-1: Scope and Flexibility of Benefits

A key goal of integration is to create comprehensive and flexible benefits that allow creative use of home- and community-based care to avoid preventable admissions to hospitals and nursing homes. The full range of Medicaid and Medicare benefits are capitated to a single contractor, who may use the pooled funding to provide needed benefits, whether or not they are specifically covered in fee-for-service. This approach was first fully implemented at PACE sites (Program of All-inclusive Care for the Elderly), and in early 1997, Minnesota became the first state to use the approach when it began enrolling elderly beneficiaries into its Senior Health Options program (MSHO).

The opportunity to integrate care stems in part from the breadth of the principal contractor's responsibility: a contractor can not integrate acute and long term care if only responsible for one or the other. For example, by design, the Oregon Health Plan (OHP) does not include long term care services. When an OHP member requires long term care services, the contractor is responsible for coordinating its primary and acute care services with the long term care services delivered through a separate service system. The expectation is not that acute and long term care will be integrated, but rather that they will be closely coordinated as the need arises.

Variation Across Programs

Of the seven programs featured throughout this paper, only two (MSHO and PACE) offer the full range of Medicare and Medicaid benefits through a single contractor for all members. The other five have or are constructing programs in which a significant amount but not all care is delivered through a single contractor. As the chart at the end of this section shows, all seven include Medicaid primary and acute coverage, but they vary in their approaches to Medicaid long term care, Medicaid behavioral health, and Medicare services.

Medicaid Long Term Care

Medicaid long term care services are included in all of the selected programs except Oregon. This usually occurs on a fully capitated basis, though partial capitation of long term care is possible. In the MSHO program, for example, Minnesota has limited its contractors' financial liability for nursing facility services to 6 months, after which the contractor continues to be responsible for care but is reimbursed on a fee-for-service basis. While this raises implications for rate design and potential cost shifting (addressed in section C-6), contractors remains responsible for overseeing the long term care services, and have a continuuing opportunity to integrate those services with others.

Medicaid Behavioral Health

States also take a variety of approaches to Medicaid behavioral health services. In conjuction with its Integrated Care and Financing Project (ICFP), Colorado will continue an existing mental health carve out program in the demonstration area, paying a capitation to a separate contractor for mental health services only. Although the ICFP contractor and the mental health contractor will coordinate their services, integration will be more challenging with organization-to-organization barriers to overcome. In Maine, pursuant to an agreement between the Medicaid agency and the mental health agency, inclusion of behavioral health will vary by sub-population. At least initially, elderly beneficiaries will receive mental health services through the MaineNET contractor, but adults with disabilities under 65 years of age will receive mental health services through a separate carve out program being planned by the mental health agency. In Oregon, all Medicaid mental health services must be provided through the county mental health provider systems.

Because dually eligible beneficiaries receive mental health benefits from both Medicaid and Medicare, and because mental health carve outs are so prevalent in Medicaid, this service is more prone to fragmentation for dually eligible beneficiaries than others. For example, a dually eligible member enrolled in a Medicare HMO in Oregon must use the Medicare HMOs mental health network for Medicare mental health services and a different network (the county's) for Medicaid mental health.

Medicare

The degree to which Medicare is included varies greatly across programs. At PACE sites and in Minnesota and Colorado, the principal contractor is responsible for the full range of Medicare Part A and B services, and is paid on a capitated basis directly from HCFA. Oregon and Arizona have constructed programs in which the principal contractor almost always coordinates Medicare services, but Medicare reimbursement is only capitated to a subset of Medicaid contractors who happen to be Medicare HMOs.

To date, three major approaches to Medicare have been developed:

- Use of Existing Medicare HMO Contract: If the principal Medicaid contractor also has an existing Medicare HMO contract with HCFA, dually eligible members may simultaneously enroll in the contractor's Medicare and Medicaid products, and the contractor ensures that only one Primary Care Practitioner (PCP) is responsible for the full range of services available through both products. This approach depends upon the beneficiary's willingness to join the contractor's Medicare HMO, since enrollment in Medicare managed care is entirely voluntary under federal law. This approach is used extensively in Oregon and to a lesser extent in Maricopa County, Arizona, and is proposed for Colorado's ICFP;

- Fee-for-Service Medicare: If the principal Medicaid contractor does not have a Medicare HMO contract, the contractor may still integrate Medicare services into the total package of care overseen by the primary care practitioner (PCP), and the PCP or the contractor may bill for the Medicare services on a fee-for-service basis. This approach depends on dually eligible beneficiaries voluntarily receiving their Medicare services through the same contractor, since they have the freedom to receive Medicare services from whomever they like. Arizona and Oregon have used a strong financial incentive to make this approach work: Medicare cost sharing is only available to members who receive Medicare services or authorization for such services from network providers. HCFA will not approve this arrangement in the future, so states must find other incentives to encourage dually eligible beneficiaries to stay in network with their Medicare benefits. MaineNET has proposed awarding points to members who stay in network; Texas is offering an expanded drug benefit; and

- Capitated Medicare to entities other than Medicare HMOs: PACE sites and MSHO have designed programs in which Medicare capitation is paid to a contractor which is not necessarily a Medicare HMO. This approach allows a capitated Medicare payment to be made to an entity that may not be interested in or able to obtain Medicare HMO certification, such as a community-based provider or a Medicaid MCO. Medicare waivers are required for this approach, as explained below.

Scope of Responsibility Differentiated from Scope of Capitation

The arrangements highlighted in Table 2 point out that degrees of integration can occur without full capitation of Medicaid and Medicare. The range of benefits that is within the principal contractor's responsibility is at least as important as whether or not they are capitated. Benefits may not be as flexible if they are not capitated, but if the contractor is at least responsible for a broad range of benefits, the contractor can work toward integrating those benefits, regardless of how they are reimbursed. At pre-PACE sites, for example, providers begin operating PACE-like programs before becoming fully certified as PACE sites. Until PACE status is achieved, Medicaid reimbursement to the site occurs on a partially capitated basis and Medicare reimbursement occurs on a fee-for-service basis, but the clinical integration of care can still occur through the interdisciplinary team at the pre-PACE site, just as it would at a bona fide PACE site. Similarly, Arizona Long Term Care System contractors are usually able to include Medicare services in their total plan of care for members, even if they are reimbursed on a fee-for-service basis.

Legal Issues Related to Scope of Benefits

Waivers are likely to be required to implement programs that offer the full scope of Medicare and Medicaid services. Medicaid waiver requirements are well known by

now, but a number of legal issues pertaining to Medicare have only recently been explored with the submission of state Medicare waiver requests. Medicare issues include the following:

- *Medicare Capitation or Alternative Payment.* As noted above, states seeking to construct programs in which Medicare services are capitated to an entity other than a Medicare risk contractor may need a Medicare waiver under §222, though the number and type of entities eligible for Medicare risk contracts is expected to expand with passage of the federal budget agreement. Section 222 waivers are also required to construct Medicare payment alternatives to the AAPCC, whether or not a Medicare risk contractor is used. For example, Colorado required a §222 waiver even though it has selected a Medicare HMO, because it will not be using the traditional AAPCC to calculate Medicare rates; and

- *Medicare Lock-In to Network.* In Medicare HMOs, beneficiaries are required generally to use network providers (on a month-to-month basis), and this requirement has also been applied in Medicare waiver programs like MSHO. As described above, Arizona and Oregon created a Medicare lock-in of sorts without a Medicare waiver by paying Medicare cost sharing only to their Medicaid contractors, but this approach will not be approved by HCFA in future Medicaid waiver requests.

Table 2. Scope of Services Delivered through Principal Contractor in Selected Programs

	Medicaid Primary/ Acute	Medicaid Long Term Care	Medicaid Behavioral Health	Medicare	Waivers Received or Requested
Arizona Long Term Care System	Yes	Yes	Yes	Usually	1115 received
Colorado Integrated Care/Finan.	Yes	Yes	No	Always	1115 and 222 received
MaineNET	Yes	Yes	Sometimes	Sometimes	1115 requested
Minnesota Senior Health Options	Yes	Yes	Yes	Always	1115 and 222 received
Oregon Health Plan	Yes	No	Sometimes	Usually	1115 received
PACE	Yes	Yes	Yes	Always	1115 and 222 received
Texas Star+Plus	Yes	Yes	Yes	Sometimes	1915(b) and 1915(c) requested

C-2: *Delivery System*

Approaches to Delivery Systems

The promise of managed care for dually eligible beneficiaries rests in the opportunities to reinvent systems of care for older people, providing more consumer centered care, developing creative alternatives to nursing home care and assuring continuity as individual needs change. Integrating delivery systems is a vehicle to fulfill this promise but it requires bridging the philosophy, history and perspectives of the Medicare and Medicaid programs. The different origins and foundations of these programs cast long shadows for those who attempt to reconcile their distinctive features and differences to design programs based on their similarities. Although this challenge occurs along each of the managed care dimensions addressed in this paper, it is critical to the development of delivery systems to integrate services. Medicare and Medicaid view and select delivery systems from very different perspectives. Medicare sets conditions of participation for managed care networks and contracts with all networks which meet those conditions. The requirements are standard across states although HCFA has limited authority to enter into reimbursement arrangements with organizations that do not fully meet the conditions.

State Medicaid agencies set conditions for managed care organizations, often in conjunction with state Insurance Departments and/or Health Departments. Most state Medicaid agencies issue a "request for proposals (RFP)" to select MCOs although states may also use a certification model.[2] RFPs contain specific requirements and timetable for contractors to submit proposals. States may contract with all bidders meeting the requirements or limit the number of contracts based on a combination of price and/or service. Once qualified, states might negotiate price with each qualified bidder. Certification approaches are more similar to Medicare since there is no time limitation and states agree to contract with all organizations meeting the standards set by the Medicaid agency. HCFA's rules generally require that states contract with organizations with at least 25% commercial enrollees, however, states may obtain waivers of this composition requirement. State rules also include standards for network adequacy, access, complaint procedures, fair hearings, and quality improvement.

Unlike Medicare, Medicaid purchasing decisions are made by the state and individual services or groups of services may be excluded from the contract. Purchasing decisions flow from the goals of the managed care program and requirements to offer beneficiaries a choice of plans or delivery systems. As a result, there is greater variation among the scope of services delivered and the organizations contracting with state Medicaid programs. However, legislation pending in Congress may significantly change Medicare contracting patterns by allowing organizations that are similar to

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[2] For more information, see *Medicaid Managed Care: A Guide For States*, Second Edition. Volume II. May 1995.

Medicaid plans to routinely serve Medicare beneficiaries.

State options for integrating services depends in large part on the state's managed care market. States with significant private managed care and/or Medicare managed care enrollment have more organizations to consider while developing Medicaid programs. States with minimal private or Medicare enrollment will have to stimulate the formation of organizations capable of accepting risk and organizing appropriate provider networks.

Role of Beneficiary Choice

The extent of any integrated managed care network will depend in part on beneficiary choice. As described elsewhere, Medicare beneficiaries always retain the right to receive Medicare services on a fee-for-service basis, while Medicaid beneficiaries may be subjected to mandatory enrollment. Medicaid managed care programs using Medicare HMOs may fail to fully integrate services because beneficiaries may decide to receive Medicare services though the fee for service system. However, effective enrollment counseling and creative incentives may encourage dually eligible beneficiaries who choose to remain in the Medicare fee for service system to receive all Medicare services through providers of the Medicaid managed network without enrolling in a Medicare managed care plan. If beneficiaries choose a network because their providers are included, and accept the rationale of managed care and continuity of care by using network providers, coordination is easier. Conflicts can be minimized if the member fully understands the philosophy of the organization and the process for accessing and coordinating services. Effective member orientation procedures can support coordination of care by stressing importance of using network providers. But the reality remains that Medicare beneficiaries retain the choice to go out of network for care. Therefore, States need to develop effective oversight systems to track out of network utilization.

Medicare Risk Contractors

In June 1997, HCFA had approved 283 risk contracts with a total enrollment of over 4.7 million beneficiaries. While the number of dually eligible beneficiaries enrolled in these programs is not known, the extent of the contracts offers opportunities in several states to use Medicare risk contractors to deliver Medicaid acute and long term care services. Contracting with Medicare risk contractors allows states to develop options through which dually eligible beneficiaries can receive the full scope of Medicare and Medicaid services. However, some states' purchasing laws may not allow those states to limit bidders to MCOs that have Medicare contracts and exclude MCOs that do not enroll Medicare beneficiaries. Where it is possible, there is no guarantee that all Medicare risk contractors will be willing to contract with Medicaid or that they will be interested in assuming risk for long term care services. Further, because Medicare payment rates vary by county, Medicare risk contractors have not offered their plans statewide, which means states with statewide programs could not use them as the sole

vehicle.

As of this writing, Medicare risk contractors must be federally qualified HMOs or competitive medical plans, but eligible entities are expected to multiply with passage of the federal Balanced Budget Act of 1997, which includes provider sponsored organizations (PSOs), preferred provider organizations (PPOs) and other entities as qualified Medicare risk contractors. Medicare risk contractors in urban areas must have at least 5,000 commercial enrollees. Currently, no more than 50% of total enrollment in the geographic area covered by the Medicare contract may be Medicare and/or Medicaid beneficiaries, but the 50/50 composition rule is also likely to change following enactment of the federal Balanced Budget Act of 1997, which replaces it with enhanced quality measures. Plans must hold an annual open enrollment period for at least 30 days. Medicare HMOs must maintain an internal complaint procedure and comply with the Medicare appeals process. Regulations also contain access standards for network adequacy, travel time, location, after hours care, monitoring and continuity of care.

In June 1997, there was no Medicare enrollment in HMOs in ten states. Only ten states have more than 100,000 Medicare members. Therefore, Medicaid agencies in many states must develop a long range, phase-in strategy, limit integration to Medicaid services or seek HCFA waivers to use unique networks to deliver Medicare services.

Other managed care organizations operate demonstration programs overseen by HCFA that could be used as vehicles for developing integrated systems such as Social HMOs, MCOs participating in the Medicare Choices Demonstration, and EverCare sites. However, these demonstrations operate in a limited number of locations and, although they represent important opportunities for states in which the sites are located, they do not lend themselves to widespread replication.

Medicaid MCOs

Based on their perceived success developing managed care programs for TANF beneficiaries with organizations that are not necessarily federally qualified HMOs, some states prefer to use their own Medicaid networks as vehicles for integration. Capitated Medicare payments may be provided to Medicaid MCOs with Medicare §222 waivers, or Medicare services may be coordinated through the Medicaid network and charged on a fee-for-service basis.

Creating Networks

Integrated delivery systems should reflect the population to be served, the source and extent of financing and the scope of services. These parameters will determine the type and the expertise of providers needed. Broader parameters require increased attention to recruiting health care providers with geriatric expertise and a broader array of community providers offering traditional residential and home and community services.

