Cite this article as:
Robert J. Master and Catherine Eng
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*Health Affairs* 20, no.6 (2001):161-172
doi: 10.1377/hlthaff.20.6.161

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Integrating Acute And Long-Term Care For High-Cost Populations

An in-depth look at two successful models, and the impediments to their expansion.

by Robert J. Master and Catherine Eng

ABSTRACT: The inadequacies of our fragmented acute and long-term care financing and delivery systems have been well recognized for many years. Yet over the past two decades only a very small number of “boutique” initiatives have been able to improve the financing and the delivery of care to chronically ill and disabled populations. These initiatives share most of the following characteristics: prepaid, risk-adjusted financing; integrated Medicare and Medicaid funding streams; a flexible array of acute and long-term benefits; well-organized, redesigned care delivery systems that tailor these benefits to individual need; a mission-driven philosophy; and considerable creativity in engaging government payers. The experience of these “boutiques” illustrates both the obstacles to, and the opportunity for, meaningful, widespread care delivery reform for vulnerable chronically ill populations.

It is estimated that there are more than three million Americans of all ages whose mix of serious disability and chronic illness places them at the highest risk for functional decline, hospitalization, or nursing home placement. This population comprises frail elders at risk for nursing home placement and a younger, more heterogeneous group of persons with complex chronic illness and disability; the inadequacies of their care have been well recognized for many years. Although these subpopulations are clinically and demographically different, their optimal care needs as well as the inadequacies of our care system’s response to those needs can be distilled to three common themes.

First, these populations require an individualized mix of medical,
support, mental health, and long-term care services to promote optimal health, function, and independence. Yet this optimal mix of services resides in the benefit designs of very different, uncoordinated, and (in the case of Medicaid-covered long-term care services) often inaccessible payer systems. Second, these populations require a new paradigm of primary care, one that is empowered to harness all necessary resources and services on behalf of the persons served. Yet the provision of primary care today is characterized by high-volume, narrowly defined ambulatory encounters in the setting of the office, clinic, or hospital, often with obstacles to the use of hospital and physician specialist services, not to mention a complete inability to allocate support or long-term care services effectively. Finally, optimal care requires a shift from an inflexible “insurance benefit” focus to a flexible “person” focus that challenges the insurance concepts of “medical necessity” and “covered benefits.” Yet these concepts are a necessity in all government- and employer-financed insurance contracts. They also require a consistency of administration that is impersonal and rigid—the antithesis of individualized flexible allocation of services.

As a consequence, the following illustrative vignettes seen repeatedly over decades of the authors’ clinical practices are commonplace. (1) A frail elderly man living at home who has progressive Alzheimer’s dementia, and functional dependence with an overwhelmed family, cannot afford or get access to personal care, respite care, or adult day health services as an alternative to nursing home placement, because his retirement income is above the Medicaid eligibility threshold. (2) An employed thirty-five-year-old woman with spastic quadriplegia and requirements for continuous catheter bladder drainage and gastrostomy tube feedings due to severe cerebral palsy requires more than $400 per month of equipment and supplies indefinitely for optimal care. Yet her insurance has a $1,500 annual durable medical equipment (DME) limit with very cumbersome prior-approval procedures and benefit exception policies. (3) A dually eligible (Medicare and Medicaid), cognitively intact but depressed eighty-six-year-old woman living alone after the death of her husband, who cannot walk more than a few steps safely because of severe arthritis and spinal stenosis, is failing because of poor nutrition and debilitation. Her busy primary care physician is unable to mobilize the mental health, personal assistance, nutritional, and socialization services that could alter the course of her decline. (4) A forty-year-old man covered by Medicaid, with quadriplegia due to cervical spinal cord injury, has a rapidly worsening Stage III buttock decubitus ulcer that his primary care physician fears will soon involve the underlying bone, a situation that would require...
orthopedic and plastic surgery, weeks in the hospital, and months of intravenous antibiotics. Yet all efforts to preempt these complications are impeded by what could only seem like a conspiracy of prevailing administrative and benefit policies. Hospitalization at the acute or subacute level for intensive nursing care does not meet standards that would justify payment. Efforts to find skilled nursing facility beds fail because this service sector has little experience with the complex needs of a younger patient with a spinal cord injury. A request for a specialized bed and private-duty nursing at home is subject to a lengthy and cumbersome Medicaid prior-approval process. Soon the decubitus ulcer progresses and a lengthy hospitalization and multiple surgical procedures ensue (all of which are fully covered!).

In response to recognized inadequacies such as these, over the past twenty years a number of promising financing and care delivery initiatives have shown the potential to greatly improve the care, function, independence, and health status of the highest-need frail elders and younger persons with serious disability or chronic illness. Despite substantial government and philanthropic support, though, the goal of widening the impact of these beneficial innovations remains elusive.

The predominant strategy of these demonstrations is to use the vehicle of prepaid financing (because of its inherent flexibility) to promote change. These demonstrations risk-adjust premium payments to varying degrees, in an attempt to better approximate the true costs of care for the target populations, expand the array of support and long-term care benefits, extend the authority of primary care physicians to allocate those benefits, and in some instances fundamentally redesign the primary care role and the care delivery system.

These demonstrations also vary greatly in their intended target populations and their comprehensiveness. Since 1985 the social health maintenance organization (S/HMO I) demonstrations have used a very small risk adjustment to the Medicare premium to health plans (100 percent of the adjusted average per capita cost, or AAPCC, rather than 95 percent) to add some limited community-based long-term care benefits (such as personal care), with a goal of reducing hospitalizations for the general Medicare-eligible population. However, the systematic substitution of community care for those at risk for nursing home care and a redesigned primary care model were beyond the scope of this effort. The S/HMO II demonstration within the Health Plan of Nevada (HPN) became operational in late 1996; it is more ambitious in its scope, degree of risk-adjusted payments from Medicare, and intent to redesign the
primary care function into a true geriatric service model. By January 1999 S/HMO membership in the HPN had grown to 27,000. However, without Medicaid long-term care premium dollars in the mix, a systematic alternative to nursing home placements for those at risk also remains beyond the scope of this effort. The Evercare demonstration focuses exclusively on frail elders in nursing homes and uses Medicare risk capitation (risk-adjusted for institutional status) to improve primary care and reduce dislocating hospitalizations through the use of on-site nurse practitioners.

Since 1996 the Special Projects of Important National Significance (SPINS) demonstrations have focused on Medicaid-eligible populations with acquired immunodeficiency syndrome (AIDS), with a goal of using Medicaid risk-adjusted premiums to redesign the primary care model to improve function and health status while reducing hospitalizations and mortality. Of these, the AIDS Health Care Foundation of Los Angeles and the John Hopkins AIDS Care Program in Baltimore are the most developed.

Because of their exclusive focus on those with the highest need, their comprehensiveness, and their sustainability, the Program of All-Inclusive Care for the Elderly (PACE) and the Community Medical Alliance (CMA) initiatives best illustrate the opportunities in, as well as the obstacles to, meaningful expansion. PACE is based on the model of care and financing developed by On Lok Senior Health Services in San Francisco that cares for dually eligible frail elderly persons at risk for nursing home placement, while the CMA program focuses on a variety of Medicaid-eligible adult and pediatric populations with very severe disabilities or serious chronic illness. Despite this very different population focus, the programs share considerable similarities (Exhibit 1).

Both programs arose out of a mission-driven philosophy rooted in their respective communities. Both are comprehensive, encompassing all aspects of acute and long-term care. Both use prepaid financing, which provides the flexibility needed to redesign the entire delivery system. Both have engaged public payers to creatively “risk-adjust” prevailing capitation rates. Both offer a mix and flexibility of benefits not found in mainstream payer and delivery systems. Both stress continuity and responsibility for enrollees through all settings and all times. Both redefine primary care from high-volume, “one-on-one,” short physician visits to a team model of care that manages...
**EXHIBIT 1**
Scope, Target Populations, Organizational And Program Description, And Reimbursement Models Of The PACE And CMA Programs

<table>
<thead>
<tr>
<th></th>
<th>PACE</th>
<th>CMA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Target population</strong></td>
<td>Frail elders at risk for nursing home placement</td>
<td>A variety of severely disabled or seriously ill Medicaid-eligible adult and pediatric populations (AIDS, severe physical disability, children with technology dependence)</td>
</tr>
<tr>
<td><strong>Year of inception</strong></td>
<td>1983</td>
<td>1992</td>
</tr>
<tr>
<td><strong>Number of enrollees (2001)</strong></td>
<td>8,800</td>
<td>1,400*</td>
</tr>
<tr>
<td><strong>Number of sites using the model</strong></td>
<td>35 in fourteen states</td>
<td>5 (four in Massachusetts, in different cities, one in Minneapolis replicating the severe physical disability care model)</td>
</tr>
<tr>
<td><strong>Organizational characteristics</strong></td>
<td>Program resides within HMOs, community health centers, hospitals</td>
<td>Program function as subsidiaries of not-for-profit HMOs with a Medicaid focus</td>
</tr>
<tr>
<td><strong>Reimbursement (premium) formula</strong></td>
<td>$2.39 \times \text{Medicaid AAPCC}; Medicaid portion calculated at 85% of estimated state per capita nursing home expenses for nursing home care</td>
<td>Medicaid fee-for-service average determined for clinically defined populations and used as basis of adjusted premiums (AIDS, $2,564; severe physical disability, $2,564; technology-dependent children, $8,000 per member per month in 2000)</td>
</tr>
<tr>
<td><strong>Primary care model</strong></td>
<td>MD, RN/RNP teams develop, manage day health center, long-term care, and medical service plan</td>
<td>MD, RN/RNP team directs and manages all aspects of care; care coordination fully integrated into primary care role; location of decision making moved from &quot;medical site&quot; to home</td>
</tr>
<tr>
<td><strong>Benefit flexibility</strong></td>
<td>Individualized mix of support, medical, long-term care, transportation services with the day health center as the organizing focus; primary care team has full authority to substitute services for hospital, institutional care</td>
<td>Primary care team has full authority to allocate medical support, long-term care, behavioral health, and nontraditional services on an individualized basis</td>
</tr>
<tr>
<td><strong>Cost and utilization experience</strong></td>
<td>Redistribution of hospital expenditures into community-based day health, long-term care, and medical services</td>
<td>Reductions in hospital use and expenditures, redistribution of hospital expenditures to primary care, medical equipment, AIDS-related pharmacy, personal care, and community-based long-term care services</td>
</tr>
<tr>
<td><strong>Quality</strong></td>
<td>High degree of enrollee and family satisfaction</td>
<td>High enrollee satisfaction; high HAART adherence rates; reduction in advanced decubitus ulcer incidence</td>
</tr>
</tbody>
</table>


**NOTES:** PACE is Program of All-Inclusive Care for the Elderly. CMA is Community Medical Alliance. AIDS is acquired immunodeficiency syndrome. HMO is health maintenance organization. AAPCC is adjusted average per capita cost. RN is registered nurse. RNP is registered nurse practitioner. HAART is highly active anti-retroviral therapy.

*Projected by end of 2001.*
the totality of needs and services for a defined population. Both redistribute care and resources from the hospital and institution to primary care, support, and community-based services by clinical strategies that effectively reduce hospitalizations and institutionalization. Both eschew traditional managed care’s “command and control” and contracting strategies; and both are highly regarded by government payers, advocates, patients, families, and policymakers.

Given these positive aspects, the question then is why it has been so difficult to bring these financing and care delivery approaches from “boutique” to a meaningful scale. This paper explores that question.

Lessons Learned In Bringing About Comprehensive Change In Care Delivery

Despite the apparent success of the PACE and CMA programs from a quality, policy, and fiscal perspective, and despite concerted efforts for more than a decade to expand the reach of these program models, the programs still remain in the realm of demonstrations with virtually no diffusion of their positive attributes into the mainstream of American health care. Not surprisingly, the factors that have defined their success are also the barriers to their expansion.

- Mission-driven spirit, perseverance, and foundation support. The historical development of On Lok SeniorHealth goes back to 1971, when San Francisco’s Chinese community came together to find ways to keep frail elders at risk for nursing home placement and hospitalizations in their community. Through the many years of grassroots work and advocacy that were required to obtain the approval of a Health Care Financing Administration (HCFA) waiver in 1983 that allowed the pooling of Medicare and Medicaid capitation premiums to finance the service delivery model, the program sustained itself through the considerable donation of time and effort of its founders, clinicians, and managers. In the early 1990s the Robert Wood Johnson Foundation (RWJF) funded the replication of the successful On Lok model through the national PACE demonstration program. Similar examples of mission-driven perseverance characterized the efforts of many of the thirty-five PACE replication sites as well, where the time line from vision to full implementation has been measured in years. This twenty-five-year effort culminated in 1997, when Titles XVIII and XIX of the Social Security Act were amended as part of the Balanced Budget Act, to define PACE as a new Medicare benefit and provider type and to give states the option to participate under Medicaid as well.

The roots of the CMA date back to 1977 in Boston, when community health centers, advocacy organizations, and clinicians created a
nonprofit clinical organization, the Urban Medical Group, to develop more responsive approaches to the care of low-income persons with serious chronic illness or severe disability. In 1983 the RWJF funded a demonstration of a physician/nurse practitioner team model of primary care for the most severely disabled clients of the Boston Center for Independent Living; this model of care demonstrated an ability to enhance care responsiveness and reduce the secondary complications that often led to hospital care. However, this model of care incurred considerable financial losses because of inadequate fee-for-service (FFS) reimbursement. Yet it was sustained for many years through cross-subsidy and “donated” effort until 1991, when the CMA was incorporated as an experimental prepaid health plan contracting with Massachusetts Medicaid to more appropriately finance this model of care. The CMA, as a very small stand-alone specialty health plan without economies of scale, remained financially precarious until 1996, when it was incorporated into Neighborhood Health Plan (a nonprofit HMO serving 120,000 Medicaid-eligible and low-income persons in Massachusetts) as a “specialized HMO” within the larger HMO.

The obvious lesson from the historical development of PACE and the CMA is that a mission-driven commitment to persevere in the face of ongoing obstacles, delays, and financial losses is essential to sustain such an effort for the many years required to go from vision to implementation. For widespread diffusion at this time, similar commitment would be required in communities where these high-need populations exist, and in the professional education and training of future generations of health care clinicians and managers.

- **Responsive government/payer involvement.** Substantial changes in Medicare and Medicaid payment policies were required to provide the necessary premium support to PACE and the CMA, a precondition for the system redesign needed to care for frail elderly and severely disabled populations. These payment policy changes, in both instances, were achieved through creative approaches to risk adjustment at both the federal and state levels. However, beyond a small number of demonstrations and waivered programs, such Medicare “risk adjustment” financing approaches are very rare. Also, most state Medicaid programs, because of so many competing pressures, find it difficult to justify the investment in the analytic and information technology infrastructure needed to support a broad-based risk-adjusted payment system required to promote the expansion of CMA-type care systems. This lack of easy access to similar appropriate risk adjustment options and combined Medicare and Medicaid (or equivalent) funding streams remains a major impediment to the expansion of program models that can offer an
integrated mix of acute and long-term care services.

In response to this lack of availability, a variety of efforts are now under way to expand access to risk-adjusted financing options. Medicare will be moving to a comprehensive individual risk-adjusted payment methodology as a basis of premiums to Medicare+Choice contractors over the next few years. Five state Medicaid programs are implementing the Disability Payment System as a basis of risk-adjusting payments to health plans for enrollment of Supplemental Security Income (SSI)–eligible persons. A broad-based initiative is under way in Minnesota that pools risk-adjusted Medicare and Medicaid payments to help promote new care delivery approaches for that state’s dually eligible vulnerable populations. And a Senior Care Organization–approved waiver is awaiting implementation in Massachusetts. Still at this time, it remains a heroic feat for a care system or health plan to successfully implement risk-adjusted pooled financing in most parts of the country.

**Reaching middle-income elders.** An important lesson learned from PACE is that its service package is attractive to middle-income frail elders but is unaffordable for them. Medicaid is now the only formal comprehensive disability and long-term care insurer in the United States with the unique benefit design (personal care and day health) that is essential to a care delivery system’s ability to substitute other services for hospital and institutional care. For care systems to offer appropriate services to the large number of middle-income elderly persons at risk for nursing home placement, Medicaid community-based long-term care benefits must be provided through a premium schedule that is affordable. Accordingly, for PACE-type programs to be a viable option for such persons, there must be flexibility in the way long-term care benefits are offered and priced. Such flexibility is not permitted by existing PACE regulations.

Similarly, for the younger disabled populations, stringent financial eligibility requirements effectively exclude most middle-income persons from Medicaid and its essential benefits and potential pooled funding. If there is to be widespread expansion of CMA-type models of care for high-need middle-income populations, these eligibility barriers to Medicaid benefits and potential funding streams must be eliminated.

**Risks of mainstreaming.** Herein lies the essential paradox. The PACE and CMA models have succeeded because they have been supported by unique financing approaches; they have been granted the empowerment to “do the right thing” at the level of the clinician and patient; and as pioneer programs they were able to develop as “culturally pure” independent entities unencumbered by competing
values or priorities. Mainstreaming, which is essential to meaningful expansion, inevitably will challenge all of these.

An immediate mainstreaming challenge is the impending requirement that the unique Medicare financing adjuster ($2.39 \times$ AAPCC) be replaced by the Medicare+Choice general risk adjustment payment methodology. The unique PACE adjuster is thought to accurately reflect the real cost of elders at risk for nursing home care, while the more broadly based risk adjustment system appropriate for the general elderly population does not. Accordingly, the substitution of this mainstreamed financing approach could unintentionally result in much lower reimbursement to most PACE programs serving fewer than 500 persons and thus undermine their viability.

The care delivery flexibility and clinician empowerment that have been so essential to the success of these models came about because of trust in these mission-driven pioneer programs and their managers and clinicians. When these program models are mainstreamed, government payers will have no such basis to trust and in fact will be obligated to require accountability, given the large amount of resources flowing to hundreds of entities enrolling and caring for the most vulnerable members of society. Such accountability will require inflexible rules and regulations that are the antithesis of the very patient-centered flexibility to move resources that is the essential ingredient for success in these models.

Mainstreaming also requires that many stand-alone specialized programs such as the CMA be integrated into larger health plans (in many ways the ideal place for these models if there are to be economies of scale and the necessary infrastructure development). The management challenges of such integration should not be underestimated. There are different cultures, imperatives, locations of decision-making control, and provider/insurer worldviews. Bridging these differences so that the core values and strategies of these specialized care models are not destroyed will take commitment, creativity, energy, resources, and time.

Finally, the CMA and PACE models of care are personal, intimately and subtly intertwined with the ecology of medical care in a community, which is unique even in different parts of a city, not to mention different states or regions of the country. Substantial time, personnel, and resources have been required in integrating CMA-employed nurse practitioners with different practices and health centers in a way that maintains the essential aspects of the team model of care. Because of this, expansion even to contiguous communities always seemed to take longer than anticipated. Without this time and effort, the successful aspects of the program model can easily be lost.
PACE’s success has been due in large part to the ability of a single organization to transmit its mission, values, and clinical model to all involved caregivers. However, this success came with the requirement that enrollees give up their personal physician when they enter the program. In fact, current regulations mandate that participating primary care physicians be employed by the program. However, elderly persons are generally very loyal to their personal physicians, who have been their lifeline to medical services for years. Essential to the expansion of this model is a more flexible mixed model of primary care where community-based primary care physician relationships can be maintained. The Wisconsin Elder Care Options demonstration is now experimenting with this approach. When involved caregivers have different imperatives and are dispersed across unrelated organizations, the challenges to sustaining PACE’s values, and its effective clinical strategies, will be great.

Discussion And Policy Implications

Three broad policy implications can be derived from the experience of these programs and the lessons learned about the difficulty in bringing these care approaches to a meaningful scale. First, we know enough now about what it takes to improve the care delivery to the most frail and disabled in our society in a cost-effective way. The PACE/CMA experience does not represent a new technology or system breakthrough; rather, it validates what has been proposed by advocates and policymakers and applied successfully, perhaps in a less systematic fashion, by countless clinicians for decades. This is particularly true of the primary care paradigm (a team model of collaborative practice), which is prevalent in many program models and medical centers throughout the United States. What we are dealing with is not an “invention” but rather a “diffusion” problem. In this regard, foundation support may play a pivotal role in accelerating the diffusion of these care approaches if the appropriate leverage points can be identified as they were in the PACE and CMA experiences.

Second, there cannot be true integration of acute and long-term care services until there is integration of their financing.
livery models would be the creation of a single source of integrated, risk-adjusted Medicare/Medicaid financing at the state level, with “buy-in” opportunities for those not eligible for Medicaid benefits, similar to the Massachusetts Senior Care Organization waiver proposal. To promote accelerated diffusion for Medicaid-eligible high-need populations, risk-adjusted payment systems within Medicaid programs must be dramatically expanded. However, it is difficult to imagine such a change in payment methodologies in the foreseeable future, given the many challenges and budget constraints facing state Medicaid programs. Once again, the leverage of foundation support may be essential if there is to be widespread adoption of the needed infrastructure changes.

Third, the experience of these programs makes a solid case for modifying the “one size fits all” definitions of medical necessity and covered benefits in public and private insurance contracts. For specialized programs caring for vulnerable populations, Medicare and Medicaid procurement policies could allow (or promote) a more flexible and broadened definition of these elements—definitions that are more aligned with the optimal care requirements of these populations.

The challenges in bringing these models to scale are considerable. The challenges in maintaining the essential core values and clinical strategies of the programs with growth and mainstreaming are perhaps even greater. Given the absence of alternative strategies for our nation’s most expensive and vulnerable individuals, though, these challenges are worthy of engagement.

The authors acknowledge Stephen Somers, the Center for Health Care Strategies, and the Robert Wood Johnson Foundation for support over many years that led to the development of the programs cited in this paper.
NOTES


8. Master et al., “A Continuum of Care for the Inner City.”
