



COORDINATING CARE FOR THE ELDERLY:
A CASE STUDY OF A MEDICAID LONG-TERM CARE
CAPITATION PROGRAM IN NEW YORK

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EXECUTIVE SUMMARY

States are exploring two strategies in developing managed care programs for people eligible for both Medicare and Medicaid: the “dual-eligible” population. The first strategy, the fully integrated model, pools capitated Medicare and Medicaid payments and makes one plan responsible for providing all Medicare and Medicaid long-term and acute care services. The second approach focuses on the coordination (rather than integration) of Medicare- and Medicaid-financed health care, with capitated payments for Medicaid services. Both strategies attempt to address the need for (1) greater coordination of long-term and acute care services, (2) greater flexibility in benefit delivery, and (3) improved incentives for the appropriate use of health care services.

Regardless of the strategy that states take, many of the same issues arise in developing managed care models that coordinate and manage the delivery of long-term and acute care under Medicaid and Medicare. States, and the health care plans that work with them, must develop systems of care delivery that cover a wide range of services across a wide variety of providers and settings—homes, hospitals, and nursing homes. The challenge of developing such systems is complicated by the fragmented nature of the long-term and acute care delivery systems; the wide diversity in health plans and local health care markets; and the complex interactions of the Medicaid and Medicare programs. Much can be learned from the pioneering efforts of states and plans that have developed early models of managed care programs for the dual-eligible population.

This report examines three plans under New York’s “Evaluated Medicaid Long-Term Care Capitation Program,” which is supported by The Commonwealth Fund. The program, which exemplifies the second approach described above, emphasizes coordination of Medicaid long-term care services under capitated payment, with acute care services financed by Medicare. In each of the three plans studied, patients’ Medicare acute care services were provided on a fee-for-service basis. Given that all three plans were in early stages of development, the study focused on first-year design and implementation experiences. Findings in this study are intended to help inform the development of other programs in New York and other states.

The three plans are the Visiting Nurse Service Community and Home Options of Integrated Care for Elderly (VNS CHOICE), Co-op Care, and Senior Network Health (SNH). The plans have different organizational origins and geographic coverage, and their approaches to program development reflect such differences. VNS CHOICE is a subsidiary of VNS of New York, the largest home health agency in the United States.

VNS CHOICE's catchment area is the densely populated boroughs of New York City (the Bronx, Brooklyn, Manhattan, Queens). The parent organization of Co-op Care is Hebrew Hospital Home, which is a sub-acute skilled nursing facility located in the Bronx. Co-op Care's service area is also the Bronx. SNH is a subsidiary of the Mohawk Valley Network, an integrated acute care system located in a relatively rural area in upstate New York (Oneida County). Highlighted below are the plans' development of financial strategies, marketing and enrollment, case management and care planning, and service delivery.

Finances. Central to the program is a capitated payment rate to cover a list of core nonacute services. The capitated payment rate provides incentives for the participating organizations to control costs while developing creative case management and service delivery strategies. The plans each recognized the fact that the capitation rate applies to the total caseload, so that any particular patient could cost more or less than the average payment rate. This gave them the flexibility, for example, to care for certain high-cost individuals who otherwise might not receive the services they need to remain in the community. The plans generally felt that the capitation rate was sufficient at present, but that the aging of the patient base will create financial pressure in the future. All three plans expressed an interest in moving toward a fully integrated acute and long-term care program under Medicare and Medicaid.

Marketing and enrollment. VNS CHOICE has enrolled 2,500 individuals since it began operations in 1998. This enrollment achievement reflects, in part, the plan's ability to recruit from among the 40,000 seniors served by VNS of New York each year. Although Co-op Care and SNH had more modest enrollment goals, each sought to benefit from its own unique potential patient pools. Co-op Care originally targeted the densely populated residential community of Co-op City, while SNH aimed to recruit patients served by Mohawk Valley Network. All three of the sites are meeting their enrollment goals. While VNS CHOICE ramped up enrollment rapidly, Co-op Care and SNH experienced a more traditional enrollment trajectory, which was relatively slow at the start of the program but then increased rapidly after the programs had become more established in the communities. Co-op Care expected to have 400 enrollees and SNH 180 by the end of the third demonstration year.

Both Co-op Care and SNH encountered considerable competition in enrollment from other Medicaid home care providers and programs in their geographic areas. The competition was exacerbated by the generosity of the home care and personal care benefits provided under Medicaid in New York, particularly in New York City. Co-op Care reported, for example, that it was easier to enroll patients who were not already receiving

Medicaid home care services than it was to recruit individuals already receiving Medicaid home care.

Case management. Patients were attracted to the three plans' case management and coordination of acute and long-term care. Because the capitation rate pays only for long-term care services, case managers are challenged to execute the required coordination with Medicare acute care, over which they had no direct financial control. To maximize the continuity of care, case managers expend considerable effort working with hospital and nursing home staff, as well as with patients' individual physicians. Because of its affiliation with a health plan network, this function was slightly less burdensome for SNH.

Another challenge facing case managers was the need to negotiate with patients and their families about types and amounts of services to be provided under the care plans. One aim is to substitute technological, social, and environmental services (such as personal emergency response systems [PERS], adult day care, and installment of mechanical aids to reduce risk of falls) for time spent by home health aides. Although patients were happy to receive the "innovations," some also expected to receive the high volume of aide visits to which they were accustomed. Intensive education and communication efforts were sometimes required to resolve differences.

All three plans use a nurse as the primary case manager but, in two cases, the same nurse performed both the direct care and service arrangement functions, while in the third, the two functions were split between an inside service arrangement and an outside direct care case manager. Finally, each plan reported some tension between the case managers' dual role of patient advocate and plan utilization manager.

Service delivery. In addition to case management of acute and long-term care services, the flexibility in service delivery available under the capitation model allows the plans to provide a host of services that are not traditionally available under Medicaid. Although home health aides' services are still most important, transportation for visits to physicians and other health care providers is also viewed by patients as a valuable benefit. In general, the plans can provide creative nontraditional services that both benefit the patients and reduce expensive future acute care episodes. For example, all three sites have installed PERS in their patients' homes. Other services that one or more of the sites have provided include installation of bathroom safety bars, big-button telephones, air conditioners, smoke alarms, and microwave ovens.

Lessons learned. The plans stressed that the start-up time and money were both more than they had expected. They also warned about undetected comorbidities (e.g., cognitive impairment) that increased the amounts and types of services needed beyond those identified by the initial patient assessment. Identifying, recruiting, and educating a wide range of providers in order to maximize the services available was also time-consuming. Starting within an integrated system, or partially integrated system (as in the case of SNH), affords a strong basis on which to develop those relationships. Maintaining contact with this network of providers is equally important, particularly during the long period between program development and implementation. Patient education about managed care and responsibilities of plan membership need to be reinforced since many patients have found these concepts difficult to understand. The plans also noted that hiring individuals who can adapt to the diverse needs of the patient pool is essential, particularly among nurses who were transformed from “home health nurses” to “case managers for life.”

