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# INTEGRATING ACUTE AND LONG-TERM CARE

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**Prologue:** *One of many legacies left by the late Rep. Claude Pepper (D-FL) was the concept of integrating acute and long-term care. His Medicare Long-Term care Catastrophic Protection Act of 1987—the original proposal for federally sponsored long-term care insurance—introduced the notion that both acute and long-term care can be strengthened if their provision is closely linked together. In this paper Walter Leutz, Mitch Greenlick, and John Capitman draw on the experience of the social health maintenance organization (social HMO) program to illustrate the success of such an integrated approach. Unfortunately, the health care reform legislation that has emerged from the debate of summer 1994 keeps the two separate. The Clinton plan and the plan advocated by Rep. Jim McDermott (D-WA) and Sen. Paul Wellstone (D-MN) were the only two plans that expanded long-term care benefits. Even if they had survived the debate, neither plan would have linked the acute and long-term care systems very strongly. As these authors point out, such a linkage can have a positive impact on the entire medical care system. Leutz is an associate research professor at the Institute for Health Policy, The Heller School, Brandeis University, in Waltham, Massachusetts. He is one of the pioneers in work on the social HMO. Leutz holds a doctorate from The Heller School. Greenlick, who received his doctorate in medical care organization from the University of Michigan, founded the Kaiser Permanente Center for Health Research located in Portland, Oregon, and has served as its director for thirty years. Capitman, who holds a doctorate in social psychology from Duke University, is a research professor and director of long-term care at the Institute for Health Policy at Brandeis.*

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**Abstract:** Advocates of health system reform are striving to assure that a valuable new benefit for homes and community-based long-term care is included. Yet in many legislative proposals, a long-term care benefit is kept separate from the rest of the benefit package. Experience from the social health maintenance organization (social HMO) demonstration shows that for the elderly at least, community long-term care can be integrated with acute care, at a manageable cost. Acute and chronic disease and disability are experienced concurrently. Moreover, disability is not confined to a small group of permanently disabled persons but affects many other persons for short periods. Integration of long-term and acute care in a managed care model serving a broad population may promote more effective acute care and more efficient and affordable long-term care.

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Throughout the health care reform process of the early 1990s, the status of a long-term care benefit has figured prominently in the discussion. In the end, however, long-term care has remained distinct from acute care, as the focus of the debate has shifted away from the Clinton administration's plan. Only the Clinton and McDermott/Wellstone plans included expanded long-term care benefits, and neither contained strong methods to integrate acute and long-term care.<sup>1</sup> Other key policy-makers and advocates have offered similar proposals that would build a community long-term care system largely segregated from the acute care system, with reimbursement, day-to-day management, and accountability separate from acute and skilled care.<sup>2</sup>

Our experience with social health maintenance organizations (social HMOs) suggests that integrating long-term and acute care is worth pursuing. Many elderly living at home suffer from acute and chronic diseases along with a disability. Community long-term care services may be more affordable when integrated with acute care than when kept separate, and they can be managed as a dollar-capped entitlement. Furthermore, integrated, managed systems may be the key to achieving the acute care savings on which health reform depends without reducing quality and access. Social HMOs can by no means solve all of our problems—they have their share of shortcomings and their critics—but they do offer evidence of the need for integration and some pathways to get there.

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### What Is A Social HMO?

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The four social HMOs in existence serve 22,000 Medicare beneficiaries at sites in Portland, Oregon; Long Beach, California; Brooklyn; and Minneapolis/St. Paul. Social HMOs compete with other HMOs and conventional fee-for-service Medicare supplemental insurance to voluntarily enroll a broad cross-section of aged beneficiaries. They are financed at full risk through capitated payments from Medicare, Medicaid (for those eligible), private members' premiums, and member copayments for long-term care benefits. Social HMOs provide all Medicare Part A and Part B benefits,

prescription drugs, and other ancillary services, plus up to \$1,000 a month of community long-term care and short-term nursing home services. Eligibility for long-term care benefits is based not on Medicare skilled care criteria, but rather on multidimensional assessments that state governments use for nursing home preadmission screening.<sup>3</sup> Because the disability rates of social HMO members are similar to rates in the sites' communities, social HMO data provide population-based estimates of community long-term care costs for the aged.<sup>4</sup> Moreover, because social HMOs deliver both Medicare and long-term care benefits, data show the extent to which community long-term care is delivered in close conjunction with Medicare hospital, home health, and skilled nursing facility (SNF) benefits.

All social HMO members complete a health status form that assesses their health, functional, and social situations. This form, updated yearly, is reviewed by a unit of service coordinators composed of nurses and social workers, who also are responsible for taking referrals from social HMO providers, assessing at-risk members, monitoring and referring members who are at risk but do not need long-term care services, developing long term care plans in conjunction with members and their families, authorizing use of the long-term care benefits, and coordinating long-term care services with acute, skilled, and informally provided services.<sup>5</sup>

Not all evaluations of social HMOs have produced positive results. Although we agree with some evaluators that there are shortfalls (for example, slow enrollment growth, frequent operating deficits, and limited long-term care benefits), we tend to emphasize the positive (for example, enrollment targets have been achieved, deficits are less for HMO sponsors than if all of their Medicare members were in their risk plans, and no other HMOs offer any long-term care benefits). We also agree with the finding that members' physicians may not be involved in long-term care service planning and that physicians seldom ask for long-term care services.<sup>6</sup> However, we disagree with the view that changing physician practice is the overriding measure of integration of acute and chronic care. Based on limited physician involvement, the evaluators concluded that care was not integrated, even though they concurred with our findings that medical directors attended service coordination meetings, that service coordinators (our term for case managers) had access to physicians when needed, and that service coordinators were well connected to professionals (such as hospital discharge planners) at other key points in the system.<sup>7</sup>

Finally, we have a basic disagreement with a new evaluation paper—one of a series that is cited repeatedly in other evaluation papers—which first uses a complex statistical analysis to show that social HMOs had very favorable enrollment and disenrollment (contradicting earlier evaluation studies) and then interprets various outcomes in this light.<sup>8</sup> The basic

problem is that on thirteen of the thirty-one variables used to analyze selection bias, the comparison group sample was asked questions that either were not asked of social HMO members or were worded more narrowly for social HMO members.<sup>9</sup> That is, this study directly tipped the scales toward finding more illness and disability in the comparison group, a fact that is obfuscated in the paper. In summary, we regret that these disagreements have clouded the picture of this important demonstration. The social HMO is not a panacea for all of the shortcomings of Medicare or all of the health care needs of the aged, but its sponsors believe, and the data show, that it can teach us a great deal about integrating acute and long-term care.

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### **For Whom Is The Social HMO Designed?**

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The case for integration is illustrated by Mrs. A, whose health status form screen and subsequent assessment showed that she suffered from Parkinson's disease, hypertension, and osteoporosis when she joined a social HMO in 1985 at age seventy-nine, along with her husband/caregiver, himself frail. At the service coordinator's request, a physical therapist from the social HMO's home health agency trained Mrs. A's husband and daughter in range-of-motion exercises, transfers, and use of safety equipment for bathing and walking. In addition to arranging these standard Medicare benefits, the service coordinator also authorized long-term care benefit coverage for bathing assistance and housekeeping from a vendor agency. The physical therapist shared his evaluation with the service coordinator as well as with the supervisory registered nurse at the vendor agency. Likewise, the bathing assistant reported to the supervisory nurse at least every ninety days, and the nurse in turn reported to the service coordinator and to Mrs. A's social HMO primary care physician. As Mrs. A's Parkinson's disease gradually rendered her unable to feed or transfer herself, this communication network ensured more frequent personal care as well as a visiting nurse to help Mrs. A with swallowing, bowel care, and skin care problems. When she could no longer travel to see her physician, the home health nurse, supervisory vendor nurse, and family coordinated by phone with the physician to adjust her medications and monitor her care needs. The service coordinator monitored family satisfaction with the vendor and whether there were any unmet care needs. In January 1993 Mrs. A died at home in the presence of her husband and daughters.

The quiet heroics of Mrs. A's case do not make headlines, but they represent a significant triumph over what, for many elderly, are typical and overwhelming odds. Mrs. A's family always knew in advance what her home care would cost: The monthly long-term care copayment ranged from \$10 in 1985 to \$85 in 1991 and to \$180 in the last eight months of her life.

During this latter period the long-term care benefit provided a total of seventy-two hours of personal care per month in increments of two to three hours a day to help her out of bed, to bathe and dress, and to eat each morning. Mrs. A's family provided the remaining care for such tasks as administering medications, other feeding, and using the toilet.

Mrs. A's situation also graphically illustrates an important point about the frail elderly: They may have multiple chronic illnesses and require concurrent acute, skilled, and long-term care services. It is not enough that these services be readily available in the community; they need to be integrated and managed by personnel who understand the financial, social, emotional, and health needs of individual patients. Contrary to the fears of those who advocate independent living for disabled persons, medically connected programs need not turn community long-term care decisions and provision completely over to professionals.<sup>10</sup> Rather, independence may hinge on social supporters who are well informed and capable regarding medical conditions. Service coordinators in social HMOs authorize long-term care services without physician sign-off, and plans of care for many members with disabilities do not require coordination with physicians. Service coordinators also work to meet patient and family preferences, and social HMOs will pay for personal care aides who are hired and supervised by members themselves. The trick is to have the medical connection readily available when needed.

Like other long-term care programs, social HMOs are designed to meet the social support system needs of the ever-growing number of elders who are chronically ill and permanently disabled. About 5 to 15 percent of current social HMO members are nursing home certifiable, according to state preadmission screening criteria, and are thus eligible to receive community long-term care benefits. At most sites the proportion of nursing home-certifiable members is higher than in initial years of operation, and also higher than the estimated 5 percent of community-dwelling aged who would meet certifiable criteria.<sup>11</sup> These criteria differ in specifics across states, but in all cases they are multidimensional, assessing such areas as activities of daily living (ADLs) (for example, bathing and dressing), need for assistance with medications, cognitive impairment, mobility, incontinence, unmet need for skilled care (for example, ostomy and catheter care), and psychiatric problems.<sup>12</sup> High ADL dependency increases the chance that one will be nursing home certifiable, but it is neither a necessary nor a sufficient condition: Of all members receiving comprehensive assessments in 1985-1987, 31 percent of those needing help with no more than one ADL were nursing home certifiable, while 69 percent of those needing help with two or more ADLs were nursing home certifiable.<sup>13</sup>

Unlike most other long-term care models, social HMOs' broad popula-

tion also makes the model responsive to those who have a short-term disability or who need help with transitions, recovery, or skilled and supportive care beyond what is covered through acute care benefits. National and social HMO data illustrate the acute care origins of many if not most long-term care needs, the importance of linkages with acute care, and the importance of broad targeting of community long-term care eligibility.

**Rising disability and acute care.** National studies show that longer life brings increasing risk of functional dependency, with as much as 80 percent of each year added to life expectancy likely to be spent in a dependent state.<sup>14</sup> Rates of coprevalence among chronic conditions are substantially higher than would be expected by chance, even for conditions not known to be related.<sup>15</sup> Moreover, rising levels of disability are a key driving force in the spiraling cost of health care. The disabled use high levels of both chronic and acute care.<sup>16</sup> Social HMO experience is similar: During 1985-1989 members who had already been identified as nursing home certifiable accounted for about 2.5 times the number of hospital admissions as their proportion in the membership.<sup>17</sup>