States may use a range of approaches to determining network capacity. Traditional measures such as the number of providers in relation to the enrolled population and time/distance measures, may not be appropriate access measures for vulnerable populations. It is important to know whether the plan's providers are willing to care for people with chronic illness and functional or cognitive impairments and whether they have experience doing so. Wisconsin's guidelines for the Independent Care Program require that the contractor must subcontract with providers with knowledge and experience relevant to the needs of people with disabilities. Network providers are compared to Medicaid's list of providers in the plan's service area that have historically served the enrolled population.

Beneficiaries in Oregon must have the same access to providers as non-OMAP members. Contractors must meet the community standard, but they must also be able to meet the needs of the enrolled population. Under administrative rules, contractors provide evidence that vulnerable populations have access to providers with expertise to treat the full range of medical conditions experienced by enrollees.

States need to ensure that members will have appropriate access to specialists and plans may need to make accommodations when they do not have a sufficient number of specialists in their service area. Arizona's contract requires that plans have networks adequate to provide all covered services. To meet these standards in rural areas, some plans must provide enrollees transportation to specialists located some distance from enrollees' homes. As part of the plan selection process, Oregon requires that plans describe how they will obtain specialty care and incorporates that description into each plan's contract. Some plans developed arrangements with specialists outside their service areas to comply with the requirement. When plans use specialists that are not part of the network, they must develop mechanisms to coordinate care and monitor utilization.

Moving Beyond Traditional Providers

Combining primary, acute and long term care funds in a single organization offers maximum opportunities to provide care that meets the beneficiary's need in the least restrictive, most cost effective setting. Fully integrated delivery systems must have the capacity to offer a full array of primary care, acute care, and long term care including institutional, residential, community and in-home services.

In order to offer a full range of services, networks require a diverse array of service options that afford consumers maximum choice and offer opportunities to use capitated payments flexibly to deliver the most appropriate and cost effective service. Traditional HMOs have limited experience serving low income elderly persons, particularly elderly persons with chronic functional limitations. However, since systems to deliver primary, acute and long term care are only now emerging in selected areas, systems must be created that combine the experience of health, community based systems and residential

options.

Delivery systems will establish formal arrangements with providers delivering services that are covered by the capitation payment and the scope of services. These variables define the services for which the system has a legal responsibility to provide. Yet dually eligible beneficiaries may also benefit from or receive required services that are outside these parameters such as the Older Americans Act, state funded home care services and Social Services Block Grant services. Arrangements will be needed to make referrals, and monitor and coordinate services.

Depending on the network's philosophy, MCOs may use the flexibility of their capitation payment to provide services which are not specified in the scope of services but which are cost effective and appropriate for the beneficiary. For example, an MCO may pay for an exterminator to reduce health hazards in a home, a nutrition assessment to evaluate risk, or installation of a phone for someone who may need access to emergency care. Often conditions that create risk can be minimized by authorizing services that are not considered health or even traditional long term care services. MCOs may want to identify the types of related services and providers and establish working arrangements in order to expedite their delivery when appropriate.

Building Home Care Networks

Delivery systems need to combine traditional health care providers and community based long term care providers. Nursing facilities, home health agencies and durable medical equipment providers have experience with both acute and long term care, but other community providers are needed. State long term care delivery systems rely on many community organizations, which may lack health care expertise, to provide personal care, homemaker, chore services, transportation, home delivered meals, adult day care, respite care and other services. These organizations meet the standards set by state agencies operating Medicaid waiver or state funded home care programs. The services maintain the functional capacity of frail elders who have physical or cognitive impairments that limit their ability to perform activities of daily living and instrumental activities of daily living.

To build networks, MCOs can rely on their current certified home health agencies or add new organizations that provide paraprofessional or less skilled services. MCOs could either contract with individual home care and related organizations or contract with an existing network of such organizations. Contracting with individual agencies can be time consuming and difficult for MCOs used to dealing with large organizations, integrated provider networks and physician groups. In contrast, home and community providers are typically smaller, independent organizations. MCOs might consider contracting with, or "renting," the existing system in states with well-developed in-home programs rather than building a new system. Contracting with an existing home care network reduces the number of contracts that must be negotiated and monitored by the MCO. These functions can be delegated to the community case

management agency. It also ensures faster start up and continuity of services for beneficiaries already receiving care. For voluntary managed care programs, beneficiaries may be more likely to enroll if they can keep their personal care attendant, homemaker or other home care provider.

There are two main functions performed in community based home care programs, a case management function and service delivery. The case management function usually includes determining eligibility for admission to a nursing home in addition to performing assessments, determining eligibility, and developing and authorizing care plans for home and community based services. State agencies perform these activities either through state field staff or contracts with a county health or social service department or an Area Agency on Aging. Some states contract directly with providers to perform assessment, care planning and authorization functions. However, in a fee for service environment, this creates incentives to over-authorize services. As independent organizations, case management organizations generally do not have a financial interest in the services used and operate within a prescribed budget or limits on service authorizations. They in turn contract with an array of community agencies to deliver care. The case management agency is responsible for monitoring quality assurance, compliance with program standards and financial activities.

MCOs developing integrated systems must decide who will perform long term care case management functions and how the MCO will build its direct service capacity. MCOs could contract both functions to the existing home care system. Rocky Mountain HMO in Colorado has developed a contractual relationship with the Mesa County Department of Social Service to perform the case management and home care functions. Integrated service networks in Minnesota approached counties to serve as subcontractors for home and community based services.

Contracting with community care systems means resolving differences between the two systems. States with extensive home care programs award contracts to a single entity for a defined geographic area (a county or a specified service area). Multiple MCOs may operate in an area and the service area may not coincide with those of the community system. MCOs serving an entire state or a large region of a state may prefer a single contract rather than multiple contracts. Community based case management agencies could form a consortium to operate as a single entity or one agency could function as a "lead" agency responsible for further subcontracting and monitoring. An MCO could instead contract with a single organization to provide services throughout the MCOs service area. Under draft specifications, Senior Care Organizations (SCOs) in Massachusetts would be required to contract with at least one Home Care Corporation to participate in the SCOs care management team and to coordinate and monitor home and community based services. SCOs would contract with multiple home care corporations or a single corporation. Depending upon the arrangement with the SCO, the home care corporation could either cover the entire area or subcontract with other corporations to maintain the separate service boundaries. These decisions will be made by the SCO.

There are few precedents for MCOs forming home care networks. As integration models emerge, they are likely to affect the organization of home care agencies just as managed care has stimulated consolidation and network development among hospitals, physicians, nursing homes and other health providers. If the MCO retains the case management activities, contracting with an existing provider network may not be possible because there is not likely to be one organization through which to do so. An MCO could contract with an existing case management agency for administrative services involved in contracting with and monitoring local provider agencies. Over time, these provider agencies may develop horizontally integrated organizations or vertically integrated systems might expand to include them. MCOs might develop short and medium range strategies for building networks that reflect the likely market response to new opportunities created by comprehensive managed care programs for dually eligible beneficiaries.

MCOs and community organizations need to be clear about the role of each organization -- how needs will be assessed, how services plans will be developed and authorized, how the activities of the community organization will be reimbursed and the extent of shared risk, if any. Community organizations also need to know what data must be collected and reported to the MCO. Although community organizations have to account for spending and report data to state agencies managing HCBS programs, those requirements may change under managed care.

MCOs also must develop linkages to services provided through other state and federally funded programs. In addition to Medicare and Medicaid, beneficiaries in Colorado and Massachusetts will also be eligible for services under the Older Americans Act and state funded long term care programs. Because the care management process includes staff from the local case management system, beneficiaries have access to benefits and services that may be outside the Medicaid capitation payment.

Assisted Living

Residential options are also important to offer supportive settings for people who can no longer live at home or who need a supportive housing setting during periods of transition. These options include assisted living, adult family care, and board and care facilities. Assisted living is a relatively new development in most states and offers MCOs an opportunity to coordinate services in a residential setting to avoid or shorten rehabilitative stays and nursing home placements. While state licensure rules vary, assisted living facilities provide personal care, medication administration, nurse monitoring and other skilled services as well as housekeeping, meals and transportation. Services may be provided by other contractors and coordinated by the MCO or by the assisted living facility itself. Developing residential options may avoid the tendency for elders to become dependent and isolated in other long term care settings and maintain family involvement that may diminish once a person is admitted to a nursing home. Assisted living is, or will be, covered as a Medicaid service in 22

states as a 1915(c) waiver service or as personal care under the state plan. Assisted living providers are included in MCO networks in Arizona, Florida and Minnesota. Some of the potential advantages of assisted living include:

- Providing a safe, supportive environment during a transition from post acute care to recovery at home;

- Offering a setting in which HMO covered home care can be delivered;

- Depending on state assisted living licensure requirements, offering HMOs a cost effective method of delivering home care services for beneficiaries with extensive needs and offering beneficiaries residential settings when they can no longer live at home;

- Providing a supportive housing and services option for HMO hospital discharge planners considering options for people who can not return home following an acute episode; and

- Offering a supportive residential option for beneficiaries who can no longer live at home due to the cumulative affects of chronic illness.

Relationships between assisted living and HMOs are not common and state dual eligible initiatives could be instrumental in forming these linkages. Assisted living offers a distinct advantage to Medicare HMOs serving dually eligible beneficiaries since they provide a service rich, supportive setting for beneficiaries with higher than average health care expenses. In 1998, the Medicare payment rates for dually eligible beneficiaries will be revised. Assisted living will no longer qualify for the "institutional" rate adjustment. However, the Part A rate for dually eligible beneficiaries living in assisted living will be considerably higher than for residents of nursing homes, more than offsetting the lower Part B payment that assisted living residents will receive compared to nursing homes residents.

Assisted living facilities are included in the networks of MCOs participating in programs in Arizona, Florida, Minnesota and Texas. These relationships have also been developed in the PACE program. Total Longterm Care, Inc., a PACE site in Denver, Colorado, has developed arrangements with facilities licensed as personal care boarding homes. The first contract allows PACE to support a person in a residential setting when the person can no longer live at home. The facilities are also used as a temporary setting when a caregiver is away for a period of time as well as for short term rehabilitation for members who became dehydrated or were recovering from surgery.

The PACE program has negotiated a "preferred" contract with a private pay assisted living facility through which PACE contracts for 18 units located on the first floor of the facility. The units are occupied by PACE members who are frailer than members in

other settings and are more likely to be incontinent or have Alzheimer's disease. PACE sends a certified nursing assistant during the evening to help with dinner and assist residents getting ready for bed.

The Bienvivir Health Services Center, a PACE program in El Paso Texas, operates two centers that provide adult day care, rehabilitation, physician services and outpatient services staffed by a registered nurse. Emphasizing the importance of housing, the organization created a new entity, which functions as a separate corporation but has the same board members, to build and operate a 40 unit HUD 202 project. The housing project contracts with Bienvivir Health Services Center to provide services to the residents. Residents accepted for move-in may not be required to participate in PACE nor can the management limit move-in to PACE members, however, the program marketed the program to its list of members who needed housing. The Center provides services to non-PACE members that are billed through the fee for service system. The Center became a housing developer because the available housing stock was limited and lacked supportive services which left residents who were aging in place with many unmet needs. The East Boston Neighborhood Health Center, a PACE site in East Boston Massachusetts, also own and operates an elderly housing building which includes a day care center.

Other Residential Options

Adult family care homes or adult foster care providers may also be included in programs that include long term care services. These providers offer residential settings for beneficiaries who require protective oversight, a supportive environment and personal care services. Beneficiaries with more health related needs can be served in some states if the provider meets higher experience and training requirements. Board and care facilities typically offer room, board, meals and housekeeping services. Some states consider board and care the equivalent of assisted living. In addition, facilities in which personal care and health services are delivered through private arrangements between the resident and an outside home health or other agency may not be licensed.

Coordinating Network Providers: Avoiding Internal Fragmentation

Simply forming an expanded network may not insure that services are integrated. MCOs responsible for serving frail beneficiaries need to develop three levels of coordination. First, mechanisms are needed to coordinate services from multiple providers during an acute care episode. Second, screening activities can be devised which identify beneficiaries with chronic conditions and develop disease management protocols to maintain health and functioning. Finally, still other mechanisms are needed to manage delivery long term care services from multiple providers - personal care, home delivered meals, adult day care - as well as to connect primary care professionals with long term care services. The broad range of needs among members of an integrated system challenges MCOs to implement processes in a manner that supports the goals of integration. Failure to address the pitfalls of coordinating services among

network and non-network providers can undermine the reason for implementing the program.

The Independent Living Services at Loretto in Liverpool, New York, a large organization which also operates a pre-PACE program, felt it was necessary to create a system within a system in order to focus care on participants. With its own transportation department, home health agency, long term home care and medical day care departments, managers found it difficult to coordinate services if staff were tied to organization units outside control of the PACE staff and served clients in multiple programs. Staff providing care did not become as familiar with the residents and develop an awareness of the subtle changes as they would if they spent all or most of their time with participants. Organizing their model, managers found that control of care and the staff who deliver it was important. Staff were identified to serve only the participants and in effect, the program developed its own capacity to provide services that previously could have been provided by separate units within Loretto's integrated system.

States need to look beyond the components of a network to determine how the MCO manages and coordinates providers within its network.

Table 3: Comparison of Delivery System Features in Selected Programs

State	Primary Contractors	Location of Case Management	Network Includes Home Care Providers?	Network Includes Residential Providers?
Arizona Long Term Care System	Mix of counties and private MCOs	Primary Contractors	Yes	Yes
Colorado Integrated Care and Financing Project	Medicare HMO	County single entry point agency, through subcontract with primary contractor	Yes	Yes
MaineNet	Medicaid MCOs and/or provider consortia	Initially, single entry point agency for members using LTC	Yes (Proposed)	Yes (Proposed)
Minnesota Senior Health Options	Mix of Medicaid MCOs & Medicare HMO	Varies - primary contractors and/or county agencies	Yes	Yes
Oregon Health Plan	Mix of Medicaid MCOs and Medicare HMOs	Primary contractors and community LTC system	NA (LTC remains FFS)	NA (LTC remains FFS)
Texas Star+Plus	Medicaid MCO, Medicare HMO, and Medicare Choices Contractor	Primary contractors	Yes	Yes
PACE	Non-profit providers	Primary contractors	Yes	Varies

C-3: Care Integration

The tools and methods to develop integrated delivery systems are most appropriately judged at the level of clinical practice. When all is said and done, have these systems transformed the delivery of care and improved care for dually eligible beneficiaries? What approaches have been found effective in re-directing the system from a provider-specific orientation to a holistic approach to care management and delivery? In this section, we consider three practices for enhancing integrated care to dually eligible beneficiaries:

- Assignment of a Primary Care Provider;
- Use of a centralized patient record; and
- Care management.

These practices shift the system from its focus on provider-specific care to an integrated, interdependent network of resources. When effective, these practices help place the beneficiary at the hub of the integrated network and allow care needs to drive the system. Care needs are defined in relation to each other and are seen as interdependent. This requires client assessments to be objective and independent of the financial implications. This is in marked contrast to a "unit" of service orientation which isolates and evaluates clinical, social, and functional services needs of clients and renders the care in fragmented and disconnected fashion.