Implications. The Commonwealth Fund’s Evaluated Medicaid Long-Term Care Capitation Program differs from integrated acute and long-term care programs, such as the Program for All-Inclusive Care for the Elderly (PACE) and Social Health Maintenance Organizations (S/HMO), in that it capitates only long-term care and is required to coordinate with Medicare acute care rather than fully integrating financing for all patient care needs. This strategy helps alleviate concerns that full integration will shortchange the long-term care portion of the program, and it may foster higher enrollment rates. At the least, given that only two states have managed to integrate Medicare and Medicaid entirely, partial capitation may be the more practicable option for some states.

Although complete integration of financing and service delivery may be simpler administratively, the relatively high enrollment at the Commonwealth project sites speaks to the appeal of coordination. A drawback of fully integrated programs has been that enrollees are asked to give up their current primary physician in favor of the programs’ staff doctors. At the Commonwealth sites, this is neither a requirement nor a problem, and patients presumably do not feel they are making sacrifices to enroll.

The capitated Medicaid long-term care program is also an improvement over the standard public home- and community-based care in New York. The plans’ ability to provide extensive family counseling, normally uncovered (but necessary) psychosocial services, and case management while individuals are institutionalized, for example, represents an expansion over the relatively generous levels of care available under New

York's Medicaid program. Moreover, such "add-ons" can be readily determined and provided without undergoing elaborate prior authorization procedures.

Whether one program design is better than another for patient outcomes remains to be seen. The Commonwealth-funded program, however, appears to be on its way toward enrolling patients in significantly greater numbers than many predecessor programs. Assuming that higher enrollment continues, the partial capitation, coordination model offered at the Commonwealth sites may prove to be a strong challenger to the integrated service and financing model. If so, lessons from the earliest sites will prove all the more valuable.

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I. INTRODUCTION

Managed care programs and capitation arrangements have received much attention as potential means to facilitate the reorganization of health care delivery and to control its costs. States' use of managed care began with low-income families and children on Medicaid during the 1980s and 1990s, and has expanded rapidly over the last five years to include low-income aged and disabled Medicaid beneficiaries. Bringing these populations into managed care raises two challenges not faced by Medicaid programs serving low-income families and children: (1) the need to incorporate long-term care services in addition to primary and acute care and (2) the need to address the complex interactions of Medicaid and Medicare, as low-income aged and disabled Medicaid beneficiaries are dually eligible for both programs.

States are exploring two strategies in developing managed care programs for the dual-eligible population. The first strategy pools Medicare and Medicaid payments in a single capitated payment and makes one plan responsible for providing all Medicare and Medicaid long-term and acute care services. This integrated approach calls for federal waivers of certain Medicare and Medicaid requirements and the associated application, review, and negotiation processes associated with obtaining a waiver approval. The second approach focuses on the coordination (rather than integration) of Medicare- and Medicaid-financed health care, with capitated payments for Medicaid services. Both strategies attempt to address the need for greater coordination of long-term and acute care services, greater flexibility in benefit delivery, and improved incentives for the appropriate use of health care services.

Despite much interest, very few states have been successful at creating managed long-term care programs that fully integrate Medicaid and Medicare.¹ Currently, only Minnesota and Wisconsin have programs that integrate the financing and delivery of acute and long-term care services across Medicaid and Medicare, and both demonstrations are limited to relatively small populations in a few counties within the states. New York and Massachusetts have received approval of Medicaid and Medicare waivers, but have yet to implement their demonstration programs.²

¹ In addition to state initiatives, a number of states are pursuing federal demonstration programs, such as Social Health Maintenance Organizations (S/HMOs) and Program for All-Inclusive Care for the Elderly (PACE). However, total enrollment in such programs remains a very small share of the Medicaid population in need of long-term care services.

² New York received approval for a demonstration program in one county. Massachusetts has been approved for a statewide demonstration program.

States attribute the scarcity of integrated programs to the complexity of planning and implementing such demonstrations and the extended time frames required to obtain the necessary waivers (GAO 2000). Beyond that, managed care plans and providers have approached capitated payments for dual eligibles with caution given the unpredictability of enrollees' health and functional status and the relatively unsophisticated risk-adjustment methodologies that currently exist (Stone 2000). As a result, at least three states, Colorado, Florida, and Texas, have turned from pursuing an integrated Medicare and Medicaid strategy to the second strategy outlined above—the coordination of Medicare and Medicaid services in conjunction with capitated care under Medicaid alone.³ These states join two others that have already implemented such models. Most notably, Arizona implemented a statewide program to provide long-term and acute care services under a capitated Medicaid managed care model in 1989. In 1998, New York implemented a series of Medicaid long-term care capitation demonstration programs across the state.

Regardless of the strategy that states take, many of the same issues arise in developing managed care models that coordinate and manage the delivery of acute and long-term care under Medicaid and Medicare. The states, and the plans that work with them, must develop systems of care delivery that coordinate and manage a wide range of services across a wide variety of providers and settings—homes, hospitals, and nursing homes. The challenge of developing such systems is complicated by the fragmented nature of the acute and long-term care delivery systems, the wide diversity in health plans and local health care markets, and the complex interactions of the Medicaid and Medicare programs. Much can be learned from the pioneering efforts of states and plans as they develop these early models of managed care programs for the dual-eligible population.

This report examines three different plans under New York's demonstration project, the "Evaluated Medicaid Long-Term Care Capitation Program," which is supported by The Commonwealth Fund.⁴ The program emphasizes coordination of Medicaid long-term care services under capitated payment with acute care services financed by Medicare. In each of the three plans studied, patients' Medicare acute care

³ In a variation on this approach, Maine has implemented a primary care case management model of Medicaid managed care.

⁴ The New York Departments of Health and Social Services developed a program design for a partially capitated long-term care pilot project program in 1994 and 1995 with support from The Commonwealth Fund. A request for proposals was released in 1996 to solicit competitive proposals for pilot projects in up to six sites. In 1997, the New York legislature passed the Long Term Care Integrated Financing Act, which created a vehicle for up to 36 demonstration programs. The state intended these pilot projects and demonstration sites as the first steps in developing a fully integrated acute, primary, and long-term care managed care program for the population eligible for both Medicaid and Medicare.

services were provided on a fee-for-service basis. The three plans were the first to start enrollment among an original five contracted sites:⁵

- Community and Home Options of Integrated Care for Elderly (VNS CHOICE) program, a subsidiary of Visiting Nurse Service (VNS) of New York. VNS is the largest not-for-profit provider of home health care in the United States with a far-reaching service area in and around New York City.
- Co-op Care, a program under Hebrew Hospital Home (HHH). HHH is a 480-bed facility serving the Co-op City housing complexes in the Bronx area of New York City.⁶ Although its primary focus is nursing home care, HHH also provides home health care, adult day health care, respite care, and rehabilitative post-acute care.
- Senior Network Health (SNH), a program under Mohawk Valley Network (MVN). MVN is a large integrated health care system providing a continuum of acute care, post-acute care, home health care, and long-term care. Located in upstate New York (Oneida County), SNH faces largely different issues and challenges than do the two more urban organizations in the case study.

Given that all three plans were in early stages of development, this study focused on first-year design and implementation experiences. Thus, this report describes the programs as they existed in the early stages of their development. All three programs have continued to evolve based on their early experiences under the demonstration. Findings in this study are intended to help inform the development of other programs in New York and in other states. Future research will be needed to assess the impacts of the programs on beneficiaries and on Medicaid and Medicare program costs.

