Managing Care for Older Beneficiaries of Medicaid and Medicare: Prospects and Pitfalls

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*Appendix A: Summary of Managed Care Programs for the Elderly*
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Summary

With the generous support of The Pew Charitable Trusts, the National Academy for State Health Policy is undertaking a demonstration project in which two states will develop plans for integrated systems of care to serve elderly consumers who are eligible for both Medicare and Medicaid. The hypothesis of the project is that, with appropriate safeguards, such care will result in better consumer satisfaction and other outcomes at the same or lower cost.

Integrating the primary, acute and long-term care services funded by Medicaid and Medicare should unify a core package of services for dually eligible beneficiaries, reducing fragmentation and resulting in more creative, less restrictive care plans that are not circumscribed by a particular funding stream. However, the first round of national integration experiments has taught us that pooling funding streams alone does not guarantee integration of or improvements in services, and the next generation of demonstrations should be strengthened accordingly. New models must also address the fear that merging acute and long-term care will result in the “medicalization” of long-term care services.

Integrated systems should also improve cost effectiveness. The opportunity to shift costs between the state and federal government is minimized when funds are pooled. Emphasis on vigilant monitoring of health and functional status and early provision of services should reduce the need for expensive institutional care. While some speculate that the greatest potential savings are in reduced hospital use, and that Medicare will therefore enjoy the greatest benefit, others believe that Medicaid will also realize savings. They argue that Medicaid payments to Medicare for “wrap around” services have been increasing rapidly, and reduced hospital utilization would temper this growth, since a significant portion of wrap around payments are for hospital deductibles and copayments. Also, Medicaid would enjoy the bulk of any nursing home savings that accrue, since it pays most of those bills. Some question the assertion that nursing home use will decline; they argue that utilization could actually increase as integrated systems focus on ways to decrease more expensive hospital stays. Existing programs provide inconclusive evidence on cost effectiveness and should be studied carefully in designing new models. While PACE programs appear to reduce hospital and nursing home use, the evidence is less clear with Social HMOs.
While financial incentives should improve overall cost effectiveness, they may also lead to undesired effects. Enrollment pressures may lead to adverse selection and threaten the viability of an integrated system. On the other hand, targeted marketing has been used successfully by some to select favorable enrollees, leaving behind those who most need services. Financial incentives can also build pressure to provide the least expensive care, regardless of its clinical appropriateness. These are concerns that must be addressed in the design of an integrated care model.

This paper describes undesirable characteristics of the current system, including improper incentives, discontinuity of care and cost shifting. It then describes the potential benefits that integration would bring to the system, as well as possible undesirable side effects, as summarized on the chart on page 6. The paper is divided into seven sections.

**Section 1** explains why services to the elderly are claiming an increasing share of the domestic pie. Demographic and expenditure trends are discussed.

- In 1990, the United States had 31.2 million people over the age of 65; that number is expected to grow to 52 million by 2020.

- In the same time period, the “very old,” those 85 years of age and older, will more than double in size, from 3.1 million to 6.5 million.

- Health expenditures are becoming more and more concentrated within a smaller and smaller percentage of the population, and the elderly make up an increasing share of the high users. In 1987, the top 1% of health care users accounted for 30% of expenditures. and nearly half of those high users were over 65 years old.

- In 1992, the elderly comprised only 11% of the Medicaid population but were responsible for 30% of the program’s outlays, a reflection of the elderly’s disproportional use of nursing homes and other long-term care services.

- In 1989, average health care expenditures for persons age 65 and over were three and a half times greater than those for adults under 65.
Section 2 explores the implications of the fragmentation of financing and delivery systems for the elderly. While service fragmentation could be greatly reduced through the integration of Medicaid and Medicare, experience shows that merging funding streams does not automatically lead to service integration. Another challenge is ensuring that essential non-medical services are developed and maintained, and that the integrated system not be dominated by a medical model of service delivery.

Section 3 discusses the dangers that older people face when they are hospitalized, and the reasons why hospitalization often leads to permanent dependency. Also discussed is the Medicare hospital payment system and how it favors admissions over length of stay, encouraging speedy discharges, often to skilled nursing facilities. Highlights include the following.

- In 1991, patients 65 years and older accounted for 47% of inpatient hospital use.

- Although the normal aging process itself increases the risk of dependency, hospitalization can accelerate the "cascade to dependency" that leads to nursing home admissions and hospital readmissions.

- When a person is immobilized (as in a hospital bed), muscle deteriorates at a rate of 5% a day on average, and vertebral bone loss is 50 times the normal rate.

- The elderly are less likely to ingest adequate amounts of food in the hospital than the non-elderly.

- Medicaid expenditures for Medicare "wrap around" coverage for dually eligible recipients, which consist largely of hospital deductibles and copayments, have increased rapidly in recent years, from $728 million in 1984 to $2.3 billion in 1992.
Section 4 describes the various home- and community-based options that exist for the elderly and shows that, despite explosive growth in this sector, total expenditures still pale in comparison with nursing home expenditures. The changing face of the Medicare home health program is discussed, as well as that program's lack of effective cost controls. The implications of the following statistics are explored.

- Out of an estimated $33 billion spent on home care of all types in 1993, $15 billion came from private sources (46%), $11 billion from Medicare (32%) and $7 billion from Medicaid (22%).

- Home health benefits are the fastest growing Medicare service. Expenditures in this category increased 47.4% in 1992, and are expected to increase by 42.4% in 1993, 34.7% in 1994 and 23.4% in 1995.

- The greatest growth within Medicare home health benefits has been in the number of visits per person served, which nearly doubled from 23.5 visits per person in 1988 to 44.5 visits per person in 1991.

- Home- and community-based services are the fastest growing in Medicaid, yet they still only accounted for 5.3% of Medicaid spending in 1991, as opposed to the 27% spent on nursing homes that year.