Assignment of a Primary Care Provider or Team Leader

All the states and PACE include features requiring beneficiaries to select a primary care provider or team leader who coordinates Medicaid and Medicare services in cases where both services are provided under the umbrella of the same managed care organization. Each of these programs have mechanisms to control the use of out-of-network Medicare services, thus enhancing opportunities to fully integrate service provision.

In Maine, dually eligible beneficiaries will have the option of having their Medicare benefits managed through MaineNET via a Medicare primary care case management option, under which the PCP assigned for MaineNET Medicaid benefits would also act as a gatekeeper for Medicare benefits. Alternately, dually eligible beneficiaries may choose to continue to receive Medicare services out-of-network. Members choosing to have their care coordinated by a single PCP will accrue points which can be used to redeem non-covered services, such as eyeglasses.

Through lock-ins and withholds on the state-share of Medicare co-payments, states are attempting to reduce movement outside the network for Medicare services under their integrated delivery programs. However, HCFA has stated that it will not permit States to restrict dual eligibles freedom of choice and withhold cost-sharing. Service

integration at the level of clinical practice, therefore, will depend in large part on the ability of the plan to attract and retain beneficiary allegiance to a single PCP, with or without mandated restrictions.

Use of a Centralized Medical Record

Core to the notion of integration is the ability of service providers to access timely and complete information regarding a beneficiary's health status, service use and progress. The logistics of achieving this goal are enormous and, with the exception of the PACE model, have not been fully realized. The On Lok PACE site recently received a grant from the Hartford Foundation to develop an electronic record which could be accessed by providers within the network caring for the same member. While visions of an electronic medical record persist, states have taken incremental steps to facilitate the exchange of clinical data among a broad array of community-based and institutional service providers.

The managed care contractor for the Colorado project is developing an automated record that the PCP and community providers can access through a secure internet. The record, which can be read only by a beneficiary's providers, includes assessment data, care plans, service encounters and progress notes. MaineNET and Texas Star+Plus require contractors to have long range plans for centralizing their medical records-keeping systems to promote information sharing among care providers and settings of care. Methods for sharing assessment data, available on all beneficiaries served in the state's long term care system, are being developed to assist the PCP in meeting the needs of members. Medicaid record requirements in Arizona, Minnesota and Oregon focus at the provider level without stipulating how records are to be shared among a beneficiary's providers.

Underlying the development of shared medical records are issues pertaining to the protection of beneficiary confidentiality. These protections relate not only to the integrity of the medical record itself but to the protocols for releasing information to practitioners caring for the beneficiary. The movement to centralized medical records must be considered with respect to placing restrictions on the types of information which can be released and the need for beneficiary consent.

Care Management

Dually eligible beneficiaries are diverse in their care needs. Many will require only preventive and acute care while others will need intense intervention due to chronic and debilitating conditions, lack of family supports, and cognitive impairments. Integration requires that programs move beyond a service-specific focus into the management of a beneficiary's total care needs.

While it is widely believed that care management contributes to improved outcomes, no single model has emerged. The PACE program is best known for its care management

approach. An interdisciplinary team of qualified professionals and paraprofessionals is responsible for assessing the needs of potential and enrolled participants and for authorizing, developing, implementing, monitoring and evaluating participant care plans. Care management is further facilitated through a physical site which serves as the center for coordination and provision of a full-range of services (e.g., primary care services, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals).

Colorado represents a variation of the centralized PACE model with the creation of a care coordination team composed of staff of the managed care contractor and care mangers from the state's single point of entry for long term care services. By bridging the expertise of the acute and long term care delivery systems, the team offers a holistic perspective on client assessment, care planning and management. A geriatric team at the managed care organization further supports the assessment and care planning process.

Texas Star+Plus screens all members to determine the need for care coordination services. Members with complex needs are assigned a care coordinator who, in Medicaid-only plans, also facilitates coordination with Medicare providers to the extent possible.

Maine, Minnesota and Oregon distinguish between care coordination and more intensive case management services. Through the assignment of either an individual or function, care coordination is provided to all members to assist in accessing the delivery system, arrange appointments or advise PCPs on the availability of community resources. The managed care organization in these states is expected to develop tools and processes for assessing members for complex care needs requiring more intensive management of services across providers and settings of care. The use of interdisciplinary teams are encouraged but their composition is not defined.

Members of Arizona's Long Term Care System are each assigned a care manager who meets with them at regular intervals to assure needs are being addressed. The same care coordinator may also provide intense case management services for persons with complex service needs. For the most part, case managers have no explicit authority or responsibility to coordinate Medicare services except where members are enrolled in the one plan which contracts with both Medicaid and Medicare.

A more elusive aspect of care management is the extent to which the beneficiary is integrated into the process. Programs are quick to point out the right of consumers to refuse treatment and services but are sometimes less clear regarding their authority to direct care planning options. PACE draft standards refer to a participant's right to self-determination in making decisions about his/her care. In situations where a participant opts for care not meeting accepted standards of practice, the team must document that this decision is a fully informed decision on the part of the participant. MaineNET identifies the beneficiary as a member of the interdisciplinary team but fails to establish

precedent for how to resolve inevitable conflicts in decision-making among team members. Without prescribing an approach for resolving these conflicts, the bidding process will require potential contractors to define their expectations for how the process will work.

Table 4 summarizes the discussion in this section.

Table 4. Approaches to Care Integration in Selected Programs

	PCP Assignment	Centralized Medical Record	Care Management
AZ Long Term Care System	Single PCP for Medicare and Medicaid services	Provider-level medical record requirement.	Generally, separate case managers for Medicare and Medicaid
CO Integrated Care and Financing Project	Single PCP for Medicare and Medicaid services	Automated record accessed through a secure internet	Care coordination team required
MaineNET	Single PCP for Medicare and Medicaid services	No current requirement; MCO must document plans to develop	Members assigned care partner; intensive care management/ team based on need.
MN Senior Health Options	Single PCP for Medicare and Medicaid services	Provider-level medical record requirements	Care coordination function required; intensive care management/team based on need.
OR Health Plan	Single PCP for Medicare and Medicaid services	Provider-level medical record requirements	Care coordination function required; intensive care management/team based on need.
PACE	Single PCP for Medicare and Medicaid services	Single medical record	Care coordination team required
Texas Star+Plus	Single PCP for Medicare and Medicaid when in same plan.	Plans required to have centralized medical record in PCP office.	Members are screened to determine the need for a care coordinator; intensive case management provided to persons with complex needs. In Medicaid-only plan, care coordinator facilitates coordination with Medicare to the extent possible.

C-4: Program Administration

The manner in which a program is administered will determine the ease with which certain processes and systems can be integrated and in turn facilitate integration of services. We have highlighted three administrative issues that are particularly important to address as states contemplate integrating care: 1) the manner in which contracts are administered; 2) the process for enrollment; and 3) the manner in which data is reported. These vary significantly across the six programs we have highlighted in this paper.

Contract Administration

A fundamental challenge of integrating Medicaid and Medicare is overcoming the diffused responsibility and authority between the two programs. HCFA, directly and through its agents, administers the Medicare program, while states administer their Medicaid programs. Contractors are accountable to HCFA for Medicare services and to states for Medicaid services. This is the case in programs where attempts have been made to coordinate Medicaid managed care programs with Medicare HMOs, such as in Oregon. In Oregon, contractors who provide both Medicaid and Medicare services on a capitated basis maintain contracts with the State of Oregon for Oregon Health Plan (Medicaid) products, and separate contracts with HCFA for Medicare HMO products. As the State, HCFA and the Medicare HMOs have worked to align the two systems, inconsistencies and overlapping requirements have been difficult to overcome because no single entity is empowered to make decisions. Efforts to make two programs look and feel like one for dually eligible beneficiaries are compromised. For example, dually eligible beneficiaries enrolling in Medicare HMOs in Oregon receive two member cards (one for the OHP product and the other for the Medicare product) and two member handbooks, and are usually enrolled in the two products with different effective dates. This has not been cited as a problem for beneficiaries in Oregon, but it has been administratively cumbersome.

By contrast, Minnesota Senior Health Options (MSHO) is demonstrating an approach to contracting in which HCFA is holding the State accountable for both Medicaid and Medicare services, and the State is executing agreements with contractors that cover both Medicaid and Medicare services. Essentially, the State acts as HCFA's agent for Medicare, and is empowered to unify certain processes with approval from HCFA. Thus, MSHO members have one membership card, receive one packet of member information, and are enrolled into a single product on one date.

Integration can also occur without unified contracting, particularly if the contractor is committed to it through its mission. PACE sites, for example, have separate agreements with HCFA and states but are organizationally committed to achieving integrated care regardless of what their contracts may require. PACE sites are also unique in having had distinct status as participants in a national integration

demonstration led by HCFA, in which a key goal of the experiment has been integration of care.

Enrollment

The enrollment process also differs significantly among existing and planned programs. One approach is to have separate enrollment mechanisms for Medicaid and Medicare, but to coordinate them to the point where they appear as one to the dually eligible beneficiary. In cooperation with the regional HCFA office and Medicare HMOs in the State, Oregon has attempted to create such a joint enrollment process for dually eligible beneficiaries wishing to enroll in Medicare HMOs. The parties in Oregon have achieved considerable success, despite formidable technical obstacles. They have developed a joint enrollment process for dually eligible beneficiaries that avoids enrollment in two separate MCOs for Medicaid and Medicare and does not require the beneficiary to go through two separate processes. Yet, they have not yet been able to establish a uniform enrollment date. OHP enrollment typically occurs sooner, with Medicare HMO enrollment following as much as two months later. The State determines the date of OHP enrollment, and HCFA determines the date of Medicare HMO enrollment. During the transition period, beneficiaries are in Medicaid managed care but Medicare fee-for-service. While this transition period does not appear to have been a problem for beneficiaries, it has resulted in significant administrative burdens for the MCOs and their providers. For example, depending on how an MCO pays its providers, it must determine with the providers who is responsible for billing Medicare during the fee-for-service period.

The other approach to enrollment, developed by MSHO, is to completely collapse the two enrollment systems into one, administered by the state in partnership with HCFA, the counties and the MCOs themselves. Enrollment forms may be completed at county offices or by MCOs, who submit the information to the State. The State completes the Medicaid portion of the enrollment to trigger a State Medicaid capitation, and also verifies Medicare information via on-line access to HCFA's Beneficiary Enrollment Retrieval system (BERT). The State identifies inconsistencies between the Medicaid and Medicare files, and makes edits in accordance with a protocol negotiated with HCFA. Applications processed up to 6 working days before the end of the month result in an enrollment date of the first day of the following month. The State sends electronic notice of enrollment to the plan and, through the Social Security Administration, to HCFA. HCFA recognizes the enrollment date established by the State and begins capitated Medicare payments as of that date. New members receive one set of program materials. Though only in use for a since early 1997, the system appears to be working smoothly to date.

Data Reporting

All of the states listed on Table 5 have or have requested §1115 Medicaid waivers and, therefore, require submission of encounter-level Medicaid data. In an integrated

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program, however, Medicaid tells only part of the story. In Arizona, where attempts are made to coordinate Medicaid and Medicare services, data reporting is split between the State and HCFA or its agents. For dually eligible beneficiaries receiving Medicare services on a fee-for-service basis, HCFA agents receive Medicare claims data and process them for purposes of making payment. For those enrolled in Medicare HMOs, the HMOs will be reporting HEDIS 3.0 measures to HCFA beginning in 1998, but HCFA has not yet required submission of encounter data from Medicare HMOs. Neither HCFA nor the State has a complete data set that allows comprehensive analysis of service utilization across funding sources.

By contrast, PACE sites report all encounters without distinction of funding source to HCFA through DataPACE, the data collection and reporting system developed for the program. The data set is comprehensive and is used as part of HCFA's ongoing evaluation of PACE.

Similarly, Minnesota and Colorado will collect encounter-level data, without regard to funding source, from its contractors. They will be able to analyze the data itself for quality and other purposes, and will also share the data set with HCFA for evaluation and other purposes.

It is unclear how unified Medicaid/Medicare reporting will work in a program like MaineNET, in which Medicaid services will be capitated and Medicare services will be fee-for-service. Currently, Maine and the other New England states have obtained Medicare claims for past years and are linking those claims to Medicaid files at the beneficiary level for the purpose of program planning. It is unclear whether it will be possible for the State to obtain live access to Medicare claims as they are filed with HCFA's agent, to be used for program monitoring and improvement.

Table 5. Program Administration Approaches in Selected Programs

	Contract Admin.		Enrollment Determin.		Data Reporting	
	Medicaid	Medicare	Medicaid	Medicare	Medicaid	Medicare
Arizona Long Term Care System	State	HCFA, when applicable	State	HCFA, when applicable	Encounter level, to State	Claims or HEDIS 3.0, to HCFA[1]
Colorado Integrated Care and Financing Project	State	HCFA	State	HCFA	Encounter level, to State (one set)	Encounter level, to State (one set)
MaineNET (Waiver approval pending)	State	State, (same contract) when applicable	State	State, when applicable	Encounter level, to State	To be decided
Minnesota Senior Health Options	State	State (same contract)	State	State (single process)	Encounter level, to State (one set)	Encounter level, to State (one set)
Oregon Health Plan	State	HCFA, when applicable	State	HCFA, when applicable	Encounter level, to State	Claims or HEDIS 3.0, to HCFA[1]
PACE	State	HCFA	State	HCFA	Encounter level, to HCFA (one set)	Encounter level, to HCFA (one set)
Texas Star+Plus	State	HCFA, when applicable	State	HCFA when applicable	Encounter level, to State	Encounter level, to State

[1]The HEDIS 3.0 requirement is being phased in. Medicare HMOs must agree to begin submitting it to HCFA in 1998.

C-5: Quality Management and Accountability

In this section, we consider approaches used by states to integrate their quality management activities across payment arrangements and settings of care. The design of managed care programs for the dually eligible beneficiary extends beyond the typical acute model of care into long term care and social support services. This expansion of services and settings of care challenges the capacity of a single managed care organization to effectively direct and be held accountable for the quality of care provided to beneficiaries.

Traditionally, quality assurance activities have occurred within individual "silos" of care - nursing facilities, home health agencies, community-based providers, mental health centers, and hospitals. Federal and state mandates and private accrediting practices have fostered the development of segregated approaches to quality assurance and improvement and must be reconciled when attempting to overlay systematic approaches to quality across a broad spectrum of service providers. States and managed care programs have accommodated these challenges to integration in different ways.

Quality Management Philosophy

The Minnesota Senior Health Options program (MSHO) and the proposed Colorado Integrated Care and Financing Project (CICFP) concede to the inevitable autonomy of service providers to oversee quality of care but place accountability within the managed care plan for beneficiary outcome. This model requires a negotiated process between the managed care plan and each of its subcontractors and allows a great deal of flexibility in how service providers approach quality management. Key to this model, however, is the development of outcome measures against which the plan and its service providers are held accountable. In the case of MSHO, these measures focus on specific clinical conditions and the ability of plans to "grease" transitions between care settings. Colorado is developing a series of process measures relating to enrollment/disenrollment and the calculation of repeat hospitalizations and emergency room use which may be indicative of poor outpatient care.

Maine, and to a lesser extent Arizona, envision a system which places greater authority within the MCO to influence quality management activities at the provider level. Through the development and dissemination of practice guidelines, shared learning, peer review activities, and other prescribed quality improvement tools, these programs hope to impact traditional practice patterns. At this point, it is unclear whether there will be sufficient leverage, resources and credibility to redirect provider behaviors and to create new models of care across service settings.

PACE and other vertically integrated managed care systems have unique advantages to span the silos of care and affect system-wide changes to quality management and improvement activities. Heavy reliance is placed on population-based needs assessments

which permit the system to set priorities for quality improvement and outcomes that are not measured at a single site of care. The system defines its expectations for care based on rigorous evidence regarding successful interventions. Standards of practice are promulgated which assist practitioners and members in making effective decisions regarding care.

These examples illustrate that, although there is agreement that the managed care organization is accountable for beneficiary outcomes, there is significant disparity in how much control is exercised by the managed care organization over the structure and process of care at the point of service.

The following four areas address aspects of quality management that are perceived to be most prone to fragmentation:

- Participation in the quality management process;
- Internal quality improvement program standards;
- Performance measurements; and
- Quality oversight.

As will become evident in our review, disparate federal and state policy and provider "turf" issues often perpetuate this fragmentation and reduce opportunities for full integration. But states are overcoming historical barriers both through collaborative and regulatory approaches to change.

Participation in the Quality Management Process

Integration can be measured by the degree to which diverse individual and institutional providers, and consumers have been effectively consulted in the quality management activities of the managed care program. Do they participate on Quality Committees or assist in the design of focused studies and surveys? What mechanisms are used to engage them in the process of continuous quality improvement? How do they become knowledgeable about best practices relevant to older persons and persons with disabilities?

Integrating key players into quality management activities can occur at the state and plan levels. In Maine, the state has assumed a leadership role in facilitating exchanges among providers and consumers in the planning phases of MaineNET through the activities of a Quality Work Group. In addition to the Work Group's ongoing interest in monitoring the implementation of the demonstration, a multi-disciplinary Clinical Advisory Panel will be formed to advise MaineNET in the review and interpretation of service data, and in the identification of intervention strategies where broad variations in practice patterns and/or poor outcomes exist. The Clinical Advisory Panel will include clinical opinion leaders in the area of geriatrics and disabilities.

The National Chronic Care Consortium Resource Center is working under a contractual agreement with Minnesota Senior Health Options (MSHO) to provide technical assistance, best practice tools and resources to health plans participating in the project. As part of this initiative, a Clinical Integration Working Group will be formed including representation from health plan contractors, participating provider systems, consumers and other key organizations. Colorado has cultivated partnerships between the managed care plan and traditional long term care providers. State-sponsored training programs have enabled providers from multiple perspectives to come together to discuss approaches to management of clinical conditions prevalent among the target population. Arizona convenes quarterly meetings of the Medical Directors, Quality Management staff and Case Managers from the managed care plans with which they contract. These meetings provide opportunities to coordinate activities among the managed care plans and identify the emergence of clinical issues affecting the care of members.

How well providers and consumers are integrated into quality management activities at the plan level is less clear. Formal requirements for such integration are frequently specified in contracting or other accrediting standards. Draft Accreditation Standards for PACE require the active participation from all areas of the PACE program, including members and caregivers, in the design and implementation of the quality improvement program. This involvement is further augmented by requirements that the policy making or governing body be reflective of the membership and composed of individuals with relevant knowledge and experience. PACE is planning to test the draft standards on a pilot basis before permanently promulgating their voluntary use among PACE sites.

MaineNET's proposed contracting standards specify that there be a Quality Improvement Committee or other structure which includes members, the Medical Director, and other medical and health professionals who are representative of the scope of services delivered under the program. In conducting their quality improvement activities, MaineNET requires Integrated Service Networks (ISNs) to show evidence as to how the organization includes input from members, family members, informal care givers and providers in the quality management process.

Arizona, Colorado and Minnesota take a far less intrusive approach to dictating how the managed care plan chooses to involve providers in their quality management activities. These states ascribe to the philosophy that there is no single solution to developing a collaborative quality management program and that each plan and network must cultivate arrangements responsive to their situation. Both Colorado and Oregon do, however, encourage the involvement of consumers in the process and Oregon further stipulates that the quality management functions must have consultation from individuals with knowledge of all populations served under the program.

Internal Quality Improvement Program Standards

As the movement to managed care has accelerated, so too has the proliferation of quality standards and review processes. Most of these standards affect how plans must organize their quality management activities or dictate the type and manner of data collection and analysis which must be conducted. In addition to regulatory standards imposed by Medicare and Medicaid, integrated service delivery systems are also subject to licensure standards, private accreditation standards, state insurance requirements and other regulatory and private review processes. Some of these standards may be the same while others may conflict in both minor and major ways . Working to comply with the standards is a costly proposition and may actually divert effort away from improvement in the quality of care.

As states develop integrated programs for the dually eligible beneficiary, interest in streamlining Medicaid and Medicare requirements intensifies. HCFA has recently launched an initiative to design a quality improvement system for use by HCFA and optionally by states in their oversight of managed care plans contracting with Medicare and Medicaid. The goal of the QISMC initiative (Quality Improvement System for Managed Care) is to propose a consistent set of standards for Medicare and Medicaid managed care. This effort to "standardize the standards" may relieve many of the redundant demands placed on managed care plans as conditions of Medicare and Medicaid participation but will not completely address similar discrepancies between public and private quality standards.

States have limited authority to tackle the fragmentation of external standards. They can, however, promote greater standardization of requirements imposed by state agencies with oversight responsibilities for managed care, such as Medicaid, licensure and insurance. Alternately, a state may "deem" another entity's standards or review process as replacement for its own, thus reducing the number of separate requirements a plan must satisfy.

MSHO provides an early example of both the challenges and opportunities in working collaboratively with HCFA to reduce redundant requirements while protecting the unique interests of the Medicaid and Medicare programs. Minnesota has carefully documented how its Medicaid standards equal or exceed those of Medicare in an effort to simplify compliance review for contracting. For example, there will be a single point of entry and process for all complaints up through and including the Medicaid fair hearing. Through a negotiated process with HCFA, determinations will be made as to whether unresolved complaints at that point are primarily Medicaid or Medicare and thus subject to different administrative reviews.

MaineNET has made a conscious effort in the design of its program standards to streamline them, whenever feasible, with those imposed by state licensure and private accrediting bodies. Implicit in these efforts has been the goal to coordinate review processes wherever another entity's standards and processes are found to be essentially

equivalent with that of the MaineNET program. Variations in standards tend to focus on standards related to access, beneficiary participation, and network capacity - areas where private sector interests are usually less stringent than those required by plans serving vulnerable public members. Standards for the Arizona Long Term Care System (ALTCS) and Texas Star+Plus are coordinated with those of the State's managed care program for acute care but are not necessarily compatible with Medicare. Efforts to streamline Medicaid and Medicare standards have not been priority in Arizona since the State has no direct role in how Medicare services are provided to its dually eligible beneficiaries.

Because of the very real differences in populations being served, integrating standards of public and private review bodies into a single set of requirements is not plausible. There are many advantages, however, to determining whether differences among agencies are material to the focus of each agency or if, through reasonable modification, they can be made equivalent. As agencies reach agreement on a "core" set of standards, it then becomes possible to integrate the results of another entity's compliance review process into the monitoring activity. Furthermore, it allows each oversight agency to focus its standards and review processes on those aspects and operational areas most pertinent to its unique interests (e.g., focused review by Medicare and Medicaid on access and network capacity).

Performance Measurement

Performance measures are often the hub driving the focus of quality improvement activity. The questions raised under an integrated model of care are whether measures reflect a single standard or outcome of care that can be assessed across providers and payors, and whether the measures are holistic in accounting for both quality of care and quality of life.

Major strides have been made to develop common sets of measures for use by public and private purchasers. Measures developed under HEDIS 3.0, The Foundation for Accountability (Facct), and Consumer Assessments of Health Plans Study (CAHPS) all aim to standardize the collection and reporting of data across payor arrangements. States have borrowed heavily from these sources and, in their design or adoption of measures for integrated delivery programs, have developed standards which cross care settings and which account for the full diversity of care needs and outcomes among the target populations.

MSHO is selecting clinical and structural measures crossing settings of care. Initial focus will be on diabetes, urinary incontinence and care transitions. Of particular interest to Minnesota will be data collected on a sample of community-based nursing facility-eligible members which capture the programmatic and clinical factors impeding and enhancing care transitions.

Maine is participating in a regional process with the New England Consortium to develop a common set of performance measures for use by all New England states in monitoring quality in priority areas. The Consortium is looking to augment HEDIS 3.0 and address physical and mental disabilities and quality of life issues. In addition, MaineNET-specific measures will be proposed which take advantage of the comprehensive database on the State's institutional and community-based long term care beneficiaries, including assessment data on functional status, cognitive impairments, and social support systems across settings and over time.

Colorado has been working with the National Committee for Quality Assurance (NCQA) to develop a series of measures focusing on system responsiveness and preventive measures which incorporate community-based and institutional care. Arizona takes a population-based approach to its measurement process and plans to phase-in measures pertaining to the elderly and physically disabilities, developmental disabilities and behavioral health over time. To the extent possible, common measures will be developed for institutional and community-based long term care members. Similarly, PACE is engaging in a process with HCFA's consultants from the Center for Health Policy Research at the University of Colorado to design an Outcome-Based Continuous Quality Improvement (OBCQI) program for the PACE sites. Outcome indicators and interventions will be developed which address how "downstream" providers affect functional and medical conditions of members.

The Self-Assessment for Systems Integration (SASI) Tool developed by the National Chronic Care Consortium examines how well a health care network integrates care across a full continuum of settings and services. Minnesota has made an initial attempt to derive performance measures from this tool for use in the State's readiness review process.

Quality Oversight

Plans serving Medicaid and Medicare beneficiaries are subject to multiple reviews to evaluate quality of care. All plans are subject to review by state licensing or insurance agencies and, in addition, may optionally seek private accreditation review. The State Medicaid agency reviews for compliance with Medicaid contracting requirements and HCFA Regional Office determines compliance with Medicare conditions of participation. Plans contracting with Medicaid and Medicare are further subject to a federally mandated annual, external quality review. Medicare external quality reviews must be conducted by a peer review organization (PRO) whereas Medicaid reviews may be conducted by a PRO, a PRO-like entity or a private accrediting body. To further complicate the situation, the State contracts for the external quality review required under Medicaid whereas the plan directly contracts with the PRO for the Medicare external review.

This labyrinth of overlapping review responsibilities and processes requires extensive resources with potentially limited quality improvement benefit. As each agency chases

after documentation to determine compliance with its requirements, the managed care plan is diverted from its primary focus on improving quality. Attempts to "standardize the standards", as previously discussed, offers an opportunity for agencies to coordinate if not consolidate the number of compliance reviews. But statutory and "turf" considerations impede progress in this regard.

Two models are emerging for integrating quality oversight activities. On the one hand, states are working internally to improve coordination among sister agencies with oversight responsibilities. Minnesota has a cooperative agreement between the Medicaid and licensing agencies specifying their unique roles and willingness to share review findings with each other. Maine has identified three areas for coordinating reviews between Medicaid and insurance: quality oversight, complaints and grievances and financial solvency.

Less dramatic convergence of Medicaid and Medicare reviews is also underway. Arizona, Colorado, Maine, and Minnesota all use or plan to use the same PRO that contracts for the Medicare external review to conduct the mandated Medicaid external quality review. In Arizona, separate reviews are conducted although by the same PRO. The other States "piggy-back" onto the Medicare scope of work hoping to facilitate shared focused studies in areas of mutual interest and to augment the scope in areas of special relevance to Medicaid. For example, a Medicare study on diabetes could include separate samples and analyses for the dually-eligible membership. Similarly, under contract with the state, the PRO may conduct satisfaction surveys comparing the experience with care among Medicaid only, Medicare only and the dually eligible beneficiary. While constrained by the statutory restrictions regarding two distinct contracts, states and their PROs are creatively developing compatible work plans.

State Medicaid agency staff and HCFA Regional Office staff both conduct onsite reviews to determine plan compliance with contracting standards. In Colorado and Minnesota, protocols for joint reviews with HCFA are being developed to facilitate the sharing of information and reduce redundant activities. Efforts to examine duplication of review areas have been undertaken by HCFA through a series of interviews with State Medicaid agencies, National Committee for Quality Assurance (NCQA) and national HMOs. Although no dramatic shifts in authority are anticipated, joint reviews are expected to continue and serve as laboratories for better understanding how HCFA and states can coordinate their roles and, in the process, promote the quality of care.

States, such as Maine and Oregon, are considering how to make use of findings from private accrediting reviews to enhance or focus State compliance review. These findings are typically proprietary and thus States must acquire the appropriate consents to ensure that the level of detail required to substitute one review for another is available.

Table 6 summarizes the discussion in this section.

Table 6. Quality Management Approaches in Selected Programs

	QM Philosophy	Participation in QM	Internal QAP Program Standards	Performance Measures	Quality Oversight
AZ Long Term Care System	Limited prescriptions in how managed care plans involve providers in QM activities.	State: quarterly meetings with plan Medical Directors, Quality Managers and Care Managers MCO: no specific requirements for provider participation in the QM process.	Standards coordinated with State's managed care system for acute care; limited coordination with Medicare.	Development of process/ outcome measures which cross settings of care.	Separate reviews conducted by same PRO for external quality review. Onsite state reviews conducted independent of other agencies and managed care programs.
Colorado Integrated Care and Financing	Flexibility in structure/process of QM at provider level; MCO/State focus on care outcomes	State: fosters partnership between MCO and traditional LTC providers MCO: no state-prescribed participation in QM process with exception of consumers.	Contracting standards under development; foresee separate standards not necessarily coordinated with state/federal standards.	Development of structure/ process measures which cross settings of care to augment HEDIS 3.0.	Joint onsite reviews with HCFA Regional Office; combined studies through use of same PRO to conduct mandated external quality reviews under M'care and M'caid.
Maine-NET	Prescribed model of QM with MCO and State playing key roles in directing & monitoring structure, process & outcome of care	State: active involvement of Quality Committee and use of Clinical Advisory Panel in monitoring service appropriateness. MCO: State requires MCO QM structure to have broad clinical, member and care giver representation.	Goal to increase consistency among standards of state oversight agencies and private accrediting bodies.	Development of functional status and preventable hospitalization measures to augment select HEDIS 3.0.	Proposing to use same PRO to conduct mandated external quality reviews for M'care and M'caid; shared reviews with state licensure and HCFA Regional Office.

	QM Philosophy	Participation in QM	Internal QAP Program Standards	Performance Measures	Quality Oversight
MN Senior Health Options	QM is a negotiated process between MCO and service provider; MCO focus on "transitions" between services and settings.	State: Ad-hoc involvement on issue-specific basis. MCO: inclusion of service providers and settings in QM process	Plans subject to blended set of M'care/M'caid standards where feasible; efforts to increase consistency among standards of state oversight agencies	Development of clinical and structural measures which cross settings of care in area of diabetes, incontinence and care transitions.	HCFA Central and Regional office oversight of state conducted under "Merged Review Guide" ; external quality reviews of plans conducted by same PRO for M'care/M'caid
OR Health Plan	Overall structure of quality improvement mandated by rules; some processes prescribed. Emphasis on outcome.	State: Rulemaking an iterative process engaging consumers and providers alike. Plan: QI committee includes representative providers and professionals.	Standards based on NCQA and QARI guidelines as well as existing state ambulatory standards, where applicable.	Builds on financial measures developed by Nat'l Assoc. of Insurance Commiss. (NAIC) and HEDIS	Different PRO for Medicaid and Medicare mandated reviews. State conducts independent evaluation visits.
PACE *	Prescribed framework for QM at PACE provider level; focus on process and outcome of care.	State: not applicable PACE Site: QM process includes active participation from all areas of PACE program, including participants and caregivers.	Separate standards not necessarily coordinated with state/federal standards.	Development of outcome measures now underway focusing on functional and medical conditions	Independent review for PACE accreditation unrelated to M'caid and M'care external quality reviews.
Texas Star+Plus	Overall structure of QM follows QARI guidelines; flexibility built into system allowing for plan variations.	State: state-sponsored advisory committee includes broad range of input. Plan: QI Committee includes older persons and persons with disabilities and community providers.	Standards compatible with those of TANF program where applicable; additional standards modeled after Contracting Specifications for dually eligible.**	State uses subset of HEDIS 3.0; considering the application of QI indicators for nursing facilities developed under the State's casemix demonstration project to track medical and functional outcomes of NF members.	State currently soliciting proposals for M'caid external review from PROs, PRO-like entities and accrediting bodies; no final decision as to whether M'care PRo will be selected.

* Responses reflect standards included in draft PACE accreditation standards. These standards are subject to future revision.

** HCFA's Medicaid Managed Care Technical Advisory Group (with assistance from The Center for Vulnerable Populations (Collaboration of The National Academy for State Health Policy and The Institute for Health Policy -Brandeis University), A Framework for the Development of Managed Care Contracting Specifications for Dually Eligible Adults November 1996.

C-6: *Financing and Payment*

A state's programmatic goals will define the parameters of the system's financing and rate structure. Often the goals will be conflicting or have multiple implementation schedules. The goals will influence, for example, what services will remain fee-for-service, the scope and structure of a capitation rate, how much risk the state wants to pass on or share, and whether the program will be voluntary or mandatory. As indicated previously, the most commonly articulated goals are to eliminate fragmented service delivery, to contain costs and to develop a coordinated service delivery system. Other goals can include: to improve the overall quality of services provided, to promote the development of community based managed care infrastructures (often most important in rural states), to provide flexibility in benefit design and to maximize consumer choice. How these goals are prioritized and the time horizon over which a state wants to accomplish the goals will ultimately determine how integrated the financing of the Medicare and Medicaid programs will be.

Continuum of Financial Integration

Financial integration can be conceived of along the integration continuum and may include combinations of Medicaid and Medicare capitation and fee for service payments. While full integration is often viewed as the ultimate goal, many other models are operating and provide successful examples of programs that are serving dually eligible beneficiaries. The following outlines a framework for the continuum of financial integration:

CONTINUUM OF FINANCIAL INTEGRATION

Fragmentation	Coordination	Partial Integration	Full Integration
	✓Significant FFS	✓Some FFS	✓Very Little FFS
	✓Limited Capitation of Selected Services	✓Partial capitation of some to most Medicaid and /or Medicare services	✓Full capitation of most/all Medicaid/ Medicare services
	✓Limited Risk	✓Risk sharing arrangements	✓Full risk

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Coordination

The first step along a continuum of financial integration often begins with the development of programs where Medicaid and/or Medicare services are coordinated and/or authorized by a single entity or provider but where significant amounts of Medicaid or Medicare dollars remain fee-for-service. For example, a primary care physician may receive a case management fee to authorize certain services or a group of physicians or a provider may be at risk for a limited number of services. Often such approaches are used during a start-up phase to allow fledgling risk-based organizations to put together their clinical team, build their administrative capacity and form their delivery system networks.

One of the most basic examples of coordinated care programs are the Medicaid primary care case management (PCCM) systems that many states have implemented for their AFDC populations. These programs usually pay a primary care provider a case management fee for authorizing and coordinating Medicaid services. Existing Medicaid PCCM programs, however, do not typically apply to dually eligible beneficiaries or to Medicare services.

Oregon is one state that has a primary care case management option for dually eligible beneficiaries and others. This option is offered as a choice in areas that do not have two capitated plans or on a case by case basis for people with exceptional care needs. Approximately one third of the dual eligible beneficiaries in Oregon are using the PCCM option. As an add-on to Oregon's 1115 Waiver evaluation, ASPE is also sponsoring a comparative analysis of the PCCM option versus HMOs.

The Pre-PACE sites represent examples of programs that started by partially capitating some but not all Medicaid services (e.g. nursing facility, physician, and all optional state plan services) while Medicare services remained fee-for-service. This approach provided the PACE sites with the time necessary to develop their clinical management and care coordination systems for integrating acute and long term care services. It also phased in the amount of risk that the organizations had to assume in the early years of the programs. This incremental approach, while providing a start-up period, does have the potential for cost shifting to the fee-for-service sector.

The MaineNET program proposes to include a Medicare Primary Care Case Management component that will be used to integrate the physician services into a Medicaid managed care program. Depending on the market response to the MaineNET program, the Medicare PCCM will be offered as part of a plan's managed care program or implemented as part of Maine's existing Medicaid primary case management program. In the instance where the PCCM program is included as part of the managed care program, the managed care plan will receive a case management fee to cover the services of the physician in coordinating and authorizing Medicare services. If the Medicare PCCM program is offered as part of the Medicaid PCCM

program, the state will administer the program and the PCP will be paid a case management fee directly from the state.

Partial Integration

As a program or health plan begins to assume greater amounts of risk for a significant number of Medicaid or Medicare services, the amount and degree of financial integration increases. The importance of having a strong case management and care coordination function also increases since the organization is at financial risk for a greater number of services. While some services still remain fee-for-service, mechanisms to coordinate the managed care services and the fee-for-service benefits are developed.

In Arizona, the ALTCS program covers the full package of Medicaid long term care services and plans are at full risk for those services. Medicare services may be provided through the ALTCS plan or through a different Medicare HMO. Medicare services may also be fee-for-service. The ALTCS contractors are responsible for the copayment and deductible amounts associated with Medicare services that are delivered through their networks. Thus it is in their interest to have a strong care management function and mechanisms to coordinate with the Medicare system.

In Oregon, Medicaid medical and acute services are capitated while long term care services remain in the fee-for-service system. If a dually eligible beneficiary chooses to enroll in an OHP plan that is also a Medicare TEFRA plan, the beneficiary must enroll in both the Medicaid and Medicare managed care program. If the OHP plan is not a Medicare TEFRA plan, the beneficiary may continue to receive Medicare services on a fee-for-service basis. If a beneficiary enrolls in a Medicare plan that is not an OHP plan, then Medicaid services remain fee for service.

Moving along the integration continuum, Minnesota Senior Health Options and the Colorado Integrated Care and Financing Project provide examples of programs that have or propose to integrate the financing and delivery of virtually all Medicaid and Medicare services. Much of the development work for these programs focuses not only on the financing and capitation arrangements but on the development of plan capacity to provide and coordinate long term care services. In Colorado, the state has taken an active role in defining and brokering the relationship between Rocky Mountain HMO (that has traditionally managed acute and medical services) and the county based agency responsible for coordinating long term care services. Minnesota, on the other hand, has defined the care coordination and eligibility determination functions that it wants the plan to perform and given the plans the discretion to either perform them internally or contract for those services.

Full Integration

This is often viewed as the ultimate goal in the development of managed care plans for the dually eligible. Theoretically, at least, a fully integrated system would include a single capitation rate for all Medicaid and Medicare services and cost savings and losses would be shared by both programs. Massachusetts recently proposed a unique approach in its 1115 Waiver application for Dual Eligible Seniors. In their proposal, Medicare and Medicaid payments to the Senior Care Organizations would continue to be made separately. Medicare payments would be based on a modified AAPCC method and Medicaid payments would be set equal to the difference between the total capitation payment and the Medicare payment. This approach, while keeping the funding streams separate, has the potential to align the incentives of the Medicaid and Medicare programs to reduce cost shifting and promote cost savings.

A number of factors have contributed to the slow development of fully integrated managed care financing approaches. First, the development of integrated Medicaid and Medicare financing mechanisms require partnerships between states, the federal government and managed care plans. While the Medicare HMO market has grown considerably in the last few years, state initiatives to capitate the Medicaid component of services for the dually eligible are still in the developmental stages. Furthermore, the number of plans that can or are willing to bear the amount of risk associated with a Medicare and Medicaid capitation payment is limited. The variability of the Medicare AAPCC by region has also had an impact on the market penetration of Medicare HMOs in different areas of the country.

From a financing perspective, the development of a common methodology for capitating Medicaid and Medicare services has been limited by the categorical nature of the two programs and until recently the segmentation of Medicaid data and Medicare data. Advances in technology and the availability of linked Medicaid and Medicare data provide new opportunities to develop common capitation methodologies and risk adjustment methodologies that would span the Medicare and Medicaid systems. This might still result in separate capitation payments from Medicaid and Medicaid but such payments could be computed using a common rate structure, risk adjustment methods, and financial incentives.

Development of Capitation Rates

The development of capitation rates for dually eligible older people and people with disabilities is still in its infancy. Since managed care programs for the dually eligible rely on two funding mechanisms (Medicaid and Medicare), it is helpful to understand and address issues related to the development of Medicaid capitation rates and Medicare capitation rates.

Standard Medicaid practice is to pay managed care plans a percentage of the fee-for-service average per capita costs adjusted for factors such as age, sex, gender, region,

eligibility status (i.e. Medicaid-only versus with Medicare Part A or Part B) and disability status (aged versus disabled). Medicare premium payments to risk based HMOs are based on 95 percent of the adjusted average per capita cost (AAPCC) of Medicare beneficiaries participating in the traditional fee-for-service Medicare program. The AAPCC is also adjusted for age, sex, welfare status, institutional status and geographic region. States that have or are developing programs to serve the dual eligible populations have also become increasingly interested in refining the more traditional capitation rate approaches (for both Medicaid and Medicare) to reflect the chronic care needs of the target populations and to address the potential for risk selection bias. A number of states discussed in this paper, for example, have requested and received approval from HCFA to use a modified AAPCC methodology for Medicare services. In addition, HCFA and the RWJ foundation have funded research and demonstration projects to develop and test risk adjusted capitation methods.[3]

The development of Medicaid capitation rates typically begins with equivalent fee-for-service costs for the services that are to be managed by the program contractors and for the target populations of interest. State policy makers need to guide the development of the rate structure to assure that the financing system remains aligned with the state's programmatic goals. Actuarial consultants will be able to test and model the rate structures and assure that appropriate actuarial principles are followed. It is, therefore, critically important that the policy objectives are clearly articulated, that administrative systems are in place that can support the capitation rate structure and that information systems are adequate to monitor the adequacy of the rates over time. If states are interested in developing more sophisticated rate structures later on, it is important to collect the necessary health status measures that might be used in future rate setting.

Some of the key questions that states must address in developing their capitation rates are:

- *How should the rate cells be structured and what costs will be included in the capitation rate cells?*

- *What kind of age, sex, or risk adjustments should there be?*

- *What kinds of risk sharing (e.g. risk corridors, re-insurance) should there be and for how long?*

- *Are the rates designed in a way that will be budget neutral?*

- *What mechanisms can be used to promote the integration of Medicaid and Medicare financing and minimize programmatic cost shifting?*

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[3] "Managed Care: Advances in Financing," *Health Care Financing Review*, Volume 17, Number 3, Spring 1996.

How should the rate cells be structured and what costs are included in the capitation rate?

One of the major advantages of capitation financing is that it provides program contractors with a great deal of flexibility in developing plans of care and services that meet the needs of individual enrollees. Unlike the fee-for-service system where services are often defined by the categorical nature of the Medicaid program, in a managed care environment the plan must work within a global capitation rate for each individual. Many states that have developed rates for the dually eligible have done so using very aggregate rate categories thereby providing maximum flexibility to program contractors and also spreading the potential risk over a large population base.

The inclusion of long term care services in capitation rates creates new challenges and opportunities for states. It is a challenge in that NF level services and NF residents have not traditionally been served in managed care programs and represent considerable risk for program contractors. It is an opportunity in that the development of new capitation rate structures that include long term care can provide strong incentives to move away from the historical institutional bias of the Medicaid program and promote the use and development of home and community based options.

Table 7 provides an overview of the rate structure used by a number of states. The costs included in the rate cells represent average per capita costs usually reduced by a factor for managed care savings.

Table 7. Approach to Medicare and Medicaid Capitation in Selected Programs

	Medicaid Capitation	Medicare Capitation
Arizona Long Term Care System	Includes weighted average of NF and Home and Community Based LTC costs. Medical and acute costs, behavioral health and case management costs also included.	Medicare TEFRA rates
Colorado Integrated Care and Financing Project	LTC Qualified: Includes NF and Home and Community Based Waiver costs. Basic LTC: Includes home care allowance and adult foster care costs for those who are not NF qualified. Medical/acute care rate based on existing managed care program.	Actual Medicare cost based rates with the adjustmentsfor elderly who are NF eligible in the community(PACE Adjustor); and new adjustments for nonelderly who are NF eligible in the community; and NF residents and others
MaineNET	NF Eligible: Includes weighted proportion of NF and home and community waiver costs. NF costs will be case mix adjusted. Community Eligible: Weighted average proportion of residential care and community based service costs. Residential care costs will be case mix adjusted. Medical/acute care costs included.	Medicare Primary Care Case Management Fee
Minnesota Senior Health Options	NH residents upon enrollment: Medical/acute costs (PMAP rate) but NF per diem remains fee-for-service. NH Certifiable Conversions: Medical/acute costs and 95% of 2 X the average monthly Elderly Waiver payment. Community Nursing Home Certifiable: Medical/acute costs and 95% of the average monthly Elderly Waiver payment and a NF Add-on. Community Non-NHC: Medical/acute and NF add-on.	Medicare TEFRA rates plus 2.39 factor (PACE riskadjustor) for NF conversions and NF certifiable rates.
Oregon Health Plan	Includes all medical and acute costs for elders and disabled. LTC not included in the program	Medicare TEFRA rates
PACE	State-specific Medicaid rates based on historical use of NF/community services	Medicare TEFRA rate plus 2.39 risk adjustor
Texas Star+Plus	Separate rate cells for Medicaid only and dually eligible: Community based Waiver clients Other Community Clients New Nursing Facility clients Voluntary Nursing facility clients Medicare copay and deductibles paid fee for service for those in non Medicare risk plan. For dual eligibles in Medicare risk plans, Medicaid excludescopay and deductible.	Medicare TEFRA rates

Medicaid Capitation Rates

The development of programs to serve the NF eligible populations and to include LTC costs has resulted in the creation of new rate cells that are not typical of the AFDC population. In Arizona, the ALTCS program only applies to those who are NF certifiable and thus there is a single rate cell for the costs associated with providing services for this population. The use of the weighted average of NF and home and community based LTC costs provides strong incentives for program contractors to provide services in the community and to move away from a reliance on institutional level of care. When the program first began, HCFA placed a 5% cap on the number of HCBS slots available to the elderly or physically disabled enrolled in the program. Currently there is a 40% statewide cap although the state believes there should be no such cap.

A significant difference between Arizona and other states is that a single contractor serves all ALTCS enrollees in a county and all NF certified Medicaid beneficiaries must use the single contractor. From a rate setting perspective, this greatly reduces the consequences associated with adverse risk selection since all eligible participants in an area are enrolling in a single plan.

The Colorado Integrated Care and Financing Project, MaineNET and PACE also use or propose rate cells that apply to the NF eligible (or NF certifiable populations). In the Colorado program, the LTC qualified rate cell includes all NF and home and community based waiver costs. The costs in this cell represent the historical distribution of people served in NFs and people served in the community and the respective costs associated with those programs. While there is an implicit distribution built into the Colorado rate cell of NF and home and community based costs, the rate cell is not built around a targeted proportion of people to be served in NFs versus in the community. Nevertheless, the structure of the rate cell provides the same incentives as those in Arizona, i.e. to serve people in the least restrictive and less costly setting. Because the program in Colorado will be voluntary, the rate structure does not have the same level of risk selection protection inherent in the mandatory Arizona program.

The MaineNET rate cell for NF eligible enrollees, like Arizona's, will include blended NF and home and community based waiver costs that will be developed based on a combination of historical and expected proportions of people who may be served in the community versus in a NF. In the start-up years of MaineNET, it is expected that this proportion (the percent in the NF versus in the community) may need to be adjusted on a fairly frequent basis to account for differences in the enrollment distributions of program contractors. The costs associated with the NF level of care will be adjusted for the case mix of individuals who enroll in the program. Case mix will be determined using the NF RUG-III system and the MDS assessments that are completed in the nursing facility. It is proposed that the capitation rates will reflect the case mix of all enrollees in a managed care plan in the prior year. For the Community-eligible rate

cell, the rates will be developed based on the expected proportion of people who are in residential care facilities and those who are in the community. Maine is also in the process of developing a case mix system for residential care facilities that will be used in the development of the community-eligible rate cell.

The Medicaid capitation rate for PACE programs varies from state to state based on the comparison group used by a state and historical use patterns of those in NFs versus those in the community. In some states (California, New York, So. Carolina and Wisconsin) the state's average per capita expenditures for a comparable NF population is used. In other states (Mass., Colorado, Illinois) both institutional and community based populations have been used for comparison and rates developed based on average per capita costs of those served in both programs based on the numbers served in each.[4]

One of the major challenges for the PACE program and for states that are developing capitation rates is to determine the appropriate weighting between these two groups. While the weighting will be developed in part based on historical experience, it is also a function of the state's commitment to the expansion of community based alternatives and the supply of nursing home beds in a state.

Minnesota has taken a different approach from the other states and has developed four major rate categories: (1) Institutionalized (NF) residents, (2) NH certifiable conversions (3) Community NH certifiable, and (4) Community Non-NHC. *For residents who enroll while in a NF*, the Medicaid rate includes the medical/acute capitation rate (PMAP rate) for institutional residents. The NF costs remain fee-for-service. *The NH Certifiable conversion rate* is assigned after an enrollee has been institutionalized for 180 days and then moves to a community setting. The rate is then based on 95% of twice the average cost of the elderly waiver program and includes the Medicaid institutional PMAP rate. *The Community NH certifiable rate* includes 95% of the average monthly Elderly Waiver payment, the Medicaid non-institutional PMAP rate and a Medicaid NF add-on. The Health Plans are responsible for 180 days of NF care for any person who enrolls while in the community. *For Community Non-NHC recipients*, the rate includes the Medicaid non-institutional PMAP rate and a NF add-on.

The Minnesota approach limits the liability of program contractors for long term nursing facility stays while providing incentives for early discharge planning. By establishing the NF add-on, the plans are also at risk for those in the community who may need short term NF care. This provides an incentive to develop preventive approaches, prevent deterioration and reduce the NF admission rate. The Minnesota rate structure also differentiates between an institutional and non-institutional rate for medical and acute care services. This also provides incentives to manage and control hospital and acute care utilization.

[4] Medicaid Rate Setting for PACE.

In Texas, rate categories have been established for those who are Medicaid only and those who are dually eligible in the following groups: Clients receiving Community Based Alternatives in the Waiver program (CBA Waiver clients); Others in the community; New nursing facility clients and Voluntary nursing facility clients (those residing in the nursing facility prior to 2/1/98). Texas has also developed its rate structure to provide incentives to serve people in the community. Historically there had been a cap on the number of people who were NF eligible who could be served in the Waiver program. With the Star+Plus program, this cap would be removed. In addition, the NF rate cells have been adjusted to reflect a discounted NF rate and the CBA rates are structured to reflect approximately 85% of the NF level costs. For those in the community, the rates will include up to 120 days of care in a NF.

The medical and acute care Medicaid costs for the dually eligible will be paid fee-for-service. For those who are receiving Medicaid and Medicare managed care services through a single plan, the Medicare HMO will cover the copays and deductibles for medical and acute care services through their Medicare TEFRA rates.

Medicare Capitation

Managed care programs that have been developed to serve dually eligible beneficiaries have had to address not only how to design Medicaid capitation rates but how to design Medicare capitation rates. Medicare risk-based HMOs receive 95% of the average adjusted per capita cost AAPCC. The actual payment to the HMO is determined through a series of adjustments. Based on a national average Medicare per capita cost, the AAPCC is determined for each county, is calculated separately for Parts A and B, for elderly and disabled and for institutional status. In Arizona and Oregon, the Medicare HMOs receive the Medicare HMO rate for the dually eligible.

When the PACE program began, an adjustment to the AAPCC was developed to reflect the enrollment of the high risk NF eligible population. This factor (measured as a 2.39 adjustment) captured the higher Medicare costs associated with caring for the frail elderly in the community. In Minnesota, the program contractors for the MSHO program receive the Medicare AAPCC rate with an adjustment factor of 2.39 for NF conversions and NF certifiable rates. Colorado is proposing to use cost based Medicare capitation rates with separate adjustments for different populations. The Medicare rate for the NF eligible elderly population will include the 2.39 PACE adjustor. The NF eligible population under 65 will have a new adjustment factor that is being developed for this age group. The nursing facility residents and all others will also have a separate adjustment

The more recent availability of linked Medicaid and Medicare data should provide further opportunities to analyze the relationship between Medicaid and Medicare costs for the NF eligible and the non-NF eligible populations and to examine whether further refinements or alternate approaches might be warranted. Massachusetts, for example,

used its linked data to propose alternate adjustment factors for Medicare payments to Senior Care Organizations. It found that the Medicare AAPCC methodology would underpay HMOs for frail seniors residing in the community and that even with a PACE adjustor, the Medicare payments for the community Nursing Home Certifiable population would be understated.

In Maine, where there are currently no HMOs doing business, a Medicare PCCM option is being developed. This will provide physicians with a case management fee for authorizing and coordinating Medicare services.

What kind of age, sex, or risk adjustments should there be?

Another question that must be addressed in the development of rate cells is whether to adjust for age, sex, region, eligibility status (people over 65 versus those with disabilities) or other risk factors. Most states include some kind of adjustments for age, sex, region and eligibility status but the use of risk adjustment methodologies is still in the early research and testing phase. Table 8 summarizes the adjustments that are currently used in the states that are being discussed in this paper.

Table 8. Approach to Age, Sex or Other Risk Adjustments in Selected Programs

	Medicaid Adjustments	Medicare Adjustments
Arizona Long Term Care System	No adjustments for age, sex, case mix. Elderly and physically disabled grouped together.	AAPCC with standard adjustments, when contractor is a Medicare HMO
Colorado Integrated Care and Financing	Medicaid financial eligibility	Adjustments for Mesa county; age, sex, institutional and welfare status, as appropriate, plus other risk adjustments (see previous table)
MaineNET	Adjustment for case mix of NFs and Residential care settings; other adjustments under review	N/A
Minnesota Senior Health Options	Adjustment for age, sex, county	AAPCC age, sex, county adjustments and PACE adjustor
Oregon Health Plan	Elderly and disabled are separate rate cells; with/without Medicare; for the elderly, adjustments for those with Medicare Part B only	AAPCC with standard adjustments, when contractor is Medicare HMO
PACE	Varies by state	no adjustments for age, sex, over 65 versus with disability, PACE Adjustor
Texas Star+Plus	No age, sex adjustments. Propose to adjust for enrollment differences of heavy users of medical and LTC.	AAPCC with standard adjustments

The use of adjustments for age, sex, region and disability group varies quite a bit from state to state. Whether to include such adjustments may be a function of the availability of data and the number of rate cells a state may want to administer. Particularly in programs where enrollment is voluntary and likely to involve low numbers, it may not make sense to include multiple rate cells for age, sex, and region.

On the other hand, voluntary programs with low potential enrollment are more prone to either favorable or adverse risk selection. Biased selection arises if the high risk type of

enrollees within a rate cell tend to be found more in one plan or program versus another (e.g. in the fee-for service system or the managed care system). For example, if Medicare HMO enrollees within each AAPCC cell tend to be lower risks, then Medicare payment rates, which are based on the average risk of FFS enrollees within each cell, would overstate the expected FFS expenditures of HMO enrollees.[5]

In Maine and Texas, it is proposed that the rates be adjusted, particularly during the start-up of the programs to reflect the actual enrollment distribution. In Texas, for example, the state will be monitoring the enrollment of those in the community rate cell to examine whether a disproportionate percent of people who have been heavy LTC users or have heavy medical/acute care needs are in enrolled in one plan or another. They propose to make adjustments either during the first year or at the end of the year to account for these differences. In Maine, the distribution of people who enroll in the NF-eligible rate cell will be monitored and adjusted to reflect major differences between the proposed and actual distribution of people in the community versus in a NF who are in the NF-eligible rate cell.

The use of risk-adjusted capitation rate structures for dually eligible individuals is extremely challenging yet important given the significant variation in costs between enrollees particularly among those with chronic conditions. A small number of people can account for a large proportion of health care expenditures and at the other extreme a large number of people can account for a very small percentage of expenditures. Depending on the enrollment distribution into plans, there is great potential for either excessive profits or losses.[6] Research from the Medicare HMOs has demonstrated that Medicare HMO enrollees were less costly than non-HMO enrollees and that disenrollees had systematically higher costs than Medicare beneficiaries in the fee-for-service sector.[7]

Some of the factors that contribute to adverse risk selection can be mitigated by state policies such as third party management of enrollment, oversight of marketing, monitoring of disenrollment and requirements for network composition. Many states, for example, use health benefit administrators to manage enrollment. This prevents plans from selectively choosing who to enroll. Similarly, oversight of marketing materials and strategies can assure that plans are providing a consistent and accurate message to potential enrollees. Nevertheless, the potential for selection bias is still a potential problem for programs serving those with chronic conditions.

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[5] Bryan Dowd, Ph.D. et al, "An Analysis of Selectivity Bias in the Medicare AAPCC," *Health Care Financing Review*, Spring 1996.

[6] Richard Kronick, Ph.D. et al, "Diagnostic Risk Adjustment for Medicaid: The Disability Payment System, " *Health Care Financing Review*, Spring 1996.

[7] Randall Ellis, Ph.D et al., "Diagnosis-Based Risk Adjustment for Medicare Capitation Payments," *Health Care Financing Review*, Spring 1996.

A number of research and demonstration efforts are in progress to develop more refined risk adjustment methodologies for Medicaid and Medicare managed care programs. With respect to Medicaid capitation methods, a Disability Payment System (DPS) has been developed for Medicaid recipients with disabilities [8] The DPS consists of groups of diagnoses that have been associated with elevated future costs. The system relies on claims based diagnoses to predict expenditures in a subsequent year. A number of states are considering the use of this system for their Medicaid populations with disability. This system does require the use of claims based diagnoses and conditions and is potentially subject to gaming and inaccuracies related to the diagnostic codings. Nevertheless, it represents a next wave of risk adjustment methodologies that are being tested and considered for Medicaid recipients with disabilities.

Risk adjustments for the AAPCC are also being tested.[9, 10] Research has been undertaken to develop risk adjustments that might be used as part of the second phase of the S/HMO demonstration. This model uses information collected from the Medicare beneficiary survey to predict health care costs. The research suggests that direct health status measures (diagnosis, perceived health and functional health status) and indirect health status measures (demographic characteristics) are predictors of resource utilization.

The biggest issue that needs to be addressed, from a state perspective, is whether it is possible to collect on a timely basis all the data that would be necessary to administer such a system. Furthermore, the use of self reported data has potential for gaming by the health plans although similar issues have been addressed in other payment systems that rely on reported health data (e.g. DRGs and case mix systems) through stepped up quality assurance programs. The use of health status measures as risk adjustors does have the advantage of reducing the selection and adverse risk bias otherwise inherent in the more global rate setting approaches. An interim step for states might be to collect much of this data as part of the enrollment process and use it to monitor adverse risk selection and plan performance over time.

Other risk adjustment capitation models are also being tested including the use of Ambulatory Care Groups (ACGs) and the Payment for Amounts for Capitated Systems (PACs) and the use of Diagnostic Cost Groups. Other research is focusing on the use of

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[8] RichardKronick,Ph.D, et al., "Diagnostic Risk Adjustment for Medicaid: The Disability Payment System," *Health Care Financing Review*, Spring 1996.

[9] LeonardGruenberg,Ph.D., et al, "Improving the AAPCC with Health-Status Measures From the MCBS," *Health Care Financing Review*, Spring 1996.

[10] *Evaluating Alternative Risk Adjustors for Medicare*, Draft Report, March 1997, Center for Economics Research, Gregory Pope, Principal Investigator.

risk adjustments for the non-elderly.[11] [12] These models focus on Medicare payments and alternatives that might be tested as adjustments to the AAPCC. These models are still in the research and development phase.

What kinds of risk sharing (e.g. risk corridors, re-insurance) should there be?

Often during the start-up phase of a program, the state and the program contractor are interested in ways to share in the risk of managing care for people with chronic conditions. Some of the ways in which this risk is shared is through the use of re-insurance provisions or through the use of risk corridors. In Minnesota and Arizona, re-insurance provisions have been developed. In Arizona, the state buys reinsurance that covers approximately 75-85% of the cost of care for individual cases that exceed certain thresholds. For example, the re-insurance will cover 75% of the costs of care in excess of $12,000 for an individual with Medicare Part A coverage in an urban area. Similar thresholds are developed for those in rural areas and those without Medicare coverage. For catastrophic cases such as transplants or those with hemophilia, the reinsurance covers either 85% of the program contractors costs or in certain instances a pre-established amount for a specified condition.

In Oregon, the health plans are responsible for obtaining their own re-insurance and are often able to do so at rates that are lower than what the state would be able to obtain.

Another approach to risk sharing is the use of risk corridors. In the PACE program, risk corridors were used in the first three start-up years of the program to develop and refine their service delivery system before assuming full financial risk. If a program's revenues exceeded its expenditures, a risk reserve was created that was used to fund losses in subsequent years or to facilitate the program's assumption of full risk at the end of the start-up period. If the program's expenditures exceeded its revenues, the losses were shared by the program and its payors. Risk corridors were established such that the PACE programs were responsible for 100% of the losses within the first tier of a risk corridor. In the second and third tiers of the risk corridor (e.g. when expenditures exceeded revenues by 5% and 10%), the proportion of losses covered by the payors increased to 90% and 95% respectively. A payor's maximum loss was also specified depending on how many years the PACE program had been operating.

Of particular interest with the risk sharing mechanisms under the PACE programs is that the Medicaid and Medicare losses were shared proportionally. Thus while the PACE sites received two capitation rates: one from Medicaid and one from Medicare,

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[11] Arlene Ash, Ronald Ellis et al , *Risk Adjustment for the Non-Elderly, Interim Report*, Health Economics Research, HCFA Contract 18-C-90462/1-02, May 1997.

[12] Allen Dobson, Jonathan Wiener et al., *The Development of a Diagnosis-Based Risk Adjustment System for Setting Capitation Rates for Under-65 Populations*, The Lewin Group, HCFA Contract 500-92-0021, April 1997.

the risk was shared by the two programs. Theoretically, at least, the pooling of the risk by the two programs provides the kinds of incentives that policy makers have been striving for, i.e. incentives to reduce programmatic cost shifting and to develop health prevention and promotion practices that will benefit both programs in the long run. In pending legislation before Congress that would make the PACE program permanent, the use of risk sharing would be eliminated.

Massachusetts is also proposing a modified version of the risk sharing model used for the PACE demonstration. Under this modified PACE model, the state would phase in increasing risk for Senior Care Organizations over time using a series of risk corridors, defined as the difference between capitation payments and its actual spending. Unlike PACE, where only losses are shared by Medicaid, Medicaid would share in both up-side (savings) and down-side (losses).

In Texas, the Star+Plus program will share in the profits but not the losses with the plans. The first 3% of profits will be kept by the HMOs. Any profits between 3% and 5% will be split between the state and the HMOs and any profits over 5%, the state will keep.

Are the rates designed using an approach that will be budget neutral?

When states submit their Section 1115 Waiver applications, they must include a section on budget neutrality. It is important to have the framework for a capitation rate structure developed as part of the Waiver submission although the final capitation rates and final methodology will likely not be included in the Waiver document. Nevertheless, the Waiver should include the assumptions that will be embedded in the capitation rates that will produce savings over the course of the demonstration. The presentation of the cost neutrality projections will be at a more aggregate level than the final capitation rates.

The steps that must be included in the calculation of budget neutrality include: selecting a method for calculating the expenditure limit, selecting a base year, developing trend factors and identifying beneficiaries and services included in the expenditure limit. The following is a brief overview of these steps.[13]

HCFA requires that demonstrations conducted under Section 1115 Waiver authority be budget neutral, that is that the state may not receive more federal Title XIX matching funds under its demonstration than it would have received without it. To ensure budget neutrality, HCFA places a limit on the amount of Federal Financial Participation that the state can receive during the demonstration. This expenditure limit is based on a projection of how much the state would have received had there been no demonstration.

[13]HCFA Document, *Budget Neutrality of Comprehensive section 1115 Waiver Demonstrations*, December 1996.

A demonstration must be budget neutral over the entire demonstration period, not on a yearly basis.

To ensure budget neutrality, states must choose one of two methods for calculating the expenditure limit --- the per capita method or the aggregate method. The per capita method allows the benefits component of the expenditure limit to vary depending on actual enrollment during the demonstration. HCFA and the state negotiate a projected cost per enrollee which becomes the basis for a cap on the amount of federal financial participation the state will receive per enrollee. The per capita cost projections for budget neutrality should not be confused with the capitation rates the state plans to pay the health plans. For example, the per capita cost projection may include services that are not included in the capitation rates.

Using the aggregate method, the expenditure limit does not vary with actual enrollment although separate enrollment and per capita costs projections may be made as intermediate steps in determining an aggregate limit. The expenditure limit is a fixed amount. A risk corridor under which HCFA could grant the state additional spending authority if caseload deviates from projected caseload can be established.

In calculating budget neutrality, a base year must be selected. This is usually the most recent year for which actual Medicaid data is available. Trend factors or growth rates are then applied to the base year data to project future expenditures with and without the demonstration program. HCFA requires the state to submit historical caseload and expenditure data in a standard format to determine historical program growth. Trend factors are negotiated between HCFA and the state.

Expenditures for those eligibility categories and services that the state proposed to include in the demonstration are included in the expenditure limit. Beneficiary eligibility categories and services for which it will be difficult to "carve-out" are also included in the expenditure limit, for example, services or beneficiaries included in the demonstration only in later years of the demonstration period.

What mechanisms can be used to promote the integration of Medicaid and Medicare financing and minimize programmatic cost shifting?

The development of Medicaid and Medicare capitation rate structures and financing systems is an intricate and subtle dance between state and federal policy makers. Each program is concerned about eliminating service fragmentation, containing costs and coordinating and improving quality care. Aligning the incentives of the two programs to meet those common goals is a challenging endeavor. If the incentives of the two programs are not more closely coordinated, the potential for significant cost shifting is great. At the same time, protocols and procedures implemented as part of the Medicaid program can result in significant savings for the Medicare program and vice versus.

Under the current system, the Medicaid program has limited ability to initiate care management programs or medical treatments that could prevent the onset of serious acute and chronic conditions. An example is pneumonia vaccines. It is clear that Pneomovax is extremely desirable and cost effective. However strongly Medicaid encourages this policy, it cannot track dually eligible clients who received the pneumovax when Medicare was billed and it cannot require the use of a service that is Medicare funded. Furthermore, the Medicaid program can have almost no impact on the majority of the Medicare population who should have received the vaccine at some point before also becoming Medicaid eligible. This is just one example of how the lack of integration between Medicaid and Medicare impedes the use of a simple yet highly effective preventive service that in the long run will save many lives, avoid hospitalizations and prevent the use of long term care services.

While much of the focus on the development of integrated managed care systems focuses on the organizational and financial dynamics between the two programs, it may be that more work could be done to develop joint clinical protocols that would improve the health and well-being the dually eligible and that would in the long run save both programs money.

D. Integration Approaches and Waivers

As the seven programs featured in this paper illustrate, multiple vehicles exist to integrate Medicaid and Medicare, and each has its particular strengths, weaknesses and waiver requirements. In this section, we review three general approaches to dually eligible beneficiaries and the particular vehicles that have emerged under each approach. We then review the various waivers that have been used to construct dual eligibility programs from these vehicles.

D-1. Approaches to Integration

The following approaches should not be viewed as models. They are means to achieving program goals and, with several Medicare and Medicaid policy changes pending in the federal Balanced Budget Act of 1997, new approaches are likely to emerge. The arrangements listed here are not mutually exclusive. States may decide to use a variety of vehicles as, for example, Minnesota has done by contracting with both Medicaid plans and Medicare HMOs. States should carefully consider all of their options and select the one or more approaches that best fit their target populations, existing delivery systems, scope of services, public and private infrastructure and timelines.

Approach 1: Capitated Medicare and Medicaid through an Existing Medicare Vehicle

The number and variety of MCOs with existing Medicare risk contracts with HCFA has been increasing and options will expand further with enactment of the federal Balanced Budget Act of 1997. Under this approach, a state contracts for Medicaid services with an entity that already receives capitated Medicare payments from HCFA. Vehicles fall into two categories: those with standard Medicare risk contracts, and those who participate in national demonstration programs.

1-A. Beneficiary enrolls in an MCO with standard Medicare risk contract and a Medicaid contract.

This arrangement can be found in Arizona, Colorado, Florida, Minnesota and Oregon and is planned in Texas. Beneficiaries receive all Medicaid and Medicare services from a single organization, which until now has been a Medicare HMO. Under provisions of the federal Balanced Budget Act of 1997, provider sponsored organizations (PSOs), preferred provider organizations (PPOs) and others will also become eligible for Medicare risk contracts.

Using an existing Medicare risk contractor, a state may pursue Medicaid waivers to capitate Medicaid services to the Medicare MCO without pursuing Medicare waivers, since the MCO already receives a Medicare capitation from

HCFA. This strategy is well suited to areas where there are sufficient Medicare HMOs to offer dually eligible beneficiaries a choice of plans. To date, Medicare risk contractors have been concentrated in the urban markets of a handful of states, where Medicare payment rates are higher, but the federal Balanced Budget Act of 1997 will reduce the disparity between high and low payment areas over time, which may stimulate the Medicare risk market in less urban areas.

Since they are required to offer their plans to virtually all Medicare beneficiaries in their service areas, Medicare risk contractors may be attractive to states designing programs for broadly defined target groups. A state that defines its target group more broadly than beneficiaries who are nursing home eligible, for example, would not choose PACE, but might choose a Medicare risk contractor. Like PACE, a Medicare risk contractor with a Medicaid contract from the state gains considerable flexibility through dual capitation payments. Coordination with other programs such as state funded home care and Older Americans Act services is still necessary, although states may consider including state funded services in state capitation payments to serve beneficiaries who are at risk but are not nursing home certified.

Contacting with standard Medicare risk contractors offers opportunities for states yet there are some implications that must also be considered. Dually eligible beneficiaries will always have freedom of choice under any Medicare managed care arrangement. A dually eligible beneficiary may join an MCO for Medicaid services but remain in fee for service for Medicare services. If they use Medicare providers outside the network, care is more fragmented. In addition, Medicare risk contractors may not be interested in contracting with Medicaid or, if interested, they may not be willing to assume risk for long term care services. Medicare risk contractors may not exist everywhere in a state and, in fact, there were no Medicare HMOs in about ten states in June 1997 (though this problem is likely to diminish in some areas as more entities become eligible for risk contracts and geographic Medicare payment disparities are reduced). This does not pose a problem for states interested in developing integrated programs in selected areas, but it limits states that seeking to develop statewide programs. Medicare risk contractors also may not contract with traditional safety net providers or have experience in long term care.

States do have real opportunities to use this arrangement to integrate care for dually eligible beneficiaries while taking fuller advantage of Medicare benefits. Since most Medicare risk contractors offer supplemental benefits (e.g., prescription drugs) which duplicate Medicaid services, states may develop capitation payments that adjust for the added benefits already paid through the Medicare capitation.

As enrollment of Medicare beneficiaries in various Medicare risk plans rises,

the potential for dually eligible beneficiaries to enroll in separate plans for Medicare and Medicaid increases. This is one phenomenon that states should actively avoid because beneficiaries will have two primary care physicians, different network providers and different benefit packages. Coordination is extremely difficult in these arrangements. Oregon avoids dual HMO enrollment by allowing members who have enrolled in a Medicare HMO to remain in Medicaid fee for service if the selected Medicare HMO does not have a Medicaid contract with the Oregon Health Plan.

1-B. Beneficiary enrolls in an MCO with a Medicare demonstration contract and a Medicaid contract.

This option allows states to design programs using existing or planned HCFA demonstration programs. The demonstration programs include PACE, Social HMO II, EverCare and Medicare Choices, a program launched by HCFA in 1996 to expand enrollment in new managed care arrangements and to test a range of delivery system options that provide beneficiaries with broader choices and HCFA with more alternative payment arrangements.

Some states may be interested in the **Medicare Choices** demonstration because it tests the impact of contracting with plans that do not necessarily qualify fully under requirements for Medicare risk programs. The Choices program will measure the beneficiary interest in receiving Medicare services through Provider Sponsored Organizations (PSOs), Preferred Provider Organizations (PPOs), open-ended HMOs, point of service options, integrated delivery systems and primary care case management systems. The demonstration has also been designed to expand implementation options in such areas as risk adjustment, payment methods, certification requirements and quality monitoring systems. State Medicaid officials might consider approaching other demonstration sites to explore options for providing Medicaid capitation payments for dually eligible beneficiaries. Though an option for states to consider, the number of sites is limited and they are not available in all states. However, many of the entities targeted for the demonstration will become eligible for standard Medicare risk contracts under the federal Balanced Budget Act of 1997.

States are actively seeking to develop new **PACE** sites. Although limited by Congress to 15 sites, the federal Balanced Budget Act of 1997 will increase the number of available sites immediately and make the program permanent, expanding the availability of this program for states seeking to target nursing home certified, dually eligible beneficiaries in relatively small sites.

The number of **Social HMOs** is also limited and states have not been major partners in their development. While the Social HMO I model offered limited long term care benefits and capped the number of at risk enrollees, Social HMO II is more suited to serving dually eligible beneficiaries. In order to be selected

as a Social HMO II site, projects had to demonstrate a capacity and approach to serving dually eligible beneficiaries. Between 40-50% of enrollees in programs approved for South Carolina and Contra Costa County California will be dually eligible.

The **EverCare** demonstration offers another, albeit limited, approach to target a sub-population or to provide a base for further expansion. Sites participating in this demonstration manage Medicare acute care services for nursing home residents using geriatric nurse practitioners to authorize hospital admissions, and schedule clinic and physician visits. As currently designed, the program reduces Medicare spending by avoiding preventable hospital admissions. While the beneficiary benefits, Medicaid does not share the savings and expenditures could be higher. States could explore contracting with EverCare sites to manage Medicaid services and consider a payment methodology that reflects some of the savings realized by reducing Medicare hospital admissions. States could also enhance the scope and effectiveness of the program by including prescription drugs as part of the benefit to be managed by the site.

Approach 2: Capitated Medicare and Medicaid through a Medicaid MCO with Medicare Waivers

This approach differs from Approach 1 in that the state uses a Medicaid contractor as its base and adds Medicare, rather than beginning with Medicare contractors.

2-A. Beneficiary enrolls in traditional Medicaid MCO where capitated Medicare services are also available.

Under this approach, Medicaid would contract with MCOs that do not have standard Medicare risk contracts. A Medicare waiver is sought to allow the MCOs to receive Medicare capitation payments and to obtain the 30 day lock-in that is not otherwise available to plans without Medicare risk or demonstration contracts.

This approach allows states to build networks using providers with a history of and commitment to serving Medicaid beneficiaries. Typically, Medicaid-only networks do not fully qualify for Medicare contracts, accept under demonstration programs, yet they have more extensive experience serving low income populations and contracting with Medicaid. Despite this experience, Medicaid plans may be reluctant to accept risk for long term care services and they will have to build an adequate network. That is, institutional and community based long term care organizations would have to expand to include hospitals, physicians and other providers while physician/hospital based groups will need to develop a broader base of home and community care providers. Further, care management models familiar to programs serving very impaired beneficiaries will be new to organizations that have historically focused on

primary and acute care.

2-B. Beneficiary enrolls in a community based organization that contracts with an MCO for health services.

States with extensive home and community based services programs which offer a single entry point for access to the long term care system might consider building on that experience. States would contract with and provide a Medicaid capitation payment to the single entry point or other community-based agency to arrange or deliver care. The agency, since it is not likely to be a health care system, would subcontract with a licensed HMO or health care providers to deliver primary and acute care services. A Medicare waiver would be needed for the agency to receive capitated Medicare payments. This approach is being pursued by the Wisconsin Partnership program, and has many similarities to PACE sites.

This vehicle may be considered to build a system that values a social model of care and emphasizes consumer-centered or consumer-directed approaches to care. It is better suited to programs that serve beneficiaries already using long term care services. Beneficiaries who utilize only health care services probably would not be interested in enrolling in a system organized by an entity that does not deliver health care services. The strength of the approach is its focus on developing a plan of care on the individual needs of each beneficiary rather than authorization from a menu of services. Other models may adopt a similar style but this focus on flexible plans of care is more consistent with the philosophy of traditional community based organizations that have experience in home and community based long term care services.

Approach 3: Capitated Medicaid with Coordination of Fee-for-Service Medicare

The third approach involves contracts between Medicaid and MCOs for Medicaid services while Medicare services are delivered on a fee-for-service basis. This arrangement broadens the range of contractors available to Medicaid. Dually eligible beneficiaries could be required to enroll in the program for Medicaid services, but dually eligible beneficiaries would retain the right to use any qualified Medicare provider, so consumer incentives, enrollment counseling and member orientation and education would all need to stress the importance of using network providers to maximize coordination of care.

There are two constraints facing MCOs in this model. Beneficiaries may use Medicare providers that are part of the MCO's network but the providers can bill Medicare fee for service. Providers may not follow MCO procedures for prior authorization, reporting and care coordination. Incentives to shift costs continue and the extent of actual coordination depends upon the philosophy and willingness of network providers to coordinate care. When beneficiaries do receive services from out-of-network

providers, coordination depends on the cooperation of providers who are reimbursed fee for service by Medicare and have no affiliation with the MCO. If the provider has affiliations with other MCOs, but not the one selected by the beneficiaries for Medicaid services, additional complications may emerge that reflect local markets and HMO-provider relationships.

Table 9 summarizes and compares the arrangements discussed above.

Table 9. Comparison of Integration Arrangements

Arrangement	Examples	Advantages	Concerns
1. Medicare Risk Contractors with Medicaid Contracts:			
A. Standard Contractors (Medicare HMOs and Others*)	Arizona, Colorado, Florida, Oregon, Texas	Medicare capitation possible without Medicare waiver; builds on existing networks; may be cost effective for states.	Medicare contractors may not want to contract with Medicaid or incur risk for long term care.
B. Medicare Demonstration Programs	Medicare Choices Demo; PACE**, Social HMOs, EverCare	Choices Demo may provide more flexibility; PACE, S/HMO and EverCare have experience with LTC users.	Demonstration programs may not be available; target population may too narrow (e.g., nursing home eligible).
2. Medicaid MCOs with Capitated Medicare via Waiver			
A. Traditional MCOs	Minnesota (MSHO)	Allows broader choice of MCOs. Uses providers with experience serving Medicaid beneficiaries. Medicare capitation and 30 day lock-in possible.	Requires Medicare waiver.
B. Community based organization with HMO/health care subcontracts	Wisconsin Partnership	Builds on LTC/ social model experience of community based agencies.	Requires strong relationship with health care partners. Better suited to nursing home eligible population. Requires Medicare waiver.
3. Medicaid MCOs coordinating with FFS Medicare	Arizona, Oregon	Allows broader choice of MCOs. Uses providers with experience serving Medicaid beneficiaries.	Medicare remains fee for service, which may promote cost shifting; integration may not be possible.

*Under provisions in the federal Balanced Budget Act of 1997,PSOs, PPOs and other entities are expected to qualify as standard Medicare risk contractors.
**PACE is expected to become a permanent option under the federal Balanced Budget Act of 1997.

D-2. Waiver Options

Note: As this document was going to print, the Balanced Budget Act of 1997 was moving toward swift enactment in the Congress. The following waiver analysis is based on current law as of July, 1997, which is likely to change significantly with passage of the budget agreement. We have attempted to indicate where current law is likely to change.

Medicare Waivers

1. Section 222

This limited Medicare waiver authority focuses on tests of new reimbursement or payment methodologies. It can be used to craft capitated Medicare payments to entities not otherwise contracting with Medicare, or to change the payment methodology for entities, such as Medicare HMOs, that already receive capitated Medicare payments. Minnesota has used a section 222 waiver for both purposes: it contracts with some entities that do not otherwise have Medicare risk contracts, and it negotiated Medicare payments with HCFA that vary from the standard AAPCC methodology. Although the HMO contractor in Colorado Integrated Care and Financing Project is a Medicare contractor, a 222 waiver was needed because the program will test an alternative to the AAPCC payment methodology.

HCFA cannot waive Medicare beneficiaries' freedom to choose their Medicare providers. Beneficiaries voluntarily enrolling in a Medicare risk plan must utilize network providers for the month in which their enrollment is effective but they may disenroll at any time for future periods.

Section 222 waivers may be used in combination with Medicaid waivers to capitate financing from both programs to a single MCO to create the financial flexibility and incentive to authorize the most appropriate and cost effective mix of services.

Medicaid Waivers

1. No Waiver Needed: Prepaid Health Plans

To date, without a waiver, states have had limited authority to capitate some but not all Medicaid services. Hospital inpatient and outpatient care, lab and x-ray services may not be included in the capitation payment. Physician services, ancillary services and long term care services may be included. Waivers are not required if the program is voluntary and the contracting plans meet the composition requirement (25% non-Medicare/Medicaid). The federal Balanced Budget Act of 1997 would expand the possibilities for Medicaid managed care without waivers. States will apparently be able

to craft fully capitated plans by filing amendments to their state Medicaid plans, but the circumstances under which a state plan amendment will be sufficient are not clear at this time.

2. Section 1915(b) Waivers: Freedom of Choice

Section 1915(b) waivers allow states to implement mandatory Medicaid managed care programs which waive three primary requirements: beneficiaries' right to select Medicaid providers, comparability of services, and statewideness (all services must be available throughout the entire state). States can develop programs in particular geographic areas that provide health benefits that differ from the regular Medicaid program. These waivers allow states to require enrollment in primary care case management or gatekeeper programs, health maintenance organizations or prepaid health plans.

Federal guidelines require that beneficiaries have a choice of at least two plans, which may include a primary care case management option. Programs may include a six month lock in and a six month guarantee of eligibility. Section 1915(b) waivers are issued for two years and the program must be cost effective in each year of the waiver, that is expenditures under the waiver may not exceed expenditures that would have been made in the absence of the waiver.

This waiver may be used to construct programs for dually eligible beneficiaries that are mandatory as to Medicaid benefits only. Dually eligible beneficiaries always retain the right to receive Medicare benefits on a fee-for-service basis. While the Balanced Budget Act of 1997 allows states to construct mandatory Medicaid managed care programs without waivers (as amendments to their state plans), dually eligible beneficiaries are specifically exempted from the new state plan option. Therefore, states will continue to require waivers for mandatory Medicaid managed care programs that include dually eligible beneficiaries.

3. Section 1915(c) Waivers: Home and Community Based Services.

These waivers are very familiar to states operating home care programs. They allow states to fund Medicaid services that allow beneficiaries an alternative to placement in a nursing facility. In addition to covering services which are not considered "medical" or are not covered by as a state plan service, states may waive comparability, statewideness, community income and resource rules and rules requiring coverage of all eligible applicants. The latter provisions allow states to limit the amount of funds that will be spent on services.

The waiver process has been streamlined and allows states to develop a capitation payment for home and community based services for nursing home eligible beneficiaries. It also allows states to use the special income level for beneficiaries whose income exceeds the traditional Medicaid eligibility level. It targets the most

costly population and is particularly helpful for serving people whose income exceeds Medicaid levels but who are likely to enter a nursing home and spend down. The 1915(c) waivers allow states to retain the special income level, up to 300% of the federal SSI benefit and the spousal impoverishment provisions for eligible beneficiaries, options not available under 1915(b) waivers. At least one state, Texas, has applied for both 1915(b) and (c) waivers to combine the long term care flexibility of (c) with the mandatory Medicaid feature of (b).

4. Section 1115: Research and Demonstration Waivers

Section 1115 offers states the broadest authority to test new approaches. The section allows states to implement mandatory managed care programs and waive federal requirements for eligibility, services (non-Medicaid long term care services may be included), comparability (amount, duration and scope of benefits), plan composition, statewideness and uniformity, freedom of choice, retroactive eligibility, cost sharing arrangements, asset limitations, deeming of income, HMO enrollment composition; and other areas.

1115 waivers are approved for five years and the waiver must be cost effective over the five year period rather than in each year of the demonstration. The cost neutrality formula measures the impact of the demonstration on all eligible beneficiaries, participating and non-participating, in the demonstration area. HCFA is responsible for contracting for an independent evaluation.

Table 10 summarizes the circumstances under which states required waivers as of July, 1997.

Table 10. Features of Medicaid and Medicare Waivers as of July, 1997

	Medicaid 1915 (b)	Medicaid 1915 (c)	Medicaid 1115	Medicare 222
Eligibility rules	May NOT be waived.	MAY be waived.	MAY be waived.	May NOT be waived.
Benefit requirements	May NOT be reduced but plans may add services.	Services MAY be added.	MAY be waived.	May NOT be waived.
Freedom of choice	MAY be waived except for certain benefits (emergency services, family planning, FQHC services). Requires choice of at least two delivery systems; permits up to 6 month lock in for federal qualified HMOs (state qualified, one month).	May NOT be waived.	MAY be waived; permits limitation of choice to once delivery system; permits extended lock in.	May NOT be waived (but plans may receive 30 day lock in).
Federal standards for full risk managed care plans	May NOT be waived.	May NOT be waived.	MAY be waived	NA
Provider reimbursement rules	MAY be waived in limited circumstances.	May NOT be waived.	MAY be waived.	MAY be waived.
State administration requirements (eligibility determination, quality control)	MAY be waived in limited circumstances.	May NOT be waived.	MAY be waived.	NA
Composition	May NOT be waived.	May NOT be waived.	MAY be waived	May be waived.

Selecting Waiver Options

States may use one or more waivers implementing programs for dually eligible beneficiaries. Programs that contract with existing Medicare risk or demonstration programs do not need waivers under section 222 to capitate Medicare payments, as long as they are willing to accept the standard AAPCC methodology. However, states may wish to broaden the pool of MCOs to include both Medicare risk contractors and other organizations that do not contract with HCFA under current programs. In some areas of the country, the Medicare payment methodology may not provide adequate

funding for program seeking to maintain very impaired beneficiaries in community settings. Section 222 waivers may be sought to propose a different payment methodology.

Partial capitation approaches, using the prepaid health plan option, may be used to establish or phase in a program. Wisconsin provided partial capitation payments to a large community based organization to initiate the Partnership Program, an approach originally developed for pre-PACE sites. This approach is easier to implement and takes less time than a more extensive waiver. It has helped Wisconsin start enrollment while a more comprehensive combination of 1115 and 222 waivers was being reviewed. While hospital, lab and x-ray services are billed fee for service, the Wisconsin has included incentives to manage fee for service utilization. Partnership plans are financially responsible for meeting performance targets for each service that is outside the capitation payment. The targets are based on historical fee for service expenditures. Utilization exceeding the targets can result in financial penalties.

1915 (c) waivers offer states an opportunity to add community based long term care services to MCOs with existing Medicare or Medicaid risk contracts. Florida is preparing to implement an integrated model using a 1915(c) waiver contracting with Medicare HMOs in selected counties. Participation is Florida will be voluntary.

To date, most states have used Section 1115 waivers to serve dually eligible beneficiaries. Though states request 1115 waivers for many reasons, the most common affecting dually eligible beneficiaries is a waiver of composition requirements, allowing states to contract with Medicaid plans that have little or no commercial enrollment.

Table 11. Medicare/Medicaid Arrangements and Waivers in Selected Programs

Program	Waivers	
	Medicaid	Medicare
Arizona Long Term Care System	1115	None
Colorado Integrated Care and Financing Project	1115	222
Florida	1915 (c)	None
MaineNet	1115 pending	Being considered
Minnesota Senior Health Options	1115	222
Oregon Health Plan	1115	None
PACE	1115	222
Texas Star+PLUS	1915 (b) and (c) pending	None

E. Conclusion

This is a time of change and opportunity for states wishing to integrate acute and long term care for dually eligible beneficiaries. The Robert Wood Johnson Foundation and the Health Care Financing Administration have both committed resources to improving care for dually eligible beneficiaries, and the early experience of existing demonstrations is beginning to provide valuable information for the next round of experiments.

Changes to Medicare and Medicaid in the federal Balanced Budget Act of 1997 are likely to expand the number of vehicles available to states as they contemplate integration projects. Provider sponsored organizations (PSOs), preferred provider organizations (PPOs) and others will qualify for Medicare risk contracts, Medicare's 50/50 composition rule will be replaced with enhanced quality standards, and Medicare payments based on the AAPCC will gradually make rural and other low payment areas more attractive to MCOs. In Medicaid, certain managed care plans that previously required waivers will not require them in the future, though any managed care program targeted to dually eligible beneficiaries will almost certainly continue to require waivers.

Changes in federal policy may open new options for dually eligible beneficiaries, but they will not make integration any easier to accomplish at the program level. States still need to break integration into its component parts and pay attention to each component, whether or not waivers are needed. Integration calls for nothing less than reinvention of care delivery, which will take strong leadership from both states and HCFA.

The array of new possibilities reinforces the importance of goal setting. Once a state has clear goals for its integrated program, it can choose from among a growing set of possible vehicles. Absent clear goals, choosing vehicles will become more confusing as the possibilities multiply.

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