**Linking with the acute care system.** Social HMO data show that acute care linkages are critical in identifying newly disabled persons, particularly those with short- to mid-term needs. Of initial referrals to community long-term care across the social HMO sites, 60 to 70 percent come from within the medical care system—primarily from hospital discharge and utilization review staff, but also from medical offices, home health agencies, and nursing homes. The bulk of other members receiving community long-term care were identified through health surveys of members at initial enrollment and self-referral.<sup>18</sup> A provision to set quotas on enrollment of new members with severe disabilities may have increased the proportion of referrals from the medical system, but the medical proportion was high, even at the site that did not use quotas.<sup>19</sup>

New disabilities after hospitalization are commonplace: Of 9,628 social HMO admissions between 1985 and 1989 for members who had never been identified as meeting nursing home-certifiable requirements prior to hospitalization, 11 percent were identified as certifiable within sixty days of discharge, and an additional 14 percent were so identified at some time later in the observation period.<sup>20</sup> These postacute nursing home-certifiable members were the most likely to regain independence.

Many postacute patients and others with short-term disabilities are adequately served under Medicare's home health and SNF benefits, but many others could benefit from supplemental community long-term care like that offered by social HMOs. For example, a stroke patient may need more extended therapy than Medicare will cover through home health, or a very frail patient living alone may need daily help with meal preparation and

other household tasks during recovery, beyond what can be provided with intermittent home health aides under Medicare. Overall, when those members who were nursing home certifiable prior to admission are included, 30 percent of social HMO hospital discharges were nursing home certifiable within sixty days of discharge and thus qualified for long-term care services.<sup>21</sup> This proportion is somewhat higher than the 23 percent of Medicare discharges nationally who used Medicare home health or SNF benefits within sixty days of discharge in 1985.<sup>22</sup>

**Targeting community long-term care.** The conventional target group for community long-term care programs has been persons with permanent disabilities. Screeners in the Channeling demonstration, for example, had to judge that applicants' long-term care needs would continue for at least six months.<sup>23</sup> The OnLok/PACE model also assumes that all of its patients have permanent and serious disabilities, since it receives nursing home-level Medicare and Medicaid reimbursement for all of its members.<sup>24</sup> Because the assumption is a long-term relationship with the patient, community long-term care programs have not been in a hurry to begin service or to terminate it. Some of the congressional reform proposals, for example, envision allowing two weeks to respond to a referral and up to a month after that to begin services.<sup>25</sup> Channeling terminated less than 3 percent of its caseload for reasons other than death or voluntary withdrawal.<sup>26</sup>

Often, however, disability is a more temporary state than is assumed in these stand-alone long-term care models. This poses a dilemma: Should a community long-term care program exclude short-term patients-as stand-alone systems have done-or should it be able to pick them up quickly and discharge them after recovery-as the social HMOs have done? Three sources of data illustrate the issue: (1) Only 43 percent of disabled social HMO patients who were still alive and in the program a year after they were first identified as nursing home certifiable had remained so at each of the four quarterly reassessments; 57 percent had regained sufficient functioning to not qualify as nursing home certifiable at some point during the year.<sup>27</sup> (2) Among survivors in the National Long-Term Care Survey, 23 percent of aged subjects with one or two ADL disabilities at baseline had no ADL disabilities two years later.<sup>28</sup> (3) Among survivors in a Massachusetts panel study, 27 percent of aged subjects with one or more ADL limitations were independent fifteen months later.<sup>29</sup>

The fact that a significant minority of those who became disabled later regained independence means that many more people are affected by disability than prevalence analyses would indicate. It also means that many persons with short-term disabilities will not receive assistance unless a program defines them as eligible, is designed to quickly assess and serve them, and is also ready to discharge them when appropriate.

A community long-term care benefit that is integrated with medical care can provide this short-term care and supplementation of acute care benefits much more responsively than a stand-alone system can. An integrated long-term care program can efficiently pick up short-term patients, help them to recover functioning, and then bow out of direct care with the knowledge that, should the need arise, the patient can again gain easy access to care through the internal referral system. Of course, the data just presented show that not all persons with functional problems qualify as nursing home certifiable in the current social HMOs. Areas requiring continuing research include better definitions of service eligibility, as well as assurances that other at-risk members will be monitored properly. All social HMO sites use service coordinators to monitor at-risk members who are not nursing home certifiable at referral or who lose nursing home-certifiable eligibility. The extent of monitoring varies widely across sites but averaged nearly 4 percent of total membership in 1990.<sup>30</sup>

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### Cost And Payment Issues

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If health care reform is to meet its goals of universal access, cost control, and community rating (charging the same rates for all individuals and employer groups), we will need to find methods to fairly pay provider/insurer systems that enroll disproportionate numbers of frail and chronically ill persons. Payment structures from state insurance pools will need to reflect enrollees' relative costs so that savings are achieved not by enrolling healthy members (as happens too often in our current system), but rather by providing efficient care to all members at all levels of need. Social HMO experience shows that functional disability is a strong risk adjuster, which can embed a chronic care perspective in the financing, marketing, and reimbursement for acute care itself.

**Reimbursing fairly for the disabled.** Medicare reimbursement now discourages HMOs from enrolling beneficiaries with disabilities. With the exception of nursing home residents, Medicare pays the same amount for a functionally disabled beneficiary as for one without disabilities, even though the former is likely to incur acute care costs that are twice as high. Social HMO and OnLok/PACE programs have addressed this problem by adding a rate cell to the Medicare payment formula that pays as much as 2.4 times the average for nursing home-certifiable members.<sup>31</sup> Recent research supports even stronger disability factors.<sup>32</sup> Disability-based reimbursement encourages enrollment of the frail and reduces incentives to enroll only the healthy. The result can be specialized systems of care for the disabled (for example, PACE) and mainstream systems such as social HMOs, which willingly enroll disproportionate numbers of the frail.

**Holding down community long-term care costs.** The use and costs of community long-term care services in social HMOs are much lower than in most prior demonstrations, including the Channeling demonstration from the early 1980s, which has been the utilization model for several reform proposals.<sup>33</sup> Several features help to control costs. First, community long term care spending caps (\$7,500 to \$12,000 per eligible per year) amount to one-third the cost of alternative nursing home care or less, rather than the two-thirds standard in prior programs (also the standard in the McDermott/Wellstone proposal). Second, the social HMOs' current fourteen to thirty days of non-Medicare nursing home care per spell of illness are much less than other proposals that include short-term nursing home coverage (the Pepper Commission, for example, recommended three months).<sup>34</sup> Although no outcome studies are available on the adequacy of these benefit levels, they have not been the subject of complaints from either clinicians or patients.<sup>35</sup> Also, few users push the limits of the caps: Only 25 percent of community long-term care benefit users between 1985 and 1989 ever had even one month during which authorizations exceeded 85 percent of the value of the cap.<sup>36</sup> Third, being at risk for costs motivates service coordinators to economize in a variety of ways. They avoid duplication by knowing what is being provided by family members and Medicare skilled care. Often no supplement to skilled or family care is needed or wanted: In a given month 30 to 40 percent of nursing home-certifiable members receive no covered long-term care service.<sup>37</sup> Also, service coordinators can reduce care for recovered patients with the knowledge that referral points in the system will call for help again should the need arise.

Social HMO spending for long-term care services plus service coordination averaged \$38 per member per month across the entire membership of the four social HMOs in 1990—about 11 percent of the \$353 average per capita Medicare payments to programs that year.<sup>38</sup> Social HMOs are now financing these community long-term care benefits (plus prescription drugs) through member premiums and savings on Medicare fee-for-service-equivalent reimbursement.

**Marketing long-term care as part of a comprehensive benefit package.** Social HMOs have been able to compete with other Medicare supplements and HMOs by occupying a high-end niche in the market and (at most sites) by controlling adverse selection via quotas on enrollment of persons with disabilities.<sup>39</sup> These strategies have worked so far, but they do not ensure long-term success or widespread replication. Because of slow growth in Medicare capitation payments in their local markets (4 to 5 percent per year from 1989 to 1994)) two sites have raised monthly member premiums repeatedly. The other two sites' growth averaged 8 percent and 11 percent over the same period.<sup>40</sup> Geographic differentials in Medicare

capitation have led to uneven HMO availability, and this in turn affects social HMOs' feasibility. Also, aging memberships mean that applicants with disabilities are turned away from the three sites that queue. The risk of adverse selection—and the need for queuing—would be reduced if there were an even stronger disability-based payment formula.

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### Impact On The Whole Medical Care System

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A community long-term care benefit that is tied closely to medical care can greatly enhance care for frail patients. It can do so either by merely coordinating with existing acute care providers (that is, ensuring close communication and coordination of services) or by acting as a partner to medical care providers who seek to restructure the way acute care itself is delivered. In either case, the community long-term care system can do much more than merely helping with household and personal care tasks. At least five other functions can be served.

**Supporting medical care.** An integrated system can support medical care by ensuring that medical appointments are kept, that transportation is available, that medical regimens (for example, diets and medications) are followed, and that emergent medical problems are spotted and reported (through both in-home helpers and covered emergency response systems).<sup>41</sup> At most social HMO sites the medical director attends long-term care case review meetings. At some sites, service coordinators have direct access to the patient's medical record, and a summary of the long-term care plan is passed on to the medical record.

**Furthering a geriatrics approach.** Geriatrics seeks to bring specialized knowledge and broader strategies concerning care of the aged into the practice of medicine.<sup>42</sup> A geriatrics approach can be strengthened if managed community long-term care benefits are included in a medical care system serving the entire aged population. The absence of coverage for such services has frustrated geriatric care, which recognizes that support for physical and social functioning and quality of life may be more relevant than "cures" for many frail patients.<sup>43</sup>

Experience with social HMOs shows that over time the presence of a community long-term care benefit and of care management professionals can stimulate an acute care system to embrace a geriatrics approach, although we have also learned that their presence is not a sufficient condition for change.<sup>44</sup> For example, one site based in a large HMO is forming teams in each of its outpatient clinics composed of a geriatrician, a discharge planner, a home health nurse, and a community long-term care service coordinator to coordinate care for patients requiring complex medical and social support. Referral protocols for use by primary care providers are being

developed and disseminated. In contrast, the other HMO-based sponsor tends to coordinate information and service delivery among providers in the existing system, as illustrated in the case of Mrs. A. The important point is that clinical effectiveness and efficiency in resource use can be achieved in either model of integration.

**Enhancing management of transitions.** An integrated system is able to oversee the moving of frail patients across all levels and settings of care, rather than having to stop at the borders of acute and skilled care. Hospital discharge planners and clinic nurses identify frail social HMO patients who may need more than conventional benefits can cover, and they make the referral to the long-term care unit.<sup>45</sup> Forty-two percent of new long-term care cases are identified within sixty days of hospital discharge.<sup>46</sup>

Care managers' knowledge of patient and family resilience allows them to supplement the medical care plan and provide continuity beyond it. For example, a seventy-six-year-old social HMO member who lived with her daughter wanted to return home after a three-month nursing home stay that was preceded by a hospitalization for a myocardial infarction and stroke. Dependent in all ADLs, she had right-side weakness as well as diabetes and arthritis. When presented with this case, social HMO service coordinators developed care plans that supported the daughter's care with a mix of community long-term care (personal care or day care five days a week, electronic alarm response system, and visits from volunteers) and skilled services from Medicare (nursing supervision of the personal care worker and physical therapy evaluation).<sup>47</sup> Again, such coordination would be virtually impossible with segregated systems. In fact, the Health Care Financing Administration (HCFA) evaluation of the social HMO has found that informal caregiving has been strengthened over time for frail social HMO members, compared with informal care for frail fee-for-service comparison-group members.<sup>48</sup>

**Linking nursing home and home care systems.** At most social HMO sites, admission to SNFs requires prior approval of service coordinators or utilization review staff; at all sites, admission to intermediate-level nursing home care requires prior approval by service coordinators.<sup>49</sup> The care management team thus is perfectly positioned to catch nursing home applicants before admission and to offer a chance to stay in the community, an approach that elsewhere has been found to save money by substituting home care for nursing home care.<sup>50</sup> Social HMO members have more frequent non-SNF nursing home admissions but fewer overall days of care than do aged HMO members who are not members of social HMOs, which indicates that an integrated system with service coordination can use nursing homes more flexibly than the existing system can, for instance, for special convalescence and respite stays.<sup>51</sup>

**Managing overlaps between skilled and long-term care.** Social HMOs track Medicare skilled care and long-term care use separately to ensure that members receive their unlimited Medicare entitlements according to Medicare criteria and their dollar-limited long-term care entitlements using long-term care criteria. The two types of benefits overlap substantially: Among social HMO patients receiving Medicare skilled care, 37 percent were found also to qualify for and receive either community or nursing home services from the social HMO's long-term care benefit during their first month in skilled care. The converse was also true: 37 percent of the community long-term care plans for social HMO members made during their first month of long-term care eligibility included concurrent authorizations for Medicare-covered skilled services.<sup>52</sup> That is, more than one-third of newly identified "long-term care" patients were eligible for and received Medicare-covered skilled services during that same month.

In both of these situations the overlap is handled by long-term care service coordinators working closely with postacute and skilled care staff to first ensure that each understands the targeting criteria and services covered by the other and then maintain close contact regarding shared patients and transfers. Although social HMOs have not always succeeded in making all system connections, the most comprehensive evaluation study of linkages between social HMO service coordinators and discharge planners found close coordination of service plans at three of four sites.<sup>53</sup> This coordination is particularly important in cases that are medically or socially complex or that involve transitions across settings.

In a long-term care system that was not integrated, these overlaps could cause a variety of problems. If the overlaps were ignored, services could be substantially duplicative—for example, by providing a frail patient with bathing assistance concurrently by a home health aide covered by Medicare and a personal care worker covered by long-term care. If managers in the two systems tried to coordinate, there could be bickering about who should pay for the bathing assistant. If policies were redrawn to avoid the possibility of overlap, there could be gaps in coverage. In an integrated system, these are internal decisions. In 1989 Medicare home health regulations were expanded to allow payment for increased care management and skilled care for beneficiaries with chronic conditions. These changes expand the range of home health, but they still leave home health and long-term care in separate systems.

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## Implications For National Health Care Reform

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Long-term care is a large, costly, and growing problem. Because social HMO benefits now exclude long-term nursing home care, the model does

not “solve” the long-term care problem, and there are barriers to replicating the model widely under current payment and market conditions. Nor do all social HMOs always deliver on the various connections discussed here. However, the social HMO’s conception of an affordable community long term care benefit linked to systems for financing and managing acute care benefits shows that there is a workable path to solving the community care piece of the long-term care puzzle and that this path can be followed independently of nursing home financing reforms. The solution coincidentally addresses the deficiencies in current acute care coverage by including prescription drugs and other ancillary services, as well as benefits that cover care for the frail where current skilled care services too often leave off.

The community long-term care benefit that emerges is surprisingly affordable. The 1990 long-term care cost of \$38 per member per month would amount to about a 10 percent increment in Medicare spending if financed directly from taxes, but the social HMO shows that some if not all of these costs can be covered instead from beneficiary premiums already being spent on acute care supplements and from savings from efficiencies. Although geographic disparities in Medicare HMO payments have forced some sites to raise premiums, these problems are not intrinsic to the social HMO concept. Costs in an integrated system can be controlled through a single payment (capitation), thus allowing payers to budget prospectively and in turn forcing administrators and care managers to think more broadly about how to achieve efficiencies. Social HMO long-term care units have operated on budgets for services and coordination; they have stayed within budgets; and long-term care benefits have been offered to members as an entitlement within Medicare (that is, covered services have been available to all members who meet eligibility criteria).<sup>54</sup>

Integration need not translate into “medicalization,” as some fear. Indeed, the social HMO concept rejects the notion that physicians (even geriatricians) or home health agencies should control long-term care. Of course, physician cooperation and easy access to medical care information are needed by long-term care clinicians, especially for complex and unstable patients. There is also room for improvement in how social HMOs and other acute care providers meet the medical care needs of patients with chronic illnesses. For many if not most long-term care users, however, service coordinators, service users, and families can plan and deliver community long-term care support services with relative autonomy.

Such carefully tailored working relationships will be difficult to develop if the proposals for segregated acute care and community long-term care systems are followed. With neither financial nor operational imperatives to cooperate, Medicare service managers and providers will be unlikely to work closely with new service coordination agencies to ensure timely refer-

ral and smooth transitions, avoid overlapping services and cost shifting, provide and then reduce community long-term care services to those with short-term disabilities, or allow the community long-term care system to support medical care. Even with careful management, the possibilities for savings and efficiencies would be segregated into two separate systems.

The few reform proposals for integrated systems, including the original long-term care coverage bill proposed by the late Rep. Claude Pepper in 1987, carry a much more profound message for national reform than the segregated model does.<sup>55</sup> Acute care reform should proceed with a clear plan for coordination with long-term care, particularly community long-term care services. Because elders with new disabilities are usually identified within the acute care system, because skilled and chronic care benefits and services overlap, and because many elders with disabilities regain independence, community long-term care should be linked closely with the acute care system serving the entire aged population—not set aside with separate management and financing.

Changing health care practice in this direction will take time, particularly if segregated financing and delivery of long-term care benefits is pursued as the most practical short-term reform strategy. Even so, steps can be taken to make integrated options available to more elders now and to move the segregated system toward more integration over time.

First, all Medicare HMOs and Comprehensive Medical Plans (CMPs) should have the option to offer community long-term care benefits. Since 1990, when Congress authorized four new social HMO sites, we have visited and been visited by at least forty HMO representatives and other potential sponsors. Protocols for expanding the social HMO model have already been developed, which would define benefits, screening and assessment tools, long-term care service eligibility, service integration components, disability-based reimbursement, and other systems. Although this would be an important step, it is limited by two factors. Medicare HMOs were available to only about half of all elders and served only 2.4 million of them (7.5 percent) in 1992.<sup>56</sup> Also, the low Medicare per capita payments in many areas would force new social HMOs to charge high premiums.

Second, national health reform legislation should contain stronger and more specific provisions for coordinating new long-term care benefits with acute care and vice versa. There should be an option to incorporate the new long-term care benefit funds into acute care systems on a capitated basis, but even without integrated financing, numerous specific actions could foster more integrated administration and clinical care—for example, by requiring agencies that manage overlapping benefits and services (skilled home health agencies and community long-term care management agencies) to have systems to coordinate care for shared patients, that hospital

discharge planners work as closely with long-term care coordinators as they do with home health, and that acute and long-term care providers share clinical information when appropriate. These more specific provisions also should apply to programs serving the nonaged long-term care populations.

Even with the support of integrated financing and organizational structures, social HMO sites have found that integration involves a myriad of small, painstaking steps, which must be tailored to local conditions. If broader systems for managing acute care result from health care reform, a community long-term care benefit also could be integrated into them. Some components of integration (for example, broad and proactive physician participation) have been particularly difficult to implement. Long-term care in the community needs time to develop its role and prove its value to acute care providers by making acute care more effective and appropriate for increasing numbers of persons with disabilities. We should start with reform and keep pushing for integrated systems, realizing that the system will not change overnight.

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## NOTES

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