Section 5 reviews expenditures for nursing homes, as follows.

- In 1990, Medicaid paid for 45% of all nursing home care, another 45% was paid out-of-pocket, and Medicare paid for 5%.

- Of the $20.7 billion in 1991 Medicaid expenditures for nursing home care, $17.1 billion was spent on the elderly. This was the only Medicaid category in which elderly spending out-paced non-elderly spending.

Section 6 describes the experience to date regarding integrated programs for the elderly and related proposals under development.

Section 7 offers a preliminary list of questions that must be addressed in the design of integration models, and outlines the next steps to be taken by the National Academy for State Health Policy in implementing its demonstration project.
INTEGRATION PROSPECTS AND PITFALLS

PROSPECTS

- Consumers experience less fragmentation of care and better health and functional outcomes.
  - Enhanced continuity of care through the integration of primary, acute and long-term care
  - Greater independence through incentives to use less restrictive forms of care
  - More creative, less medical care plans

- Cost effectiveness is enhanced.
  - Emphasis on prevention and primary care
  - Reduced incentives to use institutional care
  - Diminished opportunities to shift costs between payers
  - Less reliance on cost-based reimbursement systems

PITFALLS

- Strong financial incentives may result in undesired effects.
  - Reduced access to and quality of services
  - Adverse or favorable selection
  - Threatened financial viability or excess profits

- Savings, if any, may accrue predominantly to Medicare, leaving states with little financial incentive to participate.

- Integration of funding streams does not guarantee integration of services, nor does it alone ensure better outcomes for consumers.

- Systems may be dominated by medical providers, resulting in “medicalization” of long-term care services.
Preface

States have demonstrated that it is possible to improve care for the elderly and contain costs at the same time. Notable examples of this success are the creative home- and community-based waiver and state-funded programs operating in Wisconsin, Oregon and Washington, which have shown that people who are nursing home certifiable can be given the less restrictive services they prefer at a cost lower than nursing home care. Yet these programs and others operated by states in every part of the country can only go so far before they bump into the Medicare wall. When an elderly person needs acute care services (as they frequently do), they enter a different part of the service delivery system where Medicare is the major payer. Typically, this part of the service system is disconnected from the long-term care portion, making transitions abrupt and traumatic for consumers. Rather than working together for the maximum benefit of consumers, each part of the system is motivated to guard its resources jealously, shifting patients and their costs to the other part of the system rather than managing those costs. Naturally, this completely predictable economic behavior leads to mistrust, making coordination even more difficult.

Integration of Medicare and Medicaid offers states the opportunity to demonstrate how better care can be provided by using resources more effectively. With greater flexibility and consolidated resources, states could develop integrated systems that would promote consumer choice; provide a broader array of services, many of which would be less restrictive and less medically-oriented than current services; and improve quality by focusing on continuity of care and health promotion. Incentives to shift costs, to use expensive forms of care, and to increase units of care should be reduced, resulting in a more effective system that costs no more than the current one. Along with this opportunity come the dangers of undue access restrictions, reduced quality, and “medicalization” of services. Also important is the possibility that much effort will lead to no improvement in outcomes, and that savings, if any, will accrue predominantly to Medicare. These issues must be acknowledged and addressed in the design of new systems.

Thanks to the generous support of The Pew Charitable Trusts, two states will have the opportunity to develop blueprints for integrated systems through a demonstration project offered by the National Academy for State Health Policy. By way of introduction to the project, this paper describes the undesirable characteristics of the current system that a successful demonstration would address. It does not examine technical aspects of integration in depth; that will be the topic of future papers.
Beyond planning for demonstrations in two states, the broader goals of the project are to raise critical questions ("Where should the locus of an integrated system be?"), test commonly-held assumptions ("Expansion of home care services will reduce aggregate health care costs."), and improve upon current integration efforts. To those ends, the paper highlights relevant statistics and research, discusses briefly the limited experience to date with integration efforts, identifies some of the potential pitfalls of integration, and begins compiling a list of pertinent questions. One of the most important questions on the minds of state policy makers is "What building blocks do states need to undertake integration successfully?"

The case study included in this paper is a fictional composite of typical situations facing elderly consumers who need both acute and long-term care services. It is offered not as definitive evidence that problems exist, but rather for its value in showing, in a tangible way, how the system effects consumers, family members, providers and payers.
1. BACKGROUND

Rose is 82 years old. Her husband died 6 years ago and Rose lives alone in the family homestead, a large farmhouse on the outskirts of a small town. Rose was forced to give up driving two years ago when worsening cataracts made it impossible to pass a vision exam required to renew her license. That had come as a relief to her daughters, Mary and Martha, who had been very concerned about their mother’s driving, but who had felt unable to confront her with their concerns. It has taken its toll on Rose, however. She can no longer go shopping or visit her friends independently, and she resists using the local transportation agency. She also needs assistance getting to the doctor’s office, where she goes with varying frequency, depending on how she’s feeling. Rose has hypertension and a heart condition, for which she takes four different medications. She has been hospitalized twice in the past three years, once with pneumonia and once with a heart attack.

Mary, who is 62 years old and lives with her husband an hour away in the closest city, goes to see her mother at least weekly to take her shopping, fill her pill box, help her in and out of the bath, clean the house and prepare meals for the week ahead. Martha is 60 years old and lives several hours away in another state. She visits twice a year. She has asked her mother to come stay with her for extended visits, but Rose does not like to travel and does not want to leave the house.

Rose’s biggest financial asset is her house, which has no mortgage but is worth less than $60,000. She has a cash nest egg of $20,000. Her only source of income is $668 per month in survivor benefits that she receives from Social Security, but she is very frugal, and she manages to add a little to her savings each month.