Sections II and III of the report describe the overall New York State demonstration project and the three different models that are the focus of this study. Sections IV through IX discuss (a) program organization and staffing, (b) marketing and enrollment, (c) case management and care planning, (d) service delivery, (e) quality assurance, and (f) financial issues. The concluding section discusses the lessons learned from these demonstrations that are relevant for other states and plans as they develop strategies to manage long-term care services with capitated payments.

⁵ New York originally selected five plans to participate in the demonstration program. In addition to the three programs described here, two other programs are currently in early stages of implementation: Good Samaritan Hospital/Fidelis Care New York in Orange and Rockland Counties (Partners in Community Care) and Long Island Home in Nassau County (Broadlawn Health Partners).

⁶ Co-op City is a “vertical” community of high-rise resident-owned apartments. Since the development of the apartment communities in the 1960s, many residents have aged into senior citizen status, forming a naturally occurring retirement community. Co-op Care originally intended to serve Co-op City exclusively, but has since expanded to other communities in the Bronx.

Table 1. Summary Table of New York's Demonstration Capitated Plans

	VNS CHOICE	Co-op Care	Senior Network Health
Began Operation	January 1998	August 1998	October 1998
Expected Enrollment	2,000	400	180
Case Management	Strong team focus on case management	Case management activities split between field nurse managers and in-house nurse managers	Relies on a single nurse to provide all case management services
Service Delivery	Skilled nursing care provided by VNS Home Care	Subcontracts with other providers for all services beyond assessment and case management	Subcontracts with other providers for all services beyond assessment and case management
Quality Assurance (QA)	Focused review of nursing home and hospital admissions, reporting of falls, surveying patient satisfaction, assessment of care outcomes	Basic QA system, examines grievances, patient complaints, falls, medication errors, hospitalizations, ER use	In process of setting up formal QA system, is tracking hospitalization and ER use, conducted some patient satisfaction surveys

II. THE OVERALL DEMONSTRATION PROJECT

With funding from The Commonwealth Fund, the New York Department of Health is implementing the Evaluated Medicaid Long-Term Care Capitation Program. Under this demonstration project, New York is scheduled to issue contracts to up to six programs for provision of a package of capitated long-term care service plans to dually eligible Medicaid/Medicare beneficiaries who qualify for nursing home care. In developing and implementing their plans, the programs are to collaborate with local departments of social services (LDSSs), which administer the Medicaid program.

The state expects the capitation system to introduce greater flexibility and patient choice in delivery of long-term care, as well as to reduce Medicaid costs. The project ultimately seeks to enhance the health status of patients and improve (or slow declines in) functioning using a cost-effective mix of services that maintains patients in their homes as long as possible. In addition, the demonstration program is intended as the precursor to a fully integrated system of acute and long-term care services.⁷

New York's Medicaid demonstration project affords the opportunity for increased flexibility, patient involvement, and creativity in delivery of long-term care services to a population at risk for nursing home admission. An important feature of the program is that enrollees and the programs negotiate the contents of a mix of services or a "care plan." Covered services are then provided directly by the site or its external subcontractors. Each demonstration site, primarily through case managers, is supposed to work with enrollees, families, and physicians to arrive at care plans that best meet enrollees' needs.

Each program receives capitation payments adjusted for its mix of enrollee impairment levels. Acute care is financed through Medicaid and Medicare in the same way as before the demonstration. An important dimension of the demonstration is that it does not require prospective patients to change their current primary care physicians.

The state requires all programs in the demonstration to use capitation to cover a specific list of core services: case management; nursing home care; home health care; personal care; adult day health care; social day care; personal emergency response systems; prescription and over-the-counter drugs; audiology, podiatry, dentistry, and optometry; physical, occupational, respiratory, and speech therapies; transportation; durable medical equipment; and social and environmental supports (e.g., meals, installation of ramps, etc.).⁸ Within this list of core services, the plans differ in their service emphasis.

⁷ In fact, guidelines issued by the state for the development of the long-term care project are consistent with Medicare policies, signaling the goal of future integration.

⁸ Assisted living is an optional service that can serve as a substitute for nursing home care.

VNS CHOICE, for example, considers enrollees' homes to be the hubs of services, including case management, health care, and personal care services, and will continue the VNS tradition of organizing home visits by staff around residential clusters. VNS CHOICE describes itself as having an orientation toward prevention, education, and self-care.

In its initial design, Co-op Care hoped to take advantage of the existing neighborhood structure of Co-op City to deliver home services in residential clusters and involve enrollees in social activities at community centers.⁹ Co-op Care, however, quickly discovered that fewer Co-op City residents than expected were eligible for Medicaid. As a result, it has expanded the geographic area over which it provides services and initiated a change in the name of the program to Community Health Care Services to highlight the fact that the program is not limited to the Co-op City community.

SNH noted that its strengths are its case management staff and wide continuum of provider types in, or strongly affiliated with, the integrated network, which includes an adult day care center and a certified home health agency. In addition, SNH hopes to build on the nursing home innovations of the Eden Alternative, whose founder is medical director of Mohawk Valley Network's nursing home. The Eden Alternative, a movement to revolutionize nursing home care, seeks to create a pleasant, homelike environment in an otherwise institutional setting through the use of companion animals, plants, and child visitors.¹⁰ Finally, the integrated system includes two nursing home facilities available for SNH patients who may need institutional care.

Organizations were chosen to participate in the demonstration project in part to represent a range of geographic areas within the state—urban, suburban, and rural locations—both downstate and upstate. They also represent a variety of organizational types, including home health agencies, nursing homes, and vertically integrated health care systems. These differences may be important because they could affect project implementation, operations, and effectiveness.

⁹ HHH (the parent company) is in the process of strengthening its post-acute, rehabilitative services, which Co-op Care will be able to use for its enrollees.

¹⁰ The Eden Alternative focuses on creating better social and physical environments for elderly and disabled people to “eliminate the plagues of loneliness, helplessness, and boredom” that often arise in traditional nursing homes. Additional information on the Eden Alternative is available at www.edenalt.com/home/index.htm.

III. ORGANIZATIONAL AFFILIATIONS

VNS CHOICE

VNS CHOICE received the first demonstration contract from the state and began operations in January 1998. This demonstration health plan has been established as a new, not-for-profit subsidiary of VNS. Founded in 1893, VNS is the largest not-for-profit provider of home health care in the United States. VNS is the parent corporation of three home health subsidiaries in addition to the demonstration project. Together, these four subsidiaries—each with its own administrative structure and staff—provide a wide range of home and community-based long-term care services.

VNS CHOICE has established a contractual relationship with its parent corporation for some administrative services. It has also contracted with VNS Home Care, another VNS subsidiary, for other administrative services and for delivery of direct services, including case management and skilled home health care.¹¹ Other services (such as nursing home care, podiatry, optometry, dentistry, pharmacy, day care, and transportation) are provided through separate VNS CHOICE subcontracts.

The VNS CHOICE service area includes the four largest boroughs of New York City (Bronx, Brooklyn, Manhattan, and Queens). At the end of the first year of operations, VNS CHOICE was serving approximately 500 patients. VNS CHOICE expected to serve about 2,500 enrollees by the third year of the program, which would make it by far the largest of the programs in New York's demonstration project. As of early 2000, it had exceeded that target.

Co-op Care

The second plan, Co-op Care, began operations in August 1998. Its organizational base is HHH, a nonprofit nursing facility whose origins date back to 1923. Although its primary focus is nursing home care, the organization provides a full continuum of long-term care services, including home health care, adult day health care, respite care, and rehabilitation/post-acute care. HHH also plans to open a primary care diagnostic and treatment center for the aged.

Co-op Care has a staff dedicated solely to the project. It relies heavily, however, on HHH administrative and financial resources. In October 1999, Co-op Care's service area included much of the Bronx in New York City. At the end of the first year of

¹¹ VNS Home Care has a staff of approximately 1,500 nurses who deliver and coordinate home care services. In 1995, more than 90,000 individuals (including almost 40,000 seniors) received health care and related services from VNS Home Care (VNS, 1996).

program operations, 87 patients were enrolled. An enrollment of almost 400 individuals is expected by the end of the third demonstration year.

Senior Network Health

SNH began operations in Oneida County in upper New York State in October 1998. Its organizational base is Mohawk Valley Network, Inc., an integrated health system formed in 1992 by St. Luke's Memorial Hospital Center and Faxton Hospital as a not-for-profit entity with most services provided through its affiliates on a contracted basis. These affiliates, which include both of its founders, provide a continuum of health care services.

Faxton-St. Luke's Health Care is SNH's organizational home. A not-for-profit community hospital system, Faxton-St. Luke's currently serves a population base of more than 400,000 in the surrounding communities. St. Luke's Home, a 160-bed nursing facility, is also associated with the hospital center, raising the nursing home bed complement to 284. At the end of the first year of program operations, SNH had enrolled about 60 patients. An enrollment of approximately 180 people is expected by the end of the third demonstration year.

Advantages and Disadvantages of Organizational Base

All three programs reported that they would have been unable to develop their demonstration programs without the parent organizations' substantial investment of funds in program design and operations, administrative support, and expertise. In other respects, the programs' organizational bases have affected their experiences in different ways.

VNS CHOICE has derived significant marketing and operational benefits from its affiliation with VNS. Because VNS is the oldest (over 100 years) and largest home health agency in New York, it is popularly viewed as being synonymous with home care in the New York City area. VNS CHOICE was able to subcontract with its sister organization—VNS Home Care—for most of the home care services to be provided under the demonstration. Moreover, because VNS Home Care serves 22,000 patients per day, VNS CHOICE has also had access to a large pool of individuals already on Medicaid home care who might be potentially eligible for and interested in enrolling in the new capitated program.

Co-op Care has received fewer marketing and operational benefits from its ties to HHH. Many individuals who use HHH either are ineligible for Medicaid or have an established relationship with an existing home health provider and so are not interested in the new capitated program. Hence, as noted, the originally selected catchment area for the

demonstration project did not prove to be an ideal source of potential patients. In addition, the close ties to a nursing home that came with the HHH affiliation has made some organizations that could be a good patient source for the new program leery of making referrals, out of concern that the patients would not return to their own affiliated nursing homes should they need such care in the future.

SNH reported significant operational and marketing benefits from being part of an integrated health care system. These include preferential pricing and appointments from the network providers, easier sharing of information about patients across provider settings (including hospitals and nursing homes), and referrals from other providers in the system. Despite the clear advantages of belonging to an integrated network, being in the network also presents some complications. For example, SNH has to address tradeoffs between MVN's obvious preference that SNH use providers in the network and the preference of some potential patients to use non-MVN providers. Working through the bureaucracy of an integrated system, rather than with an individual provider, can hinder the provision of care. Finally, SNH has found, like Co-op Care, that forming relationships with providers that could be good referral sources has been impeded by those providers' concerns that they will ultimately lose patients to the MVN system.

IV. PROGRAM ORGANIZATION AND STAFFING

VNS CHOICE, backed by VNS, has developed an extremely organized service delivery team that departs from previous health care delivery systems. A nurse manager is in charge of four clinical “pods” of support staff. Each pod is responsible for about 25 patients. The team comprising the four pods includes four nurse consultants and a member service representative (MSR). Additionally, a geriatric nurse practitioner, a social worker, and a rehabilitation therapist provide support to the service delivery team.

- The nurse manager functions as a regional director with responsibility for all operations in her region, including staffing and local provider relations. She also provides overall supervision of patient care through regular case conferences and ad hoc discussions about individual patients.
- The primary coordinators of care are the nurse consultants. They develop and monitor the care plan, provide skilled nursing care, and coordinate delivery of other demonstration services. They are also responsible for patient enrollment and screening.
- Originally intended to serve as clerical support for the team, the MSR has taken a more active role as VNS CHOICE has gained demonstration experience. In addition to clerical responsibilities, the MSR is now responsible for handling patient and family service requests and complaints, and arranging for the delivery of selected services such as transportation and aides.
- The geriatric nurse practitioner provides support to the service delivery team as needed. This support can include working with a patient’s physician on a care plan or helping the nurse consultants develop and monitor a patient’s care plan. The geriatric nurse practitioner also provides direct care and skilled nursing, especially for beneficiaries with complex medical conditions.
- The social worker conducts psychological screening of each new enrollee and provides psychological counseling thereafter if needed. She also acts as liaison to New York’s social service departments, helping patients maintain or obtain food stamps, housing assistance, and other benefits for which they qualify.
- The rehabilitation therapist was a late addition to the service delivery team, recruited in response to higher-than-expected patient need. She examines the activities of daily living (ADLs) and instrumental activities of daily living (IADLs) of each enrollee and provides rehabilitative therapy as needed.

Co-op Care uses a team approach on a much smaller scale. Its team consists of an in-house nurse case manager and a field nurse case manager. The in-house nurse manager arranges and coordinates care for the patients. The field nurse manager meets with the patient in his or her home and is responsible for program marketing, enrollment activities, and care planning. Together the two nurse managers handle up to 50 patients. By dividing program responsibilities between the two, Co-op Care hoped to create an efficient team that minimized travel time and allowed each nurse to specialize in key elements of the case management role.

Co-op Care's initial program design anticipated that the nurse case managers would also deliver skilled nursing care. Because the demonstration is licensed as a managed care organization and not as a certified home health agency, however, this was not legally possible in New York.¹² As currently structured, Co-op Care relies on contracts with other organizations for delivery of all demonstration services except assessment and case management.

As demonstration enrollment has grown, Co-op Care's team has expanded to include a member services coordinator to handle the scheduling of transportation services and doctors' appointments for enrollees. The expectation is that additional staff will be added and staff roles will become increasingly specialized as the caseload continues to increase. In addition, Co-op Care plans to hire a staff member to act as liaison with social service departments (much as the social worker does under VNS CHOICE) and to hire a marketing assistant.

SNH's relatively small size has led it, at least initially, to use a less team-oriented approach than either VNS CHOICE or Co-op Care. At SNH, each nurse case manager is responsible for all aspects of the program—marketing and enrollment as well as care planning and monitoring. Each nurse case manager serves approximately 25 patients. One advantage SNH reports from using this strategy is that the nurse case manager is able to develop a strong relationship with patients and a thorough understanding of the problems and challenges they face over time. Furthermore, the patient has one person to contact in the program, a characteristic that has been well received by SNH enrollees.

