

Bringing Managed Care Home to the Long-Term Care Population

Managed care has been proposed as a solution to the problems facing long-term care: its high costs, bias towards nursing homes, lack of coordination with acute and primary care, and inflexible service delivery. Kodner and Kyriacou (2003) argue that home care agencies may have considerable advantages in creating managed care systems for this population over traditional managed care organizations because of the experience home care organizations have in caring for older adults as well as people with disabilities. Although home care agencies are likely to better understand the needs of the long-term care population, they may lack the expertise and organizational resources to develop successful managed care organizations. Addressing these deficiencies will be key in order for home care organizations to successfully operate as managed care providers.

Providing long-term care (LTC) to people with chronic, disabling conditions presents a challenge to the health care system, due to the unpredictable, complex, and costly nature of this type of care. Managed care and home care are both commonly discussed “solutions” to LTC. This brief summarizes an article by Kodner and Kyriacou (2003) that proposes a combination of managed care and home care as a workable solution, whereby home care organizations (HCOs) would act as managed care organizations (MCOs) for the LTC population.

Combining managed care and home care to provide better LTC

Home care—including carrying out treatment regimens, preventing and dealing with medical crises, and teaching people to cope with disease progression and dependency—is an increasingly important part of LTC because it allows individuals with chronic, disabling conditions to remain in their own homes. Traditional MCOs focus on acute and primary care and, thus, are likely to have a limited understanding of these needs. HCOs, which are organized around the idea of a continuum of health, offering supportive services, and focusing on partnering with family caregivers, are likely to be more suitable providers to the chronic care population. Moreover, with more than 20,000 HCOs throughout the country, a “critical mass” potentially exists nationwide to develop and operate managed chronic care programs. The pros and cons of HCOs becoming MCOs are shown in Table 1.

TABLE 1. PROS AND CONS OF HOME CARE ORGANIZATIONS SERVING AS MANAGED CARE ORGANIZATIONS

Characteristic	PRO	CON
<i>Consumer needs and preferences</i>	<ul style="list-style-type: none"> • A consumer-centric, “at home” focus is best suited to the nature and trajectory of chronic, disabling conditions • HCOs are familiar with frail older adults, as well as the needs of other target populations • Clients prefer care at home over institutional care • HCOs have a holistic orientation to clients’ need 	<ul style="list-style-type: none"> • Consumers may not perceive home care agencies as full-service or comprehensive health care providers, nor may consumers be comfortable with this role • HCOs lack in-depth acute-oriented medical know-how
<i>Service delivery</i>	<ul style="list-style-type: none"> • HCOs are community-based and community-focused • HCOs have the ability to serve different populations (e.g., by age, disability level, and condition) under one service umbrella • HCOs are oriented to post-acute and transitional care (e.g., between functional states, service levels, settings, and care packages) • HCOs are familiar with interdisciplinary/multi-disciplinary team care • HCOs are equipped with case/care management and disease management capabilities • HCOs are experienced in the delivery of flexible, personalized services • HCOs are skilled in working with families and informal caregivers 	<ul style="list-style-type: none"> • HCOs lack sophisticated organizational, administrative, and financial infrastructures • HCOs have tenuous links with primary care physicians and medical specialists • HCOs are less than optimally connected with institutional providers in acute, LTC and other sectors • HCOs lack medical leadership and management capabilities
<i>Policy</i>	<ul style="list-style-type: none"> • HCOs offer the opportunity to tap into existing home care pools, thus potentially minimizing problems related to enrollment build-up • HCOs offer a greater potential for widespread replication, possibly with lower overall cost to the health care system 	<ul style="list-style-type: none"> • HCOs are not known for openness to change, nor for their organizational/system transformation abilities • A shift to managed care services could adversely affect access to traditional home care services

Succeeding in managed care would require overcoming obstacles

Although there are many reasons why HCOs would make effective MCOs, HCOs would also face some significant challenges.

- 1) **HCOs lack a culture of innovation** – While HCOs may be increasingly open to program expansion and new service delivery and clinical approaches, for the most part they have not created new business models or developed integrated systems of care under a market-driven system. Two reasons for the lack of widespread innovation are:
 - In an environment of chronic staffing shortages, constrained reimbursement, and ever-increasing regulatory demands, HCOs focus on protecting and promoting their core services.
 - Non-profit HCOs often see a conflict between traditional home care values based on professionalism and community service and the emerging commercialism associated with managed care.
- 2) **HCOs have little or no internal capacity for medical management** – Fostering a strong primary care role, encouraging physician involvement, and marshalling expertise in medical management are *musts* for the development of MCOs, yet HCOs' traditional relationships with primary and acute care are limited to building referrals and facilitating discharge planning. Ongoing coordination with physicians is not common. In addition, there are few incentives to encourage physician involvement; physicians do not receive reimbursement for comprehensive in-home assessments or for working with home care teams to develop home care plans.
- 3) **HCOs lack managed care readiness and infrastructure** – Successful managed chronic care programs require managed care expertise in areas that are not HCOs' strengths, including marketing, rate development, service networking,

contracting, coordinated service delivery, and medical and utilization management. Furthermore, HCOs must be prepared to manage care on a capitated basis—ensuring that, on average, the cost of care per individual is kept within the capitation amount. An integrated information system is also critical to key managed care activities, such as enrollment, patient tracking, service monitoring, utilization control, quality assurance, and financial management. Most HCO information systems are relatively unsophisticated and would require major capital investments in order to make them viable for an MCO.

- 4) **Managed care is financially risky; start-up costs are high** – Managed chronic care programs are expensive to develop and can place their sponsors at substantial financial risk (see Side Bar).

On the other hand, HCOs could benefit from their ready access to potential enrollees and familiarity with the service delivery environment. Costs might also be minimized for HCOs that pursue a partially capitated/integrated model.

The Costs of Managed LTC

- **VNS CHOICE**, an HCO-managed MCO, spent between \$1 and \$2 million on programmatic and infrastructure development.
- In addition to other start-up costs, initial **Program for All-Inclusive Care for the Elderly (PACE)** sites needed approximately \$15 million in capital to fund the requisite adult day health center.
- **Elderplan**, one of the original Social HMOs, lost approximately \$11 million in the first three years of operation (1985-1988). Although this shortfall was heavily subsidized by the federal and state governments, Elderplan was responsible for several million dollars.

Financial needs, however, would still be great. With the exception of the largest HCOs, most agencies would need generous external funding or sponsorship.

- 5) **HCOs face bureaucratic and regulatory hurdles** – Implementing an HCO-run MCO is likely to be slow, convoluted, and costly. Start-up tasks include obtaining government approvals and contracts, negotiating reimbursement rates, awaiting final regulations, and dealing with the other vagaries of program implementation (often involving more than one government agency). Other problems include bureaucratic inertia, goal displacement, shifting priorities, and lack of sensitivity to provider concerns. Moreover, provider expectations at the financial, operational, and clinical levels may not match resulting regulatory requirements and funding levels. The need for Medicare waivers (in the case of fully capitated/integrated programs) from

the federal government only adds to the bureaucratic entanglement.

- 6) **HCOs face challenges in integrating a consumer-directed approach with managed care** – The consumer direction movement, which aims to give healthcare recipients more control over the services they receive, seems in conflict with the equally strong trend toward managed care, which entails more managerial control. The two movements can be seen as compatible; for example, both the medical and home care fields are seeing the value of strong consumer-professional relationships, and physicians increasingly understand the importance of encouraging self-care for people with chronic conditions. Moreover, the integration of client expectations and goals (and, when appropriate, those of family members) with the evaluations of professional team members can lead to care plans that all parties—consumers, providers, and

Mechanisms for Integrating Managed Care and Consumer-Directed Care

HCOs can:

- Use value-driven assessment tools, such as the Canadian Occupational Performance Measure (COPM), to assist clients and family caregivers in articulating problems and goals from their own personal perspectives.
- Promote consumer choice by allowing clients to select needed services from within a network and use payment mechanisms that make providers more responsive, such as vouchers or the cashing-out of benefits.
- Provide information and educational services to help consumers make informed decisions about services.
- Educate clients and their families about patient rights, program policies and procedures, care needs and service options, and treatment alternatives, risks and outcomes.
- Support clients' ability to oversee their own affairs and select providers who value client empowerment.
- Offer training to staff and providers to increase understanding of, and sensitivity to, consumers.
- Share program “ownership” with clients by, for example, having clients participate in an HCO's governing body and/or committee or integrating consumers into the quality improvement process through structured feedback mechanisms, ongoing client and family surveys, and an accessible and secure grievance process.



payers—can embrace. A variety of approaches and techniques exist that could help merge these two approaches (see Side Bar).

There are promising strategies for encouraging HCO-run managed care programs

Sponsors of HCO-managed chronic care programs need targeted incentives to encourage them to function efficiently and effectively.

Policymakers should encourage:

- **Partially capitated models** – These models are likely to be more feasible for HCOs to develop than fully capitated models, because the services provided more closely match those traditionally provided by HCOs. In addition, partial capitation is usually less complicated and costly.
- **Flexible organizational models** – Policymakers could reduce the administrative hurdles of developing an HCO-managed chronic care program. Moreover, HCOs should be able to choose from a range of managed care models including:
 - 1) those that consolidate all services under a capitated model within a single delivery system, 2) network arrangements whereby providers attempt to coordinate services across the entire continuum of care, and 3) models where HCOs develop a LTC integrated delivery system by partnering with other community- and institution-based providers and then contracting with a medical HMO or hospital-based integrated delivery system.
- **Creative reimbursement methods** – Other methods to address the financial burden of developing managed care include:
 - 1) recoupment of capital costs for program development, 2) step-down of appropriate HCO administrative overhead, 3) enhanced capitation for a specified start-up period, 4) use of temporary or permanent carve-outs, and 5) allowing a mix of capitation and fee-for-service payment arrangements.

Permitting other community health care organizations (e.g., local hospitals) to co-guarantee reserves could also help, as might mechanisms to speed up the enrollment/accretion and payment processes.

- **Connections with the medical system** – State governments can facilitate medical integration efforts. For example, a state health department can actively encourage the medical community to work collaboratively with MCOs. States can also encourage medical risk and reward systems (as used by conventional HMOs), medical case management fees, nurse practitioners and clinical nurse specialists serving as medical adjuncts or liaisons, the integration of data information systems, institutionally-endorsed clinical guidelines and protocols, and disease management programs.
- **Support for the managed care workforce** – Home care administrators, managers and clinical caregivers need to be educated about the requirements of serving people with LTC needs. There is the additional challenge of the profound industry-wide labor shortage, particularly among nurses. Short-term solutions include greater involvement of nurses' aides and informal caregivers, increased selectivity in the use of nurses, and increased use of technologies (such as palm pilots and telemedicine).

Combining managed care and home care would provide positive benefits to the LTC population

HCOs offer distinct advantages as operators of managed care systems. Most important among these advantages is their experience with the LTC population and the many complex issues associated with caring for it. As HCOs consider moving in this direction, the following three points are important to keep in mind:

- 1) HCOs need to be supported in their efforts to develop MCOs for older adults and people with chronic or disabling conditions.

- 2) HCOs can themselves take steps that will improve their ability to operate an MCO. These include efforts to foster a more entrepreneurial approach to home care, develop better relationships with primary and acute care providers, and make strategic changes to their operation and infrastructure.
- 3) Policymakers can take steps to encourage the development of MCOs by HCOs by establishing creative reimbursement strategies to ease the burden of start-up costs, providing the ability for HCOs to choose from a variety of managed care models, and finding ways to support the home care workforce.

References

Kodner, D.L., & Kyriacou, C.K. (2003). Bringing managed care home to people with chronic disabling conditions: Prospects and challenges for policy, practice and research. *Journal of Aging and Health*, 15(1): 189-222.

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