The increasing average age of people in this country is a well-known trend. The 1990 census of persons 65 years of age and older in the United States was 31.2 million and is expected to grow to 52 million by 2020. More significant, however, is the projected growth in the “very old,” those 85 years of age and older. They will more than double in size during the same period, growing from 3.1 million in 1990 to 6.5 million in 2020. (Vladeck, Miller and Clauser 1993, 6) Many of the family members and friends providing informal care to the very old are elderly themselves.

In their review of longitudinal health expenditure data from 1928 to 1987, Berk and Monheit (1992) found that health expenditures have become more and more
concentrated over a smaller and smaller percentage of the population. By 1987, the top 1% of health care users accounted for 30% of expenditures. Furthermore, nearly half of those high users were over 65 years old in 1987, up from a third in 1970. While increasing insurance coverage and proliferating technology fueled expenditure concentration in the 1960s, the “aging of America” has since become the significant force behind the trend, a force that will not abate for several decades. In 1989, average health care expenditures for persons age 65 and over were three and a half times greater than those for adults under 65. (Bringewatt 1992, 3) Absent major unexpected changes in other factors, the demographics alone portend significant increases in the portion of GNP spent on health care well into the next century. Many have predicted that our economy will not be able to absorb the precipitous increases that are inevitable absent significant changes in the way health services for the elderly are delivered and financed. States are particularly concerned about unsustainable increases in their nursing facility expenditures.

Perhaps the most significant development in service delivery and financing over the last decade has been the growth of managed care. By 1993, 39 states and the District of Columbia operated managed care programs of some type for their Medicaid beneficiaries, and 13 states have indicated that they will implement new managed care programs in 1994. (Simon, Chait and Rosenbaum 1994, 12) This rapid acceleration of managed care, however, has been focused mostly on AFDC beneficiaries, leaving the preponderance of SSI beneficiaries (aged, blind and disabled) in traditional fee-for-service arrangements. On its face, this is a curious development, given the most commonly cited benefits of managed care: better coordination and lower costs. SSI beneficiaries tend to have more complicated needs that could benefit from enhanced coordination, and their per enrollee Medicaid expenditures are far greater than those of AFDC beneficiaries. In 1992, per enrollee expenditures for the aged, blind and disabled were nearly $8,400, while per enrollee expenditures for all other Medicaid groups were just under $1,350. In that same year, while the number of aged comprised 11% of total enrollees, expenditures on them represented 30% of total Medicaid outlays. (Coughlin, Ku and Holahan 1994, 20-21) This disproportionate use of resources in the Medicaid program becomes even more significant when we remind ourselves that Medicaid expenditures for the elderly include relatively little acute care, since those services are paid predominantly by Medicare.

Many view the Medicaid/Medicare bifurcation as harmful to dually eligible elderly consumers, and as a significant obstacle to service delivery innovation. States control their Medicaid programs, and the federal government has shown increasing willingness to allow experimentation within that program. But the elderly tend to move back and forth between acute and long-term care services, so states see limited value in managing the long-term care portion of the system.
(where Medicaid is the major payer) without regard to the acute portion (where Medicare is the major payer). This leads to the question: would integration of services for the dually eligible achieve significant improvements in service delivery and financing?

2. FRAGMENTATION

Mary has a mild heart attack and is hospitalized for 3 weeks. During that period, Bob, her husband, makes the weekly visits to help Rose. Bob becomes very tired and stressed after 2 weeks of worrying about both his wife and his mother-in-law, and he quickly comes to the conclusion that Rose will need assistance from someone else. Furthermore, neither he nor Rose are comfortable with having him carry out the more personal tasks, such as helping with the bath. He approaches Rose about obtaining professional assistance and, after offering some resistance, she agrees to let Bob gather information.

Bob begins his research by calling Blue Cross/Blue Shield, which is the Medicare intermediary in that area. BC/BS explains that Medicare pays for certain home services, but that the enrollee must meet eligibility requirements for the service. BC/BS refers Bob to Rose's physician.

After 3 days trying, Bob finally reaches Dr. Carr. Dr Carr concurs that Rose really should have homemaker and personal care services, but he explains that, because Rose does not need skilled nursing services, physical therapy or speech therapy, and because she is not actually homebound, she does not qualify for home services under Medicare. He explores with Bob whether private resources are available to purchase services. When Bob indicates that money is limited, Dr. Carr suggests that he call the Department of Human Services to see if Rose qualifies for any form of public assistance.

When Bob explains to the Department switchboard operator that he is seeking services for his elderly mother-in-law, he is referred to the Division on Aging, which in turn refers him to the Area Agency on Aging in his area. The AAA tells Bob that Rose's cash nest egg makes her ineligible for homemaker services funded under the Social Services Block Grant and, while they can not make an official Medicaid determination, they are certain that Rose will not qualify for that either, ruling out public funding for personal care services. They explain that transportation and Meals on Wheels are available to all elders in Rose's area on a donation basis. Meals on Wheels would address one of Rose's needs, but Bob wonders how her medication monitoring, personal care and homemaker service needs will be met.
Bob gets the name of a reputable agency serving private pay patients from the AAA. The agency estimates that the types of services Bob is describing would cost about $300 per week, but they explain that they must first conduct a comprehensive evaluation, which will cost $350. They also warn Bob that, because they do not currently have people on staff who live in Rose’s area, there is likely to be a wait for services while they recruit. Bob recognizes that he must convince Rose to spend her nest egg on these private services. It is the only way to receive certain services now, and it will clear the way for Medicaid services in the future.

Rose, however, digs in her heels. She will not “throw away” the life’s savings that she and her late husband had scrimped to put away. She does agree to have meals delivered through the AAA, and she suggests having bars installed in the bathroom and getting a larger pill box that Bob could fill once every two weeks, rather than once a week. She also agrees to purchase and wear an emergency response device.

When consumers and family members come to the point of seeking assistance (often after a long period of denial, avoidance, cajoling or soul-searching), they generally find a confusing maze of services, each with their own eligibility requirements. Each program requires new exhaustive forms to be filled out, even though all of the information on the form has already been provided, in a different format, to a previous program. Those who are lucky find good care management services, and the burden of ongoing coordination is removed from them.

An ideal integrated system would provide “one-stop shopping” for elders and their families and ensure more consistent and reliable care, particularly in periods of transition. Chronically ill elderly persons often have fragile health conditions, characterized by an ongoing need for long-term care, and repeated, unpredictable needs for acute care. When an elderly person is hospitalized, there is often no communication between the hospital and the community-based providers until it is time to discharge the patient.

While integration of Medicare and Medicaid services could go a long way in reducing fragmentation, experience with the Social HMO sites suggests that financial integration alone does not guarantee service integration. In their report to HCFA regarding proposed design of “second generation” S/HMOs, Finch et al. noted that the first generation sites “did not change the nature of health care for the elderly. Fragmentation between acute-care and LTC [long-term care] remained; the case management was directed primarily at the long-term benefit.” (Finch et al. 1991,
24) It should be noted that, by design, S/HMOs serve the typical Medicare population; very few of their enrollees are dually eligible, and relatively little long-term care is provided. The experience of PACE sites, which serve enrollees who are much more frail than the typical Medicare population, may be more relevant, since virtually all enrollees are dually eligible and have long-term care needs. PACE sites have integrated care successfully, largely through status monitoring at their adult day centers, where most enrollees spend several days each week; it is not known whether the service integration achieved at PACE sites can be accomplished in a service model that does not employ day centers.

Integration of Medicaid and Medicare does not address directly the fragmentation of other services important to the elderly, including Meals on Wheels and other services funded by the Older Americans Act; transportation, homemaker and other services funded through the Social Services Block Grant (SSBG); housing, supported by federal Housing and Urban Development subsidies, SSI state supplements and other programs; and food stamps, funded by the U.S. Department of Agriculture. States also have general fund programs not mentioned here of various sizes and types. Responsibility for these programs are dispersed throughout state government, with most states having at least three separate agencies for Medicaid, aging, and income support programs. Fragmentation of funding and services within the states has led to the proliferation of costly case management systems designed to organize the current system. In order to reduce fragmentation significantly for older people, integration must go beyond the state-federal marriage of Medicaid and Medicare funds; it must mitigate the fragmentation within state government.

3. HOSPITAL CARE

Unbeknownst to Bob, Rose, becoming increasingly concerned about money, has been rationing her medication, intermittently returning dosages from the pill box to the bottles. Rose becomes dizzy and falls in the tub, and is hospitalized with a hip fracture.

Naturally, Rose does not admit to rationing her medication, and the doctors do not know whether the low blood levels indicate improper administration or ineffectiveness. A period of medication adjustment ensues, resulting in various side effects. In the meantime, Rose develops a urinary tract infection from a catheter. Her bad eyesight makes it very difficult for Rose to become familiar with her surroundings, and she becomes very discouraged and disoriented. The doctors worry about her slow recovery from the hip fracture.
The hospital administrators are also concerned about the slow progress, since they are now at risk of losing money on Rose under Medicare's diagnosis-related groups (DRGs) payment system. The hospital does, however, participate in the swing bed program, in which it can offer Medicare-reimbursed skilled nursing facility (SNF) services in a limited number of its hospital beds. Finally, one of the swing beds opens up, allowing continuing Medicare reimbursement for Rose. However, the hospital social worker understands that shortly, the hospital will want to use the swing bed to move another Medicare patient out of an acute bed, and the race begins to put a placement plan together for Rose.

Mary, Bob, Martha (who has taken a leave from her job out-of-state and is temporarily living at the house) and the hospital social worker agree that it would be confusing and upsetting for Rose to attend a planning meeting, so the four of them sit down to write a plan. Martha makes it clear that, as soon as Rose is situated, she must get back to her job. Bob and Mary explain their diminishing ability to make the trip to the house on a regular basis. They also feel that, in retrospect, the home services Rose had been receiving were not adequate. The social worker agrees that it would be best to continue SNF services outside the hospital, since Rose clearly qualifies for them. Bob wonders if there is a waiting list for such services. The social worker explains that a subsidiary of the hospital runs a SNF and gives priority to patients awaiting discharge from the hospital.

When the plan is presented to Rose, she strongly objects.

The hospital can be a dangerous and upsetting place for the elderly. In a review of the literature on this topic, Creditor (1993) has described the "cascade to dependency" that so frequently engulfs elderly patients in hospitals. Clearly, the normal aging process itself increases the risk of dependency, but Creditor argues that, because elderly persons generally have less reserve function to lose, hospitalization may provide the additional stresses that project them over the "threshold of functional disability," as shown in the following examples.

Example A: A patient comes to the hospital and bed rest is ordered. Immobilization leads to rapid deterioration of muscle (5% a day on average), and loss of vertebral bone at 50 times the normal rate. The patient falls and breaks a bone trying to get out of a bed that is much higher than the bed at home. This leads to prolonged bed rest, and a discharge to a nursing home.

Example B: An elderly person comes to the hospital from a home environment that included noisy grandchildren, pets, and adults leaving for work and returning in the evening. At the hospital, a quiet room with subdued lighting
reduces sensory stimulation significantly. The patient becomes confused and disoriented.

Example C: An elderly person with marginal bladder control has established toileting patterns at home to avoid incontinence. At the hospital, barriers and tethers (bed rails, IV tubes) lead to incontinence, which in turn leads to family rejection and institutionalization. The use of a catheter leads to infection.

Rejection of hospital food is also more of a concern for the elderly. A study of the dietary intake of hospitalized patients found that the elderly are less likely to ingest adequate amounts of food than the non-elderly. Patients in that study who were under 65 met 87% of their caloric requirements, whereas those 65 and older met only 56% of their requirements. (Rammohan, Juan and Jung 1989, 1777)

The elderly confront these dangers frequently. In 1991, patients 65 years and older accounted for 47% of inpatient hospital use. (Bringewatt 1992, 2) In that same year, Medicare, the primary acute care funding source for the elderly, spent over $62 billion on inpatient hospital services, with 90% of that ($55 billion) spent on the elderly and the remainder spent on non-elderly persons with disabilities. The $55 billion represented 42% of Medicare’s total Part A and Part B outlays of $130 billion. (Committee on Ways and Means 1993, 142, 210) By contrast, combined state and federal Medicaid expenditures on inpatient hospital use were just under $20 billion, with only $1.6 billion of that spent on the elderly, a reflection of the fact that the elderly use Medicaid predominantly for long-term care needs. (Congressional Research Service 1993, 820)

Although Medicare is clearly the biggest payer for hospital services to the elderly, states have become increasingly liable through their Medicaid programs. Medicaid programs have long picked up Medicare cost-sharing amounts as the payer of last resort, but payments to Medicare have jumped dramatically in recent years as a result of the Medicare Catastrophic Cost Act of 1988, which requires states to provide limited Medicaid coverage for Qualified Medicare Beneficiaries (QMBs). QMBs are Medicare beneficiaries whose income is at or below 100% of the federal poverty level and whose assets are no greater than 200% of the SSI limit. Medicaid must pay Medicare premiums, deductibles and copayments for QMBs, and have the option of providing full Medicaid benefits to them. As a category of Medicaid expenditures, payments to Medicare increased from $728 million in 1984 to $2.3 billion in 1992. Growth in this category alone accounted for 2.25% of the total Medicaid growth between 1988 and 1992. (Coughlin, Ku and Holahan 1994, 23 and 139) Medicare premiums cost a state the same amount regardless of the level of services used, but deductible and copayment expenditures increase with use of the system, and the potential per-person liability is great. For 1994, the Part A hospital

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deductible is $696 per benefit period. (A benefit period begins on the first day of hospitalization and ends 60 days following discharge.) In addition, days 61 through 90 of the benefit period are subject to a copayment of $174 per day. Beyond 90 days, the copayment becomes $348 per day for a limit of 60 “lifetime reserve days,” beyond which Medicare does not pay. Some analysts believe that payments for beneficiaries who have exhausted their “lifetime reserve days” are becoming increasingly significant. If the patient goes to a skilled nursing facility, a copayment of $87 per day applies from day 21 through day 100. (Jensen 1994, 3) Although the state has a clear financial stake here, it is a silent partner, having no say in the service mix, but being required to pay increasing Medicare bills.

It is obviously in the State’s interest to avoid hospital admissions altogether, to minimize the length of stay when admissions do occur, to choose SNF services over hospital services when those are the only options (although it then risks conversion to Medicaid NF when the SNF benefit expires), and to support home care whenever that is possible. If the state were a participant at this stage of service planning, the potential synergy of pooling Medicaid and Medicare funds could be directed at the goal of avoiding unnecessary admissions.

Under Medicare’s diagnosis-related groups (DRGs) payment system, however, admissions are favored over length of stay, since a hospital gets a set amount based on the diagnosis of the patient, regardless of the actual expenses incurred by the hospital in treating that patient. Elderly patients “awaiting placement” represent a serious financial liability to hospitals. While a hospital gets revenue by admitting patients, it can only profit by discharging them as soon as possible, before expenditures surpass DRG-prescribed revenue.

Partly in response to DRGs but also as part of a broader survival strategy in the face of managed care acceleration, hospitals are recreating themselves into integrated delivery systems that offer acute and post-acute care, day services, home health services and nursing facilities. In a recent survey of 1,200 hospital executives, the accounting firm of Deloitte and Touche found that 71% of the respondents were already developing integrated delivery systems. (Rich 1994) A fully integrated hospital system gains both access to services needed for the hospital’s patients and the ability to shift patients to whichever service the funding sources will pay for at various points in time. Some analysts worry that such systems create incentives to move patients based on greatest possible revenue, rather than on patient needs alone. They also worry that any hospital-based system will favor medical services over non-medical services, and many consumers will receive unnecessarily expensive care.
Medicare’s interest is in getting people out of the hospital. The DRGs payment system has transferred this interest to the hospitals, whose financial risk increases with length of stay. The state’s interest is in keeping people out of nursing homes, since Medicaid picks up the bulk of that bill. The consumer’s interest is in staying out of both hospitals and nursing homes. When each player considers only that player's interest, cost shifting is at its height and the consumer loses. Hospitals seek discharges to nursing homes because they are often more quickly and easily arranged than other, less restrictive options offered by a fragmented array of providers and funding sources. Medicaid reduces its short-term liability when a nursing home patient is re-hospitalized.

Pooling of resources and financial liability through integration could provide incentives for both sides to work toward the obvious win/win solution: providing the least restrictive appropriate care. Since consumers strongly prefer less restrictive forms of care, they win too, provided that adequate quality assurance mechanisms are in place to ensure that consumer choice and clinical appropriateness are the paramount criteria in selecting services. Experience to date is mixed. Social HMO data do show lower hospital use when compared to the general Medicare population, but no clear pattern of reduced utilization emerges when admissions per 1000 and average length of stay are compared to those for Medicare HMOs. PACE statistics are more promising: PACE sites show fewer days per 1000 and shorter average length of stay when compared to the general Medicare population, a particularly significant finding given that PACE enrollees must be nursing facility certified, making them more frail than the Medicare population generally. (Irvin, Riley, Booth and Fuller 1993, 19-20; 28-29)

4. HOME- AND COMMUNITY-BASED SERVICES

Bob, Mary, and Martha want to respect Rose’s objection to the nursing home, but they do not feel that she can go home, and they ask the hospital to keep her for a while longer. The hospital, however, is getting anxious to free up its swing bed, and the doctors feel that Rose can go home if an appropriate package of services is in place. Rose now easily qualifies for Medicare home health services (she needs both skilled nursing and physical therapy services), and she is expressing increasing unhappiness with being in the hospital, so her children reluctantly agree to proceed with a home care plan.

A Medicare-approved home health agency agrees to provide skilled nursing, physical therapy and other related medical services to Rose in her home. The agency, which is paid on a per visit basis, puts together a plan of frequent visits.
They explain that this will have no financial impact on the family, since the Medicare home health benefit is not subject to deductibles or copayments. This will also allow the family to minimize the amount of other supports they provide, since they can count on the agency to be in the house on a daily basis.

Bob arranges to have the AAA begin Meals on Wheels again. He finds a local teenager who agrees to maintain the yard in the summer and keep the driveway clear of snow in the winter. He returns to the private-pay agency he had used previously to arrange homemaker services. He and Mary do their best to coordinate these various services by telephone. Once the glitches are worked out, the system of care for Rose works fairly well. She is clearly very happy to be home, and progresses slowly but satisfactorily.

Perhaps because of the greater visibility of the Medicaid home- and community-based (HCB) waiver program, it is sometimes assumed that Medicaid is the largest public payer of home and community-based services, but 1993 estimates give that distinction to Medicare: out of an estimated $33 billion spent on home care of all types, $15 billion will have come from private sources (46%), $11 billion from Medicare (32%) and $7 billion from Medicaid (22%). (Vladeck, Miller and Clauser 1993, 11) Medicare expenditures for home health benefits are rising faster than any other Medicare service. The Health Care Financing Administration reports that expenditures in this category increased 47.4% in 1992. It was projected to increase by 42.4% in 1993, 34.7% in 1994 and 23.4 in 1995. Projected to rise during this period are aggregate expenditures ($7 billion to $17 billion), visits per 1,000 enrollees (3,717 to 6,810), and average charge per visit ($59 to $70). (Committee on Ways and Means 1993, 162)

Much of this growth has been attributed to broadened access to the benefit in the wake of a 1988 class action suit against the federal Department of Health and Human Services (Duggan v. Bowen). The Department was forced to abandon its requirement that services be both part time (less than 8 hours per day) and intermittent (less than seven days per week). That rule was changed to require that services be either part time or intermittent, increasing the universe of potentially eligible beneficiaries. Although more study is needed regarding the changes this has caused among users of the benefit, it appears that, as a group, they are becoming more a long-term chronic care population and less a short-term, post-acute care population. (Bishop and Skwara 1993, 106) Yet Medicare has not acknowledged this shift by offering less medically-oriented services, so it may be that more and more recipients of Medicare home health services are persons with chronic conditions who are getting unnecessarily expensive medical services because that is what their funding source reimburses.
Medicaid funds home- and community-based services in three categories: home health, personal care and waiver services. The HCB waiver program is specifically targeted to consumers who would otherwise be institutionalized, which limits its use. Taken together, these three categories of care are the fastest growing in Medicaid, yet they still only accounted for 5.3% of Medicaid spending in 1991, as opposed to the 27% spent on nursing homes that year. (Congressional Research Service 1993, 134, 143)

Assuming services are needed and delivered, growth in both Medicare and Medicaid home health is not inherently bad. However, both the federal government and states fear that increases in these services are not being carefully targeted or controlled, and an influx of significant new resources could result in the surfacing of a large latent demand. Given the financial incentive to avoid more costly services, an integrated system would be motivated to target home services to those at risk of entering a hospital or nursing home, but would not enjoy the increased payments that come with increased volume in the fee-for-service system.

In Medicare specifically, Duggan v. Bowen rule changes may have masked the growth attributable to improper incentives in the payment system for home health. Charges per visit are capped at the average allowable cost. While this does provide an incentive to keep per visit costs at the average, it also creates an incentive to deliver as many separate visits as are clinically supportable, since the provider will receive reimbursement at the average cost for each visit. In fact, the greatest post-Duggan growth in the Medicare home health benefit has been in the number of visits per person served, which nearly doubled from 23.5 visits per person in 1988 to 44.5 visits per person in 1991. (Bishop and Skwara 1993, 103)

Clearly, both the states and federal government have an interest in finding ways to use this benefit more effectively. If there are savings to be had by using home- and community-based services more carefully, some of those savings might be redirected to providing a more flexible and comprehensive package of home services that are not currently covered under Medicare or Medicaid. Careful consideration must be given, however, to design features that would encourage low technology care and avoid undue “medicalization” of home-based services. It is also not clear that capitated funding would result in more home-based care being provided as a substitute to more expensive forms of care, nor that costs can be reduced in this area without reducing quality. In a home care report commissioned by HCFA, Shaughnessy et al. compared Medicare home health services provided by HMOs with those provided by fee-for-service agencies and found that the HMO enrollees received fewer visits and had a lower frequency of visits than fee-for-service patients. While the cost of home services in the HMOs averaged two-thirds of the fee-for-service costs, the fee-for-service patients had significantly better
outcomes. (Shaughnessy, Schlenker and Hittle, 1994, 5.1-5.12) This suggests that at least some unknown portion of the additional services provided to the fee-for-service patients was effective, and was not simply excessive delivery fueled by the financial incentives inherent in fee-for-service systems. The authors point out, however, that the study looked at a relatively short period of time (12 weeks), and further study is needed to see if HMO enrollees have the same or better outcomes over a longer period of time.

5. NURSING HOME CARE

After a few months, Rose no longer needs frequent visits from the nurse, but it is very clear that she is deriving other benefits from the visits. The nurse always arrives first thing in the morning, so Rose waits for her assistance getting out of bed, rather than risking another fall. Also, the nurse routinely picks up the mail on her way into the house and goes through it with Rose before taking her blood pressure. She also dials the phone for Rose before she leaves, enabling Rose to initiate calls with her friends.

Inevitably, the visits are cut back, first to four a week, then to two. On one of the days with no visit, Rose falls getting out of bed and is re-hospitalized. Although she has escaped another fracture, Rose is deeply demoralized and becomes very confused. She refuses to eat. The doctors can do little for her, yet she requires 24-hour care at this point and can not return home. She makes the transition from acute bed to swing bed to SNF. When her Medicare SNF benefit is exhausted, she spends the remainder of her savings in two months as a private-pay patient at the nursing home, and applies for Medicaid. Her income puts her slightly above the federal poverty line, making her normally ineligible for Medicaid through SSI (maximum 75% of poverty) or through SSI-related eligibility (up to 100% of poverty), but the State does exercise a medically needy option for nursing home services, which also applies to its HCB waiver program. Under the medically needy option, Rose can offset her excessive income against her medical expenses, making her eligible for Medicaid. Unfortunately, Rose’s needs are now so great that the HCB program is not a cost-effective alternative, and Rose’s only option is to stay at the nursing home.

It was noted in Section 1 that in 1992, the elderly comprised 11% of the Medicaid population and were responsible for 30% of the program’s outlays. This disproportionate use is clearly attributable to the elderly’s high use of nursing facility services. Of the $20.7 billion in 1991 Medicaid expenditures for nursing home care, $17.1 billion was spent on the elderly. This was the only Medicaid service category in
which elderly spending out-paced non-elderly spending, reflecting the fact that the elderly use Medicaid predominantly for institutional long-term care services. In 1990, Medicaid paid for 45% of all nursing home care, another 45% was paid out-of-pocket, and Medicare paid only 5%. (Congressional Research Service 1993, 60, 821)

It is during medium- to long-term stays in nursing homes that options begin to disappear for consumers. On the road to Medicaid eligibility, modest assets are quickly depleted. Leases on apartments expire; houses are sold. Family members experience relief for the first time in months, and are hesitant to reestablish themselves as the principal care givers. PACE sites have shown an ability to reduce nursing facility utilization, but the degree to which lower utilization is contingent upon use of PACE’s adult day centers is unknown. Also unknown is whether integrated systems would increase the use of nursing homes in an effort to reduce their use of hospitals.

6. EXPERIENCE TO DATE; RELATED INITIATIVES

Although Rose’s deteriorating condition would probably have made her eligible for PACE services, no site exists in her area. Even if one did, Rose has never been particularly social and has made clear her disinterest in a daily visit to a day services center. The Social HMO in the nearby city where Mary and Bob live has placed Rose on a waiting list, since they already have as many high cost patients as they can risk financially. In any case, Dr. Carr has continued to see Rose at the nursing home, and she does not want to go anywhere if it means changing her doctor.

Operating Integration Models

Two models that integrate Medicare and Medicaid services for the elderly currently operate, as follows.

Social HMO Model (S/HMO): S/HMOs currently operate in 4 sites, and the Health Care Financing Administration (HCFA) has recently issued a solicitation to develop up to 4 additional “second generation” sites that will refine features of the existing sites. By design, S/HMOs serve the typical Medicare population which, as a whole, is healthier than the dually entitled population. This limits the number of high use consumers who can be enrolled in any given S/HMO. From the perspective of states, another limitation of S/HMOs is that they are provider-based and site specific. Although a state must be a willing participant that formally submits needed waiver applications, the force behind initiating a
S/HMO is the entity that will operate it. That entity (an existing HMO or other provider) receives the capitated Medicaid and Medicare payments from the state and federal governments, respectively. This model does not allow the state to receive Medicare payments and integrate them with Medicaid dollars. Also, as mentioned earlier, it is not clear that S/HMOs have favorable rates of hospital and nursing home use, nor that they have effectively integrated services in a manner that improves care.

Program for All-inclusive Care for the Elderly (PACE): PACE is also a demonstration program authorized by HCFA. The PACE program replicates an integrated program pioneered by On Lok Senior Health Services in San Francisco. The program currently operates in 10 sites. Legal authority exists for up to 15 sites, and most of the health care reform bills before Congress include authority for additional sites. The people served by PACE have higher needs than those served by S/HMOs: PACE enrollees must meet nursing facility certification requirements. Observers note that, while preliminary PACE outcome data look promising (fewer hospital days than the general Medicare population, for instance), PACE by design does not intervene early on, before a person regresses to the level of being nursing facility certifiable. Also, like S/HMOs, PACE sites are provider-based, with a minimal role for the State. Difficulty achieving desired census growth has also been an ongoing concern. (Kane, Illston and Miller 1992, 780) (Shen 1993, 31)

Although it does not currently integrate Medicare payments, the Arizona Long Term Care System (ALTCS) is notable for its unique delivery of Medicaid-funded services to the elderly and people with disabilities. Medicaid pays a capitated rate to program contractors for all of its covered services. The contractors bill Medicare separately as appropriate for dually-eligible enrollees. As part of its waiver renewal application (currently pending), Arizona is seeking HCFA permission to capitate Medicare payments along with Medicaid payments.

Summary information regarding S/HMO, PACE, ALTCS and other managed care programs for the elderly are included in Appendix A. For a more thorough discussion of these programs, see Irvin, Riley, Booth and Fuller, 1993.

State-of-the-Art Integration Initiatives and Related Developments

Minnesota Long-term Care Options Project (LTCOP): Currently, the State of Minnesota is seeking waivers from the Health Care Financing Administration under Section 1115 of the Social Security Act (Medicaid), and under Title 42, Section 1395b-1 of the United States Code (Medicare), to conduct a
demonstration known as the Long Term Care Options Project (LTCOP). The Robert Wood Johnson Foundation has supported the project since planning began in 1992. Now ready to implement the demonstration, Minnesota seeks necessary federal approval to receive Medicare funds for program enrollees and combine them with Medicaid to create one capitation rate that covers acute and most long-term care services. For enrollees, the state’s current Section 1915(c) home- and community-based waiver program would also be integrated into the project. By combining state and federal funding sources, Minnesota hopes to eliminate cost-shifting incentives that lead to less effective and more costly care. The state also seeks to promote prevention, early intervention and provision of services in the least restrictive setting by emphasizing managed care systems in which service providers share financial risk with the state and federal governments.

Washington State: As part of the Washington Health Services Act of 1993, the Washington Health Services Commission was charged with preparing a plan to integrate long-term care services into the state’s Uniform Benefits Package (UBP) by 1999. As part of this process, the Commission is charged with conducting two demonstration projects, the Washington Life Care Projects, to test various elements of the integration. The state has applied to The Robert Wood Johnson Foundation for support in planning the demonstrations. The state plans to submit a Medicaid/Medicare waiver application to HCFA by late 1994, with the goal of implementing the demonstrations by July, 1995.

Oregon: Oregon is considering a host of incremental steps toward integration as it moves to implement its Health Priority Plan. Although the Plan makes a clear distinction between medical and long-term care services (it covers medical services only), the State and the prepaid health plans are exploring various measures that might be taken on the road to integration for dually eligible enrollees. For example, joint application forms (Medicare/Medicaid), simultaneous enrollment, and the possibility of “locking in” dually eligible enrollees are all matters under discussion with regional HCFA officials.

Other Robert Wood Johnson Foundation Activities: Currently, The Robert Wood Johnson Foundation is reviewing applications from 17 states under the Foundation’s “State Initiatives in Long-term Care” program. Up to 7 states will be awarded 18-month development grants to reform their long-term care financing and delivery systems. While integration of acute and long-term care is one objective of the program, RWJ’s broader goal is to improve access to long-term care services in the context of federal and state health care reform initiatives.
RWJ also seeks to stimulate better organization, financing and integration of services through its chronic health conditions initiatives, which include "Building Health Systems for People with Chronic Illnesses" and "Chronic Care Initiatives in HMOs."

Other Health Care Financing Administration Initiatives: In addition to the S/HMO II demonstration, HCFA’s Office of Research and Development plans a solicitation later this year to promote integration for dually entitled consumers. Although the solicitation will be broad enough to include various target populations, the non-elderly disabled are of particular interest to HCFA.

7. PRELIMINARY QUESTIONS

The notion of integrating care for the elderly is admittedly an abstract one. It also is not without controversy, which is to be expected, given the magnitude of system change that is envisaged. Following are some initial questions that must be considered as demonstration projects are developed.

Quality

1. By what outcomes should success of integration be measured?

2. What quality assurance structures need to be in place to ensure that appropriateness of care takes precedence over cost containment?

3. How will the integrated system protect consumer choice? How will choice be effected by incentives to contain costs?

4. What safeguards are needed to ensure that an integrated system is not dominated by a medical model of service delivery? How does such a system promote the use of lower-cost, more flexible non-medical services?

5. What mechanisms are needed to ensure that integration will result in better coordination of services with better consumer outcomes?

Infrastructure Needs

6. What building blocks must a state have in place to undertake integration successfully? What kind of experience and infrastructure are needed within state government? Within the provider and payer communities?
7. What federal Medicaid and Medicare waivers must a state receive? Does the Secretary of Health and Human Services have sufficient authority to grant waivers under current law? Do other state or federal laws (other than the Social Security Act) present barriers to integration?

Program Design

8. Where is the locus of care? Who plays the central coordination role: a state agency? A health care provider? A case management agency that provides no other services?

9. What is the role of case managers in this system? Do they broker services, act as a gatekeeper, or do both?

10. What degree of integration is desirable? Complete integration of funding and services in an HMO capitated model? Enhanced linkages among the various parts of the current system? If Medicare and Medicaid are fully integrated, how will that new system build on and connect to other state programs outside of Medicaid?

Financial Matters

11. What is the best way to ensure adequate and sustainable participation? How can enrollment difficulties be avoided? How can adverse or favorable selection be avoided?

12. How does the payment mechanism in an integrated system recognize the variable health status among participating consumers? To what degree should the system adjust payments based on a provider’s degree of risk?

13. How will cost savings or cost effectiveness be predicted and measured?

14. If cost savings are realized, how should they be allocated? What share should go to expanding services? To states? To the federal government? To providers? How should losses be allocated?

15. If cost savings are realized, will they come from Medicare or Medicaid? If, as some predict, savings accrue predominantly to Medicare, how can financial incentives be provided to states?
Eligibility

16. Who is included within the target population of "dually eligible?" Does this include all Qualified Medicare Beneficiaries (QMBs) or only those receiving full Medicaid benefits? Should those who will become eligible in the future through spend down be included?

17. At what point should a consumer enter this integrated system? How will the system enhance prevention and early intervention efforts?

18. At what point, if ever, does a person leave the system? For example, is participation discontinued after a certain length of stay in a nursing home?

These questions, and many more that have yet to be identified, must be explored with care in a collaborative process that includes the state and federal governments, consumers, providers, health plans, foundations and researchers. The generous support of The Pew Charitable Trusts allows the Academy for State Health Policy to establish such a process. Next steps include the establishment of a national steering committee and the selection of two states to participate in a demonstration program.
References


## Appendix A
National Academy for State Health Policy
Summary of Managed Care Programs for the Elderly

<table>
<thead>
<tr>
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<th>S/HMO</th>
<th>PACE</th>
<th>ALTCS</th>
<th>Frail Elderly Option</th>
<th>LTCOP</th>
<th>Medicare HMO/CMP</th>
<th>EverCare</th>
<th>PMAP</th>
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¹ FY 1991 Data
² NFC - Nursing Facility Certified

Updated from: Managed Care for the Elderly: Profiles of Current Initiatives, National Academy for State Health Policy, November 1993