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Integration of Health and Long Term Care Services: A Cure in Search of an Illness?

Today, states are considering a number of schemes for the integration of health and long-term care services. This integration would take place under a managed care umbrella where health and long-term care dollars would be packaged and sent together in a bundle to a managed care entity. This organization would globally manage care delivery.

These integration proposals would fold long-term supports for elderly, people with developmental disabilities and other disabilities under large managed care entities (MCEs) . Most envision build outs of existing managed health care entities that would be more broadly charged with managing long term services and supports in addition to health care both for the general population and for disabled subpopulations. Others envision the MCEs as creations of other organizations, public and private. Under these cross-population arrangements, developmental [1] disabilities support networks that now stand alone would become subspecialty branches of bigger care delivery systems.

The belief is that consolidating currently disjointed service systems under MCEs will save money by enabling states to reduce administrative costs. Service

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costs are expected to be lowered by cutting out duplication and improving "care coordination". Substituting more generic for present day standalone, population-based systems might also promote more "equitable" distribution of resources.

Some policy-makers perceive the current distribution of resources among populations to be less than equitable, and see this cross-population approach as an attractive, politically distant (safe) mechanism through which to effect a redistribution.[1]

Advocates for the specialized needs of vulnerable populations with chronic disabling conditions (e.g. persons with brain and spinal cord injuries) worry that with cross-population MCEs the needs of these populations will suffer. They worry that narrow, rigid "medical necessity" criteria will be used to cut back the types of services and supports that would be provided. Advocates for persons with developmental disabilities in particular worry that because services for this population consume 10 percent or more of the typical state's Medicaid budget even though the number of individuals involved is very small (about 1-2% of all recipients) (Smith and Gettings, 1993), they will be perceived as over-funded and stand a good chance of losing funds as part of any redistribution—this, in spite of growing waiting lists of persons with developmental disabilities for long term services and supports in most states.

[1] Others object. Their view is that the rationing of public funds among constituent populations in need is intrinsically a political, policy-making responsibility, not a responsibility to be contracted out to system management entities.

Advocates for persons with developmental disabilities worry that the not-so-hidden agenda with integration is to dilute the "voice of the retarded" and other persons with developmental disabilities. They worry that with the sizable loss of Medicaid Disproportionate Share funds, hospitals are on the prowl for replacement funds, developmental disabilities funds among them.

These concerns and others have led many advocates and providers representing the interests of the developmental disabilities community to oppose the generic integration models. Instead they argue for integration models at the "subpopulation" level (e.g., pulling together health and long-term supports in a specialized way just for people with developmental disabilities under a single umbrella organization (Malloy, 1995; Bachman, Burwell et al, 1997). Still others, unpersuaded as to the benefits of integration period, argue for simple health care coordination models.

This paper looks at what little we know about the utility of these three options--a) cross-population integration, b) special-population integration and c) care coordination—from the standpoint of the three rationales commonly advanced for integration, describes the status of known integration initiatives in different states and offers a word of caution. The three rationales for the integration of health and long term care under single managed care entities are:

- ✓ **Improved care coordination and system efficiencies**. Tying health and long-term care dollars together

is expected to result in improved care coordination and thereby create more incentives to minimize the use of expensive institutional and hospital care. The typical case in point is where disabled "patients remain unnecessarily in expensive acute care hospitals because nursing home or home care services are not immediately obtainable, appropriate follow-up physician care cannot be arranged, or financing for long term care is not available" (Weiner, 1996, p. 7). It is reasoned that care coordinators within integrated systems would act to bridge health and long term supports. Moreover, if dollars are packaged together, financial barriers to securing appropriate services would be overcome.

✓ **Stem cost shifting**. It is argued that so long as health and long term care services remain apart, the two systems will seek to shift expenses from one to the other. Health care systems will send people with significant care needs to the long-term care system to avoid the expense of serving them. Long-term care systems will exploit any and all openings in the health care system to shift services and expenses to those organizations. Cost shifting between Medicare and Medicaid is frequently cited as an example of how two disjointed programs behave in a fashion that leads to higher costs overall (and frequently inappropriate or inefficient care delivery). Such cost shifting also can occur within a state's Medicaid program.

✓ **Management and financial capacity**. Finally, the argument is advanced that by holding managed care entities accountable for providing the care needed while at the same time fixing the payments that the federal and state governments are obligated to provide for their care, government will save money. Competent managed care entities are seen as able to manage care delivery within these fixed budgets and to cover any costs of care that exceed the agreed payment—to assume the risk.

Care Coordination and System Efficiency

The notion that health care and long term care delivery systems can be made more efficient by integrating them under a managed health care entity is an intriguing idea, but one for which there is little substantiating evidence. Leutz (, p24, 1997) in his insightful review of health / long term care integration experiences in the United Kingdom and United States concludes that while " Full integration may be very effective and even efficient for a *few*, it is important that " while we are trying to identify who those few are, what they need, and how to provide and pay for their care, we should ensure that the *many* also get what they need." The *few* to which Dr. Leutz alludes are "the small numbers of persons with disabilities [who have] less stable medical and functional conditions and who need specialized types of interventions,

expedited access to them, and close collaboration between knowledgeable professionals." (Leutz p.8, 1997) The *many* to which he alludes are those persons who have "mild and moderate impairments as well as stable medical and functional conditions that are unlikely to become unstable and need urgent attention, . . . [who] may receive short-term or long-term specialized services but whose care is usually but not always routine." (Leutz p.8, 1997)

As Weiner observes, "the number of demonstrations of this concept are few, and the best known demonstrations, Social Health Maintenance Organizations (SHMOs), On Lok Program of All-inclusive Care of the Elderly (PACE) and the Arizona Long-term Care System (ALTCS) are inconclusive. Social HMOs do not appear to do better than conventional HMOs in reducing acute care expenditures. The very early evidence from ON Lok/PACE is more encouraging but the findings must be heavily qualified as they do not adjust for case mix and are based on a relatively small sample. The Arizona Long term Care System (ALTCS) program does appear to save money, but largely because it serves substantially fewer people than would be served under a conventional Medicaid Program." (Weiner, 1996, p. 2). In other words, most all of the savings are attributed to a reduction in the number served, not to greater system efficiency. Laguna Research Associates figures the ALTCS program saved 2% by serving 16% fewer people! At the same time, administrative costs rose significantly offsetting most of these savings (McCall et. al., 1993).

The jump in administrative costs is to be expected. The utilization management and prior authorization mechanisms characteristically used to control costs under managed care arrangements are labor intensive and require significant investments in sophisticated information and control systems. The administrative costs in Arizona's Health Care Cost Containment System (AHCCCS) were reported to be 8.2% of medical costs compared to 3.5% in traditional fee for service programs (Kaiser and Flinn Foundations, Dec. 2, 1995). The increase is explained by the need for additional administrative tasks integral to managed health care approaches, e.g. bidding process or capitation rates, eligibility determination and enrollment, program administration, management information systems and network management. As Kastner, Walsh and Criscione (1997) explain, state Medicaid systems currently operate with an overhead cost of 3%. This stands in sharp contrast to the 6 - 16% overhead costs of managed care entities—22 to 26% when profit is included. The authors view this as a major obstacle to the integration of long term services and supports for persons with developmental disabilities under managed health care entities.[2]

On the other hand, though the evidence is again sketchy, integrated managed care models for special, high-service-use populations appear to have more positive results than the integrated general, cross-population models due largely to improved care coordination. In Maryland, the Diabetes Care Program uses

[2] As do the authors of this paper!

specialized care managers to coordinate the care of persons with diabetes. This has reportedly improved care and resulted in a lowering of expenditures, fewer hospitalizations, reduced recidivism and fewer inpatient hospital stays among enrollees as compared to non-enrollees (Bachman and Burwell, 1997). In Massachusetts, lower expenditures, reduced recidivism and fewer inpatient hospital stays have been reported for two programs managed by the Community Medical Alliance, one for persons with late-stage AIDS and another for persons with chronic multiple handicaps (Master, Dreyfus, Connors, Zhou and Kronick, 1996). These programs feature nurse coordinators who work closely with primary care physicians to coordinate medical and social supports.

The advantages of integrated acute and long-term support systems with regard to services to persons who are elderly and frail, and to persons with chronic multiple physical disabilities are particularly evident in programs designed for special disability subpopulations. The demand for acute and long-term support services and supports by these persons is highly interdependent, and thus the integration of acute care and long-term supports within a capitated payment system can lead to more cost effective patterns of care by improving care coordination.

In the case of adults with developmental disabilities, this health / long term care interdependency applies to a very small subgroup. National data on acute care expenditures among people (mostly adults) with developmental disabilities under the Home and Community Based Waiver indicate that expenditures for acute care are a small fraction of expenditures for long-term supports--approximately 5% (Smith and Gettings, 1993). Though, as demonstrated in New Jersey, modest savings on the health care side are possible through improved health care coordination (Criscione, Walsh and Kastner, 1995), these savings pale in comparison to the savings possible within the developmental disabilities service sector alone—savings possible principally through the substitution of supported, non-facility based arrangements for comprehensive, facility-based arrangements. A recent comprehensive assessment of the savings possible through this type of restructuring in one state was in excess of $100 million or more than 10% of the state's annual budget over a five year period (Ashbaugh and Melda,1996). If one were to target priority areas for improving the efficiency (cost savings) of developmental disabilities care systems, the integration of health and long term care would be well down the list.

Already a number of states have health care coordination models in place. New Hampshire and Rhode Island have cadres of specially trained nurses employed by long term care providers to coordinate the health care of persons with developmental disabilities under their supervision (Ashbaugh and Fair, 1997). Still other states require the health plans themselves to designate advocates to help coordinate the medical services disabled beneficiaries receive General Accounting Office (1996). These states reportedly have been able to coordinate care and realize savings without having to integrate

the health care and long term care delivery through a single managed care organization.[3] In view of the need of many people with disabilities for specialty care, the limited experience of practitioners in most managed health care plans in dealing with enrollees with substantial handicaps and the widely reported practice of managed health care plans to discourage specialty referrals, care coordination models for subpopulations with special needs appear to make sense (Tobias and Master, 1997). Whether or not these models operate within or without an integrated MCE is inconsequential.

Stem Cost Shifting

A good deal of the impetus for integrated care models springs from what is termed the “dual eligible” population – individuals who are eligible both for Medicare and Medicaid benefits. There are major differences in the treatment of “long term care services” under the two programs. Medicare is more constricted than Medicaid. Medicare costs are held down by shifting individuals into Medicaid-funded long term care arrangements. Medicaid programs attempt to leverage what they can out of Medicare. The result is “cost shifting”.

About one in four people with developmental disabilities is a “dual eligible” (Office for Research and Statistics, 1991). In the rush toward integration, it is assumed that cost shifting occurs in this particular population group to the same extent it does among the frail elderly (who have been the targets of the various integrated care experiments that have been sponsored). However, the typical example of cost shifting is shuttling individuals out of Medicare institutional settings into Medicaid-financed nursing homes. For a variety of reasons (including the nursing home reform provisions contained in the federal OBRA ’87 legislation), there is little evidence that such shuttling is common. So, if the goal of integration is to stem this type of cost-shifting, any savings would likely be minuscule —at least insofar as people with developmental disabilities are concerned.

With respect to people with developmental disabilities, the more serious issues around cost shifting between health and long-term care are mainly internal to state Medicaid programs and not well understood. It is advantageous for developmental disabilities systems (which operate under fixed rather than open-ended budgets) to lay off costs to a state’s general purpose Medicaid program. Similarly, it can be advantageous for the Medicaid program to deny coverage based on the view that the service in question is (or ought to be) available through the developmental disabilities system. While Medicaid dollars fuel both systems, each strives to get the other to pay for services in order to meet its particular cost containment or budget management objectives. This jockeying – which mainly covers “gray area” benefits such as therapeutic services and durable medical equipment – is not sensible from a global perspective and certainly not in the interest of the individual.

[3] Actual savings have not been documented.

Hence, it can be argued that pulling all the relevant dollars together under a “single stream” funding approach could eliminate this problem. At best, however, this is an argument for integrating at the subpopulation rather than the cross-population level. Even at the subpopulation level, it is not entirely clear that there would be major savings and/or improved outcomes as a result of integration. The “gray area” services rarely make up a significant share of spending on behalf of people with developmental disabilities. Erecting a managed-care, integrated service delivery apparatus based on these issues seems akin to pulling in a tank battalion in pursuit of small game. The prime achievement, if one can term it that, would be in shifting these “coordination of benefit” issues from the political arena to the MCE operational arena.

Management and Financial Capacity

Managed health care entities have the know-how to manage health care expenditures within fixed budgets. They have the state-of-the-art claims payment / prior authorization systems and other utilization management procedures--including various triaging, gatekeeping, and primary care case management mechanisms--suited to controlling expenditures. They have elaborate cost finding and rate setting systems to aid in negotiating advantageous rates with health care providers. They have systems to monitor and report performance on the basis of selected performance indicators. They have the financial reserves needed to insure the health care of the persons in their charge–that is, the reserves needed to cover this risk.

These management capacities apply to the health care industry; they are minimally transferable to the long term care industry. The utilization management procedures, which the managed health care companies continue to refine, are of limited use in LTC generally and developmental disabilities systems specifically. In fact, as managed care mainstays, these systems would represent a return to the centralized, rule-bound (regulated) systems of governance that turn front-line workers into passive actors, that needlessly override consumer and family choice, and that result in lower consumer satisfaction and higher costs.

While effective price negotiation can be an important source of savings in the health care industry, in the long term care industry with worker pay scales a step—a large step--below those of medical professionals and turnover already at or approaching unacceptable levels in most areas, the savings potential of rate negotiation is relatively limited. Any substantial savings in the developmental disabilities arena must derive from the substitution of less expensive forms of support for more expensive forms of support. These savings are not the sort to be unlocked through the negotiating savvy and power of the MCE. Rather, they must derive principally from individual planning / budgeting processes where natural supports are found to substitute for paid supports, and with the ability of consumers to choose those forms of support and providers thereof offering the most value.

In short, the management capacities of the managed health care entities are ill-suited to the demands of the long term care industry. Consumer-driven mechanisms, unknown in the world of managed care health care, promise to be centerpieces in the managed care of persons with lifelong disabilities (Agosta and Kimmich, 1997). Family support, consumer-managed personal assistance programs, and supported living programs provide ample evidence that consumers and families can get considerable mileage out of very limited funds.

Consumer managed care refers to arrangements whereby each individual with disabilities, his or her family or guardian has the authority within pre-defined limits to decide how to expend funds or in support of the person with disabilities. This approach operates under two basic assumptions: (1) consumers working on limited budgets will spend more prudently in order to get the most value for their money and will increase their use of natural supports in lieu of public supports, and (2) consumer choice will spawn a competitive market economy where those providers, new and old, representing the most value to all consumers will survive (Smith and Ashbaugh, 1996).

Already, with a boost from the Robert Wood Johnson Self-Determination grants, nineteen states are demonstrating different approaches to the individualized planning, budgeting and support development. A number of these states and others, e.g. Michigan, Vermont, Kansas, Minnesota and Colorado are actively engaged in the development of consumer-driven systems of managed long term care for people with mental retardation and developmental disabilities. There are also a number of organizations, public and private, in the developmental disabilities field designing the management information and control systems needed to support consumer-driven managed care (Human Services Group, 1997; VT). These consumer-driven approaches to managed care are well-suited to the long term care industry generally and to the developmental disabilities field specifically; they are not at all suited to the professionally-driven health care industry.

All this is to say that organizations within the health care industry have developed the management systems and know-how to manage the provision of health care on a capitated basis. Organizations within the long term care industry are in the process of developing the know-how and systems to manage the provision of long term services and supports on a capitated basis. It makes sense that any integrated approaches to the management of health / long term care—i.e., integrated MCEs take advantage of these respective management capacities.

However, there is the realization that in any marriage of health and long term care partners to form an MCE, the health care partner is the odds-on favorite to be the controlling partner. This is because money is power. When one adds up all the money (Medicare and Medicaid), health care spending dwarfs long-term care spending (even though under Medicaid alone the opposite is true). It is also because, even though the risk of

overspending a capped budget on the developmental disabilities side is minimal, the risk on the health care side is substantial. In fact, the health care risk is such that the only organizations with sufficiently deep pockets to run an integrated health/long term care system (particularly under a managed care construct) would be those in the health care industry.

This is the conundrum that states pursuing integrated managed health / long term care systems are facing. How to marry two systems with successful but different management philosophies and systems without having to sacrifice one to the other? It is hardly a marriage "made in Heaven".

Conclusion

In summary, there appears to be little to suggest that integrated health / long term care MCEs make sense at least for most persons with developmental disabilities. The findings relating to each of the rationales for integration are capsuled below.

- ✓ **Improved care coordination and system efficiencies.** Evidence to date is that integration brings with it higher rather than lower overhead costs. The utility of integration thereby depends on whether these higher overhead costs are offset by lower care costs and/or improved health and other outcomes. In the case of people with developmental disabilities, it seems unlikely that these offsets are present except where common sense would lead one to believe they might: for individuals who require relatively high levels of medical interventions. There is some evidence that care coordination models can improve the quality of care and save money; there is no indication that the care coordination needs to operate under an MCE for these benefits to be realized.

- ✓ **Stemmed cost shifting.** Of particular concern to states is the shifting of costs from federal Medicare to state Medicaid programs. Such shifts relate primarily to dual eligibles other than people with developmental disabilities. The opportunity for such cost shifting with regard to services and supports for adults with developmental disabilities is actually quite limited. States also have some concerns about the shifting of costs from Medicaid Waiver Programs on fixed budgets to the general purpose Medicaid program where there are no such limits. These issues are of little significance monetarily and might more practically be resolved through improved care benefits coordination as opposed to cross-population or sub-population integration.

- ✓ **Management and financial capacity.** Organizations within the health care industry have developed the management and financial capacity needed to manage the provision of health care on a capitated basis. Organizations within the long term care industry are in the process of developing the equivalent for the provision of managed long term services and supports. It makes

sense that any integrated approaches to the management of health / long term care take advantage of these respective management capacities. States must be careful to spawn integrated arrangements where the health and long term partners coming together to form MCEs, complement, rather than override or interfere with one another.

A Look at Integration Initiatives Around the Country

Insofar as adults with developmental disabilities are concerned, it appears that integrated health / long term care approaches are likely to be of marginal if any benefit. This reality, coupled with the strong resistance of the developmental disabilities community, explains why cross-population integration initiatives in most states--even those with strong mandates to include the developmental disabilities population --have derailed and stalled. A number of these states now appear likely to pursue the management of health care / long term supports for persons with developmental disabilities separately from other Medicaid subpopulations.

In Maryland, the Long Term Managed Care Advisory Committee was established under legislative mandate in Senate Bill 750 to advise the Secretary of the Department of Health and Mental Hygiene on the development of a managed care plan for health and long term care services for the Medicaid long term care population. While the Committee was able to develop a cross-population integrated plan of care for other long term care populations, it recommended a separate integrated care system for persons with developmental disabilities (8,p44). In Delaware, an analysis of the options for managed long term care in that state led Medstat (1996) to make recommendations to the Delaware Department of Health and Social Services similar to those of the Long Term Managed Care Advisory Committee in Maryland. The strategy in other states has been to concentrate first on the development of managed long term care arrangements for persons with developmental disabilities, and then on the coordination or integration with managed health care arrangements (Michigan, Kansas, Vermont and Colorado).

Still, a number of states continue to work toward cross-population, integrated health care / long term care approaches. Under a 1115 Waiver, the State of Minnesota has waived many state regulations and is working with a number of counties in the state to forge integrated health / long term managed care approaches. Counties are developing a variety of managed care models; however, these are still largely defined at the conceptual level, not the operational level.

The Wisconsin Department of Health and Family Services has developed a proposal for a system serving the frail elderly and younger adults with chronic illness, physical or developmental disabilities and eventually serving children with long term care needs. The plan would cover health and long term all persons, Medicaid eligibles and non-eligibles. Care management

organizations would manage the services on a capitated basis sharing some risk with the state and would be required to offer “high levels of consumer choice and self-determination. ”An aging resource center and disability resource center would provide information, counseling and functional screening for consumers and prospective consumers (Wisconsin DHFS, 1997). The proposal has recently been withdrawn “for further review and consultation” (Leean, 1997).

The six New England states (Massachusetts, Maine, Rhode Island, Vermont, New Hampshire and Connecticut) are submitting waivers to demonstrate new health care and long term care system models, called integrated service networks (ISNs). These networks will provide for “the integration of the delivery and financing of Medicare and Medicaid covered services. The states struggled to find enough common ground to submit a joint waiver, but in the end could not and will be submitting individual waivers. The ISNs are expected to offer enhanced coordination of services, to be more convenient, to emphasize prevention, to offer support services and home and community-based care, and simplify the process of accessing services and obtaining health care information. The status of the efforts in only one of the states, New hamshire, is known. In that state, only one of two ISN demonstration sites originally planned continues to develop. Reportedly this ISN has already spit into a long term care ISN and a health care ISN with the idea that these sister networks will coordinate care for a time and look to integrate care sometime in the future.

A Word of Caution

Whether these more ambitious cross-population, integrated health / long term care plans ever come to pass on even a demonstration let alone full-scale basis is hard to tell and of little concern. What is of concern is that such plans not be forced prematurely, i.e. that managed care entities not be asked to cover the costs of the health care / long term care for the different subpopulations until the magnitude of these costs are understood and unless the prospective payment (cap) is sufficient to cover them.

It is when the risk is unknown or unmanageable that outcomes detrimental to disabilities subpopulations and systems are likely. MCEs will inevitably be made up of health and long term care partners. If an MCE is faced with an unknown risk or unreasonable risk, one can only expect the MCE to act to contain it. The most expedient and likely approach would be for the health care partner, as the primary risk bearer, to assume control over the LTC as well as health care operations and to extend the types of controls used in managing health care service utilization to the long term care sector. As explained earlier, this would be inappropriate and far less cost effective than consumer-driven approaches.

If the marriage of health care and long term care entitities is to work, the management and the care management techniques employed must fit each industry. So long as states don’t compel the health care partner to dominate the

arrangement by introducing an inordinate amount of risk, cooperative if not integrated arrangements can be forged that allow the health care and long term care sectors to manage operations efficaciously without undue interference from one another. Through the health / long term care coordination pilots and demonstrations mentioned in Maryland, Massachusetts, New Jersey, New Hampshire and Rhode Island, we are beginning to understand the costs of caring for different subpopulations and the types of care coordination needed to build viable integrated health / long term care models. Still. there isn't yet a good understanding of the health care and long term care expenditures / risk for most chronically ill, frail elderly, and developmental disabilities populations and subpopulations. Until there is, states are best advised to operate any integrated arrangements on a limited risk basis. Otherwise, in the rush to integration they are likely to trample both the interest of the taxpayer in efficient care and the interest of consumers in quality care.

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