As with Co-op Care, SNH does not have a license to provide care; all skilled nursing care is provided through contracted Certified Home Health Agency services. Also as with Co-op Care, SNH anticipates adding additional staff and increasing staff

¹² In contrast, VNS CHOICE staff—who are VNS of New York employees—are licensed under the parent company's Certified Home Health Agency license to provide such care.

specialization as the caseload grows. SNH is planning to add an MSR to take on the more clerical aspects of the nurse case manager's job. As enrollment continues to increase, it also expects to add a secretary, billing and claims staff, and provider support staff. With additional specialization, it expects to be able to increase the caseload for each case manager to 30 patients.

V. MARKETING AND ENROLLMENT

Marketing

As managed care programs, the demonstration's capitation plans are subject to direct marketing regulation by the state. They are not allowed to sell their programs door-to-door or through unsolicited phone calls, and all marketing materials must clearly explain the requirements and limitations of the plan.

VNS CHOICE's initial marketing strategy had two parts: (1) referring individuals already being served by other VNS programs to VNS CHOICE, while (2) building an external community-based patient referral system. Within the first year of operation, about 90 percent of VNS CHOICE enrollees come from internal VNS referrals.

Marketing efforts by VNS CHOICE beyond the current VNS caseload have focused on outreach to referral sources in the community rather than prospective patients themselves. Advertising efforts have focused on building and maintaining relationships with such community members as physicians, community-based organizations (CBOs), community and religious leaders, and hospital discharge planners.¹³ VNS CHOICE staff indicated that partnering with CBOs is seen as very important for the long-term success of the program.

Co-op Care and SNH, in contrast, did not start with a strong internal referral base. Thus, both have had to rely on referrals from their local departments of social services (LDSSs), which administer the Medicaid program, and on reaching out to the community to identify potential enrollees.

The referral of potential enrollees from the local departments of social services (Social Services) is the subject of some controversy, because Social Services have operating responsibility for determining eligibility for Medicaid's home care program and are also an alternative service provider for demonstration-eligible individuals. SNH reported that the Social Services in its area tended to refer more difficult cases (geographically or medically hard to serve patients, as well as those with difficult personalities) to SNH. This practice was motivated primarily by the lower cost limits available to the Social Services for the direct provision of home care for Medicaid recipients in the area. Because SNH has a relatively higher per person per month expenditure cap, Social Services reason that SNH would be better able to care for needier patients. SNH reported that in the first year 50

¹³ VNS is using an account management model to build its referral network. Each potential referrer is assigned to an account manager who is responsible for that relationship.

percent of its patients were obtained through Social Services referrals. Co-op Care reported that the Social Services in its area appeared reluctant in general to refer patients. In the first year, only 10 percent of Co-op Care's patients are Social Services referrals (about the same proportion as for VNS CHOICE).

Reaching out to the community to identify potential enrollees has proven more difficult and costly than either SNH or Co-op Care expected. Both attributed the difficulty to competition from New York Medicaid's standard home care benefit, particularly the very generous personal care program.¹⁴ Many prospective enrollees see the demonstration as potentially entailing changes in their home health aides, adult day care centers, and/or pharmacists for what they perceive as little or no additional benefit. Furthermore, under New York City's extensive personal care program, patients may be able to obtain aides for more hours per week than Co-op Care deems necessary.¹⁵ More generally, while Co-op Care and SNH offer at least some services beyond those offered under the existing programs, the value of those benefits as perceived by many potential enrollees appears insufficient to change their provider relationships. Both plans noted, in particular, that a significant share of potential enrollees who chose not to enroll disliked the idea of having a case manager—a key element of the demonstration design. SNH reasoned that the potential enrollees did not understand the total set of functions the case managers would be providing, but instead viewed working with a case manager as an unnecessary step in obtaining access to home care. An eligible individual who wanted only a home health aide, for example, could obtain one directly through other programs without having to negotiate a care plan with a case manager, as is required under the demonstration program.

To help deal with the recruitment problem, Co-op Care has turned to the Medicaid applicant population, helping new applicants complete their enrollment forms. It viewed this group as particularly attractive because, not having had experience with Medicaid's regular long-term care services, they are more receptive to information about the benefits of managed care generally and of the demonstration in particular. About half of Co-op Care enrollees are new to Medicaid, and they tend to be substantially less impaired than Co-op Care had anticipated. (In contrast, only about 10 percent of SNH enrollees are new to Medicaid.)

¹⁴ New York accounts for 65 percent of the *country's* Medicaid personal care expenditures. Within New York, personal care services account for about 70 percent of total spending on home care, and 80 percent of the personal care expenditures are incurred in New York City (Holahan et al., 1997).

¹⁵ This is not the case for SNH, because in Oneida County the personal care program offers fewer hours than SNH and requires that individuals share their aides.

SNH, in contrast, has concentrated on marketing to the provider community, particularly the physicians of current demonstration enrollees, whom it hopes will refer other patients. SNH has also made some progress in developing relationships with hospital discharge units, including those within MVN's integrated care system. About 25 percent of its referrals in the first year were from hospitals, reflecting an advantage enjoyed by SNH because it is part of MVN. This high rate of hospital referrals contrasts with a common perception at SNH (and at the other two sites) that it is difficult to change the perspective of hospitals to view the plans as viable locations for discharge.

All three sites have found attempts to market directly to individuals largely unsuccessful. In general, public meetings to explain the programs (e.g., a meeting in an apartment complex in which several current enrollees lived or a meeting at a senior center) tended to yield relatively healthy attendees whose levels of need were not sufficient to qualify for the program.

Enrollment

Enrollment procedures at the three sites are similar in their strategy of making multiple visits to allow potential patients and, if relevant, their caregivers, to process information about the demonstration. Education of the patient, patients' caregivers, and, in some cases, patients' physicians, is considered crucial to the enrollment process for all three sites—and has proven more difficult and time-intensive than had been anticipated. In part, this difficulty reflects the greater extent of depression and cognitive difficulties among the population than had been anticipated, as well as a general lack of understanding of managed care.

The general enrollment process is as follows. First, a nurse case manager meets with the potential applicant. During this meeting, this manager explains the program to the potential enrollee and provides a copy of the member handbook and the provider directory. Reviewing the directory of non-physician providers with the potential patient early in the enrollment process is particularly important to Co-op Care, because it enables the patient to ascertain whether a key provider is available under the plan. If not, the potential patient often withdraws from the application process. SNH is addressing this issue through a phone call to the potential patient prior to the initial visit, in which SNH staff gather basic information about the potential patient, including whether the individual is already enrolled in a very popular adult day care center. Since that particular provider does not serve SNH patients, potential enrollees currently in that center typically decide they are not interested in SNH. SNH reports that approximately 20 percent of applications are withdrawn following the preliminary phone call.

As part of the initial visit by Co-op Care and SNH, the case manager begins the assessment process. Based on the results of an initial visit, SNH staff schedule a second visit, along with Social Services staff, to complete the official assessment. Co-op Care may schedule a follow-up visit with the patient if additional information is needed. VNS CHOICE routinely schedules a second visit for a more in-depth discussion of the program and to complete the initial assessment. In the cases of both VNS CHOICE and Co-op Care, Social Services staff do not participate in the assessment process, although they review the assessment materials.

For individuals found eligible for the program, VNS CHOICE, Co-op, and SNH develop a preliminary care plan in consultation with the applicant and family as well as the community physician and, if relevant, other providers. Another patient visit is then scheduled to discuss the care plan.

Following completion of the application, each of the sites forwards the materials to the relevant Social Services for review. All three organizations reported that it takes four to six weeks to gain Social Services application approval. Since this approval is necessary before services under the plan can begin, the plans make interim provisions, when possible, to ensure that patients receive necessary services while their enrollment is being processed.

The types of applicants who do enroll are broadly similar across sites. Enrollees tend to be attracted by (1) the availability of a single person providing case management services to help them negotiate the health care system, (2) the availability of transportation support (which is viewed as superior to the transportation services available under Medicaid), and (3) greater flexibility in the types of services available. In the case of VNS CHOICE, many enrollees also like the idea of remaining part of the VNS “family.”

Individuals who withdraw their applications also share common characteristics. These include a dislike or distrust of managed care, a preference for managing their own care (as opposed to having a case manager), and an established relationship with existing providers who are not in the plan’s network (particularly an established relationship with an aide). In some cases, disagreement over the care plan as proposed by the site has also led applicants to withdraw.

Enrollee characteristics. Demonstration sites are required to conduct assessments of their patients using a state assessment form (DMS-1) and the Outcome and Assessment Information Set (OASIS). OASIS, which is also required of all Certified Home

Health Agencies (CHHAs), provides the plans and the state with data on medical and functional status and status changes over time. The three sites in this study are in varying stages of fully automating and integrating OASIS into their respective management information systems. Since most sites are still working on this, the study was able to obtain OASIS data on only a small sample of patients, which is part of the caseload of all three sites. Table 2 presents this information.

To the extent that the small sample reflects the demonstration population, the sites are serving many individuals who are very medically and functionally dependent. About half the sample has an overall prognosis of “good” or “fair,” but only about one-third have a rehabilitative prognosis that is “good.” Almost half the sample has vision impairment and more than 70 percent indicate that pain interferes with activities or movement at least some of the time. Almost 40 percent have evidence of depressive feelings and 14 to 17 percent have indications of cognitive impairment. It is noteworthy that high levels of depression and cognitive impairment among enrollees was one of the surprises all three plans noted as they began operations.¹⁶ Cognitive impairments, in particular, significantly increase the resource intensity (and therefore cost) of a patient’s care plan, because of the need for both more supervision and more case management. Large percentages of the patients (56 to 98 percent) are also dependent in both activities of daily living and instrumental activities of daily living. Finally, although many of the patients have primary informal caregivers, more than half are living alone.

¹⁶ Cognitive impairment is not picked up by the assessment form (DMS-1) used to determine demonstration eligibility.

Table 2. Characteristics of Enrollees at Start of Care

Characteristic	Percent
Sample Size	341
Gender	
Male	20.5%
Female	79.5
Overall Prognosis	
Poor	32.0
Good/Fair	49.6
Unknown	18.5
Rehabilitative Prognosis	
Guarded	52.8
Good	31.1
Unknown	16.1
Vision	
Normal	56.3
Impaired	43.7
Living Arrangements	
Alone	54.3
With spouse/significant other	12.0
With others	33.7
Primary Caregiver	
None	9.1
Spouse/significant other	9.1
Child	45.5
Other family member	12.6
Other	5.3
Unknown	18.5
Pain Interferes with Activities/Movement	
None of the time (includes no pain)	29.0
Some of the time	61.3
All of the time	9.7
Enrollee Has Open Wound	4.1
Enrollee Uses Oxygen at Home	3.2
Enrollee Is Incontinent	3.2
Evidence of Depressive Feelings Observed	39.6
Cognitive Impairment	
Memory deficit	17.3
Impaired decision-making	13.8
Enrollee Needs Assistance with:	
Dressing (upper body)	85.0
Dressing (lower body)	91.2
Bathing	97.7
Eating	84.2
Transportation	97.9
Housekeeping	91.5
Medications	56.0

Source: Tabulations on OASIS data by New York Department of Health.

VI. CASE MANAGEMENT AND CARE PLANNING

As noted, the state expects each demonstration program, primarily through case managers, to work with enrollees, their families, and their physicians to arrive at a plan of care that delineates the mix of services that will best meet enrollees' needs.¹⁷ The case manager's role is to coordinate multiple services, including primary and acute care services (e.g., physician visits, hospital stays, and mental health and substance abuse services) that remain outside the capitation rate for the demonstration.

A nurse is the primary case manager for individual plan members at all three sites. In general, case management involves home visits, telephone contacts with the member and his or her caregivers, communication with other members of the service delivery team, and communication with other providers. Within this basic framework, differences in the structure of service delivery across sites leads to some differences in case management.

VNS CHOICE has a strong team focus to case management. While the nurse consultant has primary responsibility for case management, other team members also play a role. Social workers and member service representatives, in particular, are more active in case management than had been anticipated in the program's initial design. Furthermore, the VNS CHOICE service delivery team holds weekly case conferences that enable all of the skilled staff to consult and confer on the management of individual cases. In addition, given that the nurse consultant also provides hands-on skilled nursing care to the patient, the case manager makes more frequent home visits under the VNS CHOICE program than occurs at the other two sites.

At Co-op Care, case management activities are split between the field nurse managers and in-house nurse managers. The in-house nurse managers are responsible for coordinating the care provided to the member, while the field nurse managers undertake the home visits. The field and in-house nurse managers talk with each other daily and have a monthly formal review of each case with case management supervisory staff.

SNH relies on a single nurse to provide all case management services to patients. Case managers then meet weekly to review each patient's care plan with one another as well as with case management supervisory staff.

¹⁷ The state expects demonstration programs to involve beneficiaries' primary care physicians, even though physician services are not covered by the capitation payment.

In addition to the expected case management tasks under the demonstration, VNS CHOICE and Co-op Care reported that an important case manager skill they have had to develop is the ability to negotiate with patients about the level of services to be provided. When patients want more home health aide hours than the demonstration site feels is necessary, the plans must negotiate with the patients about other ways in which service needs can be met. As an alternative to additional home health aide hours, for example, VNS CHOICE has installed personal emergency response systems (PERS). Co-op Care automatically installs a PERS unit unless the patient refuses. SNH has installed PERS units in the homes of most of its patients. Smoke alarms and telephones have also been installed in the homes of patients to increase their safety and independence. Given the higher number of program patients living in single unit housing in the relatively rural area served by SNH, in contrast to patients living in apartments in urban areas, SNH has also invested extensively in home modifications (e.g., installation of ramps, widening of doorways, and bathroom modifications).

Case management versus gatekeeping. For any capitated payment model, the potential exists for conflict between the case manager's dual roles as patient advocate and plan utilization manager. All three programs reported that case managers operate more as patient advocates than as gatekeepers. VNS CHOICE staff indicated that while they track the cost of the care plan relative to the capitation rate, they do not try to stay within a cost capitation for any particular case. The expectation is that some cases will have costs that exceed the capitation rate and some will have costs that fall below. Nor, with the exception of podiatry care, do case managers attempt to limit particular services.¹⁸ Rather than limiting services, VNS CHOICE staff reported, the capitation rate allows for much greater creativity in care planning than they had in the traditional home health program, when they would simply provide the needed acute care and leave. VNS CHOICE staff characterize their service delivery strategy as focusing on using less expensive services when appropriate, meeting needs rather than just providing hours of care, improving functional capacity (to reduce need for care), and encouraging more family and member responsibility for care.

Co-op Care, in contrast, has been surprised by the low use level of some services. Their patients have been reluctant to use dentists, podiatry, and adult day care, for example—three services that were expected to be used by much greater shares of the caseload.

¹⁸ A review of utilization data by VNS CHOICE suggested that podiatry services were being used at unusually high rates. VNS CHOICE now requires prior approval by the case manager of requests for podiatry care to insure that the care is appropriate.

All three programs expect the tensions between gatekeeper and advocate functions to grow as their populations become increasingly disabled and their costs increase accordingly.

Physician relations. Service delivery under a partial capitation model creates the problem of a discontinuity between acute and long-term care. The three case study sites have undertaken somewhat different strategies for improving the links between the two.

VNS CHOICE works collaboratively with community physicians to serve its enrollees and has found most physicians to be very receptive to the program. Enrollees' physicians with a working relationship with the VNS network are asked to join and, if they do not, VNS CHOICE develops alternative strategies to work collaboratively with them on an ongoing basis. In addition, VNS CHOICE requires physicians to obtain plan authorization for covered services.¹⁹ Physicians who have met the VNS credentialing standards have signed a collaboration agreement to receive a monthly care coordination fee for each enrollee.

Neither Co-op Care nor SNH has such a formal relationship with its patients' physicians. SNH's strategy is to ensure that the program imposes few burdens on the physician while providing significant benefits by reducing the workload for the physician's office. They take an active role in ensuring that the patient arrives for his or her appointment on time, gathering information on the care plan prescribed by the physician during the visit, and ensuring that the individual complies with that plan. A key element in this strategy is use of a form for gathering information on the doctor visit. That form, which accompanies the patient to the visit, provides SNH with the information needed to integrate the services they provide with the physician's care. SNH has found most physicians to be very supportive of the program, which they attribute in part to the significant penetration of managed care in upstate New York.

Co-op Care has had less success building relationships with their patients' physicians, largely because many Co-op Care patients use public clinics, where they are treated by residents and, therefore, seldom have long-term physician-patient relationships. Because continuity of care tends to be poor, there are few cases in which a physician is actively involved with the overall care of Co-op Care patients. The high turnover in staffing and a strong focus on acute care further hinder extensive relationships with the clinics. Co-op Care also found that most physicians wanted to minimize their role in the

¹⁹ Because physicians can order services covered under the capitation payment, their decisions have financial consequences for the plans.

project, including having little involvement in developing the patient's care plan (although they have never disagreed with Co-op Care about the plan). Case managers at Co-op Care, or the aides accompanying the patients, do speak with the physician to learn about the outcome of the visit. Like SNH, Co-op Care found physicians' offices and clinics appreciative of the plan's role in ensuring that patients arrive for scheduled appointments.

Relations with hospitals and nursing homes. The transfer of members between home and nursing home, and home and hospital, are program operations that have been challenging for all three sites. When a member is admitted to a hospital or nursing home, program staff will monitor the member's health care; however, their ability to obtain information from these patients' providers has varied tremendously. SNH, as a member of an integrated health care system, has access to patient records across all providers in their system, which facilitates its ability to track care and monitor hospital and nursing home discharges. Co-op Care has the advantage that its parent organization is a nursing home, so that transitions by Co-op Care patients to and from Hebrew Hospital Home are relatively smooth. However, Co-op Care has had difficulties tracking transitions between home and hospital. VNS CHOICE, which lacks formal ties with either hospitals or nursing homes, has had difficulty tracking transitions to and from both types of facilities. Building better relationships with hospitals for Co-op Care and with both nursing homes and hospitals for VNS CHOICE are key elements of their efforts to improve coordination of care across acute and long-term care settings.

VII. SERVICE DELIVERY

Demonstration plans receive capitated payments for all long-term care services. Thus, a key challenge for the sites is to provide care in a cost-effective manner. The three sites have developed a number of strategies for delivering care in a more cost-effective way. First, less expensive options—such as PERS or chore services—may be substituted for more costly direct care alternatives, such as more supervision time from home health aides. Social and environmental modifications (such as microwave ovens, minor home repairs, and installation of bathroom safety bars) may similarly eliminate the need for more expensive personal care. Second, by closely monitoring members through in-home visits and telephone calls, needed services can be delivered in a timely manner, reducing the potential for complications as a result of delays in getting care. Third, delivery of preventive services, a particular emphasis under the VNS CHOICE and SNH programs, can potentially reduce the need for higher-cost care in the future. Fourth, encouraging and supporting family involvement can both reduce the use of high-cost services in the community as well as delay entry into a nursing home. For example, SNH offers respite care as a means of supporting informal caregivers. Finally, use of cluster care can reduce the costs associated with delivery of home care services, particularly in more densely populated areas, where home health aides can make multiple short visits to several members over the course of a day or week. As noted, Co-op Care intended to utilize cluster care as a key element of its service delivery strategy in the Co-op City complex.

Because VNS CHOICE, Co-op Care, and SNH are approved as managed care organizations (rather than service delivery organizations) under the demonstration, they are not permitted to deliver skilled services directly. As a result, SNH subcontracts with other providers for all services beyond the assessment and case management activities. Co-op also subcontracts with other providers for all services with the exception of enrollment and case management. In establishing such contracts, SNH has benefited from the ability to subcontract with other members of the MVN integrated health care system for many of the demonstration services. VNS's CHHA license permits VNS CHOICE's case managers (as employees of VNS Home Care) to provide skilled nursing care under the demonstration in addition to case management.

A basic premise of the demonstration is that nontraditional services may be used to reduce future hospital and nursing home costs. All three sites offer an array of these services, such as home improvements and special medical equipment. Home improvements include structural changes (e.g., ramps, roll-in showers) as well as equipment such as PERS, microwave ovens, fans, air conditioning, vacuum cleaners, and telephones. Special medical equipment, including bathtub seats, walkers, special mattresses, and wheelchairs, are also provided. All three plans undertake reviews of patients' homes to

identify opportunities for improvements that will reduce risk. SNH reported, for example, that it had undertaken home modifications for 12 of its 60 patients.

An important care-giving strategy highlighted by VNS CHOICE was the approach to “front-load” services to its members. Staff explained their objective as identifying areas of unmet need and neglect for new members to prevent functional decline. The intent, after identifying these unmet needs, is to deliver many services during the initial enrollment period to reduce future costs.

Service use data. As part of the program evaluation, this study, in collaboration with the participating projects, developed a monthly use form to record services provided during the demonstration. Table 3 presents this information for a sample of program participants from all three sites in February 1999.

The vast majority (81 percent) of patients received case management by nurses during the month. Of the home care services provided, the most extensive function was provision of home care by home health aides. Home health aides averaged 21.1 visits in a month, each averaging more than five hours.

About one-fifth (19 percent) of patients received physical therapy and 6 percent received occupational therapy in a one-month period. Those receiving such services averaged about one visit per week. Medical social services were used by a quarter of the patients, which reflects the higher than expected proportion of patients with cognitive impairment and depressive moods. The demonstration’s orientation includes a focus on social and economic problems of patients in conjunction with their health and functional needs.

Although the three sites viewed the role of adult day health and social day care in the array of available services as potentially important, the monthly service statistics indicate that relatively few patients have used such services. Almost half the patients used transportation services, by comparison, averaging more than one occasion per week.

Not surprisingly, 69 percent of patients received prescription medications through the program, with the number of medications averaging 5.6 and costing \$191 a month (more than \$2,000 a year).

Almost half the program’s patients had a PERS. This electronic device was considered important by all sites to ensure the health and safety of elderly persons with disabilities. Only 3 percent of patients had social/environmental support services in a month, costing an average of \$203.²⁰ Use of all other services in Table 3 was rare. One

²⁰ Because this service tends to be a “one time” activity, data for a single month may not be a reliable basis for an estimate of how many people will receive this service in a year.

percent of the patient population used nursing homes, for example, with a monthly average of 15 days.

Table 3 presents information on services used for an illustrative month after all three sites had been in operation for more than a year. It should be recognized that a one-month cross-section contains average service use of patients recently enrolled as well as others who have been in the program for longer periods of time. Longitudinal information from the monthly use form will eventually yield sufficient data to estimate the trajectory of service use for patients with different needs.

Table 3. Average Level of Selected Services Provided Under Medicaid Capitated Payment in February 1999

Service Category	Service	Percent Receiving Service Within Month	Average Amount of Service Received Within Month ¹
Sample Size		680	—
Case Management	Nurse	81%	85.6 hours
Home Care	Nurse Visits	88	2.4 visits
	Home Health Aide	85	21.1 visits / 114.1 hours
	Personal Care Aide	4	58.1 hours
	Homemaker/Housekeeper	1	6.3 hours
	Physical Therapy	19	4.5 visits
	Occupational Therapy	6	3.9 visits
	Speech Therapy	< 1	N/A
	Medical Social Services	24	1.4 visits
In-Home Supports	Meals	5	19.0 meals
	Social/Environmental Supports	3	\$203.7
Day Care	Adult Day Health Care	< 1	N/A
	Social Day Care	5	5.5 days
Other Services	Transportation	48	4.6 trips
	Prescriptions	69	5.6 prescriptions / \$191.1
	Hearing Aid	< 1	—
	Glasses	< 1	—
	Dentures	< 1	—
	PERS	48	—
	Prosthetics/Orthotics	< 1	—
	Durable Medical Equipment	< 1	N/A
	Medical Supplies	< 1	\$99.5
Residential Care	Nursing Home	1	15.9 days

Note: PERS is personal emergency response system.

¹ Average for all patients who received the service at least one time during the month.

Source: Tabulations on monthly use data by New York Department of Health.

VIII. QUALITY ASSURANCE AND PATIENT SATISFACTION

The demonstration requires that the plans establish quality assurance (QA) and quality improvement (QI) plans approved by the state. In terms of broad QA/QI efforts, the state requires that plans establish board-level accountability for the program; hire a designated person to oversee implementation of QA/QI activities; set performance benchmarks for service access, availability, and continuity; track quality indicators (including outcome measures) that are objective and measurable; establish a plan of analysis for aggregated data; maintain enrollee and caregiver involvement in quality efforts; and form a quality review committee that meets quarterly.

VNS CHOICE builds its quality management program on VNS's current systems for assessing and improving the quality of patient services. These QA/QI activities are numerous, including focused review of nursing home and hospital admissions, reporting of accidental falls, surveying patient satisfaction, and assessment of care outcomes. The member satisfaction survey is conducted by telephone for VNS by the Gallup Organization and addresses overall program quality issues as well as satisfaction with particular types of providers, such as therapists. In 1996, VNS initiated an agency-wide, outcomes-based quality improvement program that includes information from the OASIS database. This outcomes-monitoring program stems, in part, from VNS's participation in the national and New York State OASIS demonstration projects.

SNH is in the process of setting up a formal QA system and is tracking SNH hospitalizations and emergency room (ER) use. It had also conducted some patient satisfaction surveys. Staff doubt the validity of these surveys, however, because they are unsure whether the patients are able to fill them out accurately. The most effective feedback mechanism in their view has been focus groups at organized lunches, because they are a social outing for patients. SNH has also established a committee that has representatives from every subcontractor to facilitate identifying problems and their solutions.

Co-op Care has a basic QA program that examines grievances, patient complaints, incidents (falls, medication errors), hospitalizations, ER visits, and re-hospitalizations. It reports that it has made several changes in the program as a result of its QA efforts, including increased emphasis on education, greater coordination with other program services patients are receiving, and obtaining names of emergency contacts at sign-up. Co-op Care case managers also rely on their patients to report problems with subcontractors. Both Co-op Care and SNH expect to be in a better position to monitor care once their

new management information systems are in place. Co-op Care, in particular, reported the need for an adequate management information system to facilitate case management.

The few complaints reported by the sites were very similar. They tended to relate to transportation issues, aides not arriving or arriving late, and, in some cases, a patient's desire to go to a provider outside the network (typically for eyeglasses and prescription drugs).

IX. FINANCIAL ISSUES

New York’s demonstration program places plans at financial risk for long-term care services provided to enrollees. Risk is present for two main, interrelated reasons: the potential for adverse selection (which occurs when a plan enrolls a sicker population than that captured in its capitation rate); and the potential for benefit outlays to exceed, on average, the amount on which the capitation payment is based.

The state has blended the demonstration capitation rates to take into account a two-part variation in the disability level of enrollees—health-related facility (HRF) versus skilled nursing facility (SNF) rates—obtained as part of the DMS-1 assessment process. Capitation rates are based on an actuarial blending of the two subgroups, whose proportions are projected prior to the state’s establishing the plan’s capitation rate. If plans market to an HRF level population yet their rate is weighted toward the SNF level, the plan may experience favorable selection and net revenues in excess of those anticipated by the state. The state will retrospectively adjust for such an occurrence by updating capitation rates in the following year to reflect the actual DMS-1 scores of plan enrollees in the third quarter of the previous calendar year.²¹ Table 4 shows the rates received by the three plans for 1999.

Table 4. Demonstration Capitation Rates (Per Member Per Month), 1999

Disability Level of Enrollees	VNS CHOICE	Co-op Care	Senior Network Health
Institutional Eligible	\$3,598	\$4,073	\$1,911
Community Eligible	\$3,507	\$4,006	\$1,157

Source: New York Department of Health.

The three plans expressed only moderate concern about the financial risk at the present time, as the rates per member per month exceeded costs. The plans’ efforts to ensure financial solvency in the long-run are primarily linked to utilization management, including substitution of less expensive for more expensive services. VNS CHOICE highlighted its focus on preventive care. VNS CHOICE staff hope that by providing low-cost, “one-time” items (such as a special mattress to prevent recurrence of decubitus ulcers), more costly and severe expenditures can be avