
Managed Care and Long-Term Care: A Potential Solution?

This brief summarizes research by Sparer (2003) and Hughes (2002) on managed care issues for people with long-term care needs. Managed care has been proposed as a solution to the difficult problem of managing the health of this complex population. Sparer's research examines the reasons behind the failure of states' attempts to encourage commercial managed care plans to take on this task. He argues that understanding these reasons can yield important lessons for the mostly provider-sponsored plans that currently serve the long-term care population, as well as for states, that aim to save money and better serve this population. Hughes' evaluation of a small, provider-sponsored organization found that when the organization became a managed care provider, it faced significant organizational challenges that forced it to become more efficient. Importantly, it showed that the use of capitation reimbursed the plan more effectively than fee for service, increased the range of services provided to clients, and maintained client satisfaction; however, capitation did not affect the rate of nursing home admission.

People with long-term care needs pose a challenge to the health system

The research of Sparer and Hughes addresses a fundamental problem: the difficulty of serving individuals with long-term (LTC) needs, who often have multiple and complex health conditions that require daily oversight. The fragmentation of the health care system in the United States makes it difficult to serve them well. Members of this group are also expensive to serve, particularly when they live in nursing homes. States and providers have been searching for more cost-effective ways to care for this population.

Managed care is a possible solution for LTC

Managed LTC (MLTC) has the potential to benefit the LTC system by:

- Organizing a disorganized and fragmented delivery system;
- Replacing the nursing home bias with an emphasis on home- and community-based services (HCBS); and,
- Stabilizing rising costs.

MLTC also has the potential to add competition to the LTC market, increasing choice for consumers and creating incentives for health plans to better serve consumers.

Potential Benefits of Managed Long-Term Care

- **Constrain costs through:**
 - Systems-level interventions (e.g., bulk purchasing)
 - Individual-level interventions (e.g., substituting more expensive nursing home care with HCBS)
 - Competition among providers
- **Improve coordination of care and continuity of care through:**
 - Care coordination techniques such as interdisciplinary care teams
 - Information sharing among providers
- **Enhance the clinical appropriateness of care through:**
 - Prevention
 - Systematic use of guidelines, protocols
 - Enhanced flexibility
 - Better information
- **Provide plans with the capacity and responsibility to assess outcomes for defined populations**
- **Encourage the development of new services and providers because of managed care's ability to purchase services outside the typical Medicaid benefit package**

The history of commercial plans serving the Medicaid population is not encouraging

Sparer (2003) observes that states interested in MLTC have looked to commercial managed care plans because of their experience in making changes in the organization and delivery of health. The exit of so many commercial health plans from the traditional Medicaid program, however, calls into question the feasibility of commercial plans for serving the LTC population.

During the late 1980s and early 1990s Medicaid managed care seemed to be a promising solution to the dramatic increases in Medicaid program costs, which were growing at a rate of 25-30 percent annually. States that looked to commercial managed care, however, soon found that:

- *Medicaid managed care increased, rather than reduced or simplified, the tasks performed by government, including setting capitation rates, measuring plan performance, supervising marketing and enrollment, educating beneficiaries, and regulating an increasingly complicated market.*
- *Commercial plans often relied on the same “safety net” of health care providers already serving the Medicaid population, rather than encouraging the development of new service providers. It had been hoped that managed care would attract sorely needed provider infrastructure—particularly primary care providers—to low-income communities.*
- *The focus on the young and the healthy minimized the potential cost savings. The most costly populations—the aged and the disabled—were generally excluded from the initiatives, as was the fastest-growing component of the Medicaid benefit package, namely LTC services.*
- *The plans themselves saw disadvantages in serving the Medicaid population. Commercial plans, many of which were suffering losses in their core commercial business, did not want to take on the additional losses they were taking on with their Medicaid clients. The fact that government spending patterns seemed unpredictable and its regulatory oversight seemed arbitrary were additional negatives.*

By the late 1990s, commercial health plans were reducing their participation in the Medicaid market. States came to rely on provider-sponsored plans, of which many communities have only one or two. Typically, these plans serve only the Medicaid (and other public insurance) market and would be bankrupt shells without their Medicaid enrollees. The role of states shifted from prudent purchaser to cooperative partner with the

provider plans, raising capitation rates (though not enough to entice the commercial plans back into the market), consulting with plan officials on program changes, and collaborating on regulatory approaches.

The factors that have prompted the commercial plans to exit from the primary and acute care markets are equally relevant in the LTC arena. Therefore, it is not clear whether commercial health plans would be willing or able to serve the LTC population. These plans may not have experience with providing LTC, nor might they understand the needs of the LTC population.

Consequently plans that attempt to serve the LTC population may focus resources on acute care rather than LTC services, possibly shortchanging people with LTC needs.

Models of Managed LTC

- **Social Health Maintenance Organizations (SHMOs) - Add a limited LTC benefit to a commercial health insurance package, enrolling both healthy and disabled persons needing LTC**
- **Fully integrated programs - Provide and capitate all Medicare and Medicaid services, including a rich package of LTC benefits, to nursing-home eligible individuals. Programs include PACE and Minnesota Senior Health Options**
- **Partially capitated programs - Provide and capitate only some services. These include the Wisconsin Family Care program**

Non-profit plans have emerged as the most promising providers of MLTC

Sparer reviews a number of MLTC efforts, which vary considerably in their design (see Side Bar), to find that

the majority of successful efforts rely on non-profit, mostly provider-sponsored plans rather than commercial managed care plans:

- Federal and state policymakers continue to promote the non-profit **Program for All-inclusive Care for the Elderly (PACE)** despite its limited enrollment. The limited enrollment may be a result of PACE's use of a closed panel of providers and its reliance on adult day centers for service delivery—a lack of choice typical of commercial plans.
- The **Social Health Maintenance Organization (Social HMO)** demonstration, which pays commercial health plans an enhanced capitation rate to cover a modest HCBS benefit for Medicare enrollees, has not been successful in improving service delivery.
- Florida's **Community Diversion Project**, which aims to use commercial plans to provide acute and LTC services to frail elderly Medicaid beneficiaries, has had difficulty attracting interest from commercial plans.
- Minnesota's **Senior Health Options** program uses three non-profit health plans to provide a full range of services, including LTC, to older adults in ten counties.
- The **FamilyCare Program** in Wisconsin switched from its initial reliance on commercial plans (in the design stage) to a successfully implemented MLTC program that uses county-run organizations to provide MLTC (though plans to phase in commercial plan competition remain intact).
- The number of fee-for-service primary care case management (PCCM) programs, under which states pay a primary care provider a monthly fee to manage client care, continues to grow. Such programs aim to achieve the goals of managed care (primarily, coordinated care) without capitation.

However, some programs continue to focus on the use of commercial plans:

- In Arizona, while the traditional Medicaid program moved away from using commercial plans, the leg-

islature mandated that the Medicaid program for the aged and disabled (the **Arizona Long Term Care System**) shift from using the county-led organizations that had been acting as managed care providers to using commercial plans.

- The **Texas Star+Plus** program requires elderly and disabled Medicaid beneficiaries residing in one Texas county to enroll in one of three plans (two commercial; one provider-sponsored) that provide a full range of acute, primary, and LTC services, though the nursing home benefit is limited to 120 days.

Sparer’s 2003 review raises a number of questions. First, can individual MLTC plans achieve the goals that policymakers have set for them? Currently, there is limited evidence available to address this question. Second, if non-profits are the best hope for MLTC, what issues do these organizations face when attempting to provide MLTC?

An evaluation of a non-profit MLTC plan found promising results

Hughes attempted to answer these questions by studying a capitated MLTC run by a provider-sponsored plan. The **Managed Community Care Program** (MCCP) demonstration, which took place from 1995-1998, provided capitated payment for an enriched package of LTC services (see Side Bar) provided by the non-profit Council for the Jewish Elderly (CJE), which serves a Chicago neighborhood. The target population for the demonstration was frail and low income community dwelling older adults who were at risk of nursing home placement and eligible for the Illinois’ Community Care Program.

The study encompassed both an implementation/process analysis and an outcomes assessment of 752 enrollees over the three years of the demonstration. The implementation/process analysis found that the tasks associated with setting up and

running a managed care entity—contracting with the state and negotiating a capitation contract for providing care within a managed care context—constituted a significant challenge. In addition, the demonstration revealed benefits in terms of capitation, care management, and outcomes.

In their search to find appropriate and cost-effective ways of serving the LTC population, policymakers have turned to managed care in the hope that it can help solve some of the seemingly intractable problems associated with LTC: the lack of care coordination, the high cost of services, an inadequate infrastructure, and an over reliance on nursing homes. Although policymakers have looked to commercial managed care plans to step in, the history of commercial plans that have provided care for

The Managed Community Care Program

Services under fee-for-service:

- **Adult day**
- **Homemaker/chore**
- **Money management**

Additional services provided under capitation through the demonstration:

- **Benefits Eligibility Check-up, a program that checks client eligibility for a variety of publicly funded benefits**
- **Care management**
- **Home delivered meals**
- **Home maintenance and repairs**
- **Information and referral**
- **Light meal preparation and laundry**
- **Medication monitoring**
- **Personal care**
- **Social activities**
- **Transportation**
- **Additional social programs and services through the Neighborhood Resource Center**

Table 1. Demonstration Illustrates Benefits of MLTC

Capitation:

- To negotiate an adequate capitation amount, the agency needed to develop a fuller understanding of the unit costs of service delivery and, in order to do so, had to develop a new cost-accounting system.
- The new understanding of costs led to experiments with resource-management strategies:
 - The cost-accounting system allowed managers to identify client outliers and better target services.
 - The agency tested the use of more telephone time with clients as an alternative to in-home visits.
 - A geographic review of clients prompted a clustering plan that was ultimately adopted. It assigned teams of in-home personal care workers and case managers to multi-unit dwellings and to specific areas of the city.

Care Management:

- Care managers had to adjust to their new role as gatekeepers who were responsible for approving care plans in addition to their usual role as client advocates.
- The new responsibility for care planning led to the development of clinical pathways, assessment tools, and decision trees, as well as the formation of case management strategy groups for special populations.

Outcomes:

- As a result of efficiencies in management attributable to capitation, the agency's deficit was reduced from \$100 per person under customary fee-for-service (FFS) to \$50 per person under MLTC.
- MLTC was more efficient for billing.
- MLTC allowed the agency to reduce the fixed deductible charged for services, making services more affordable for clients.
- Satisfaction with care at 12 months remained stable among clients who converted from FFS to MLTC.
- When matched to comparable FFS clients, MLTC enrollees had the same level of discharge to nursing homes.

publicly-funded programs does not bode well for the LTC population. Sparer outlines this history, and notes that LTC policymakers continue to seek the involvement of commercial plans, even though the most promising MLTC efforts are non-profit, mainly

provider-sponsored plans. Hughes provides evidence on the experience of one such provider-sponsored plan; outlines some of the key issues the plan faced; and presents results that show that managed care has benefited the agency while keeping client outcomes stable.

Policy implications for managed care and the LTC population

- Managed care is an attractive option for agencies that aim to improve service delivery to people needing LTC.
- Commercial managed care plans are not promising as potential providers in this market, despite continued policymaker interest.
- Non-profit, mainly provider-sponsored plans appear to hold the most potential.
- Non-profit providers face significant organizational challenges in instituting and implementing MLTC.
- Outcomes for people receiving MLTC appear to be at least as good as under fee-for-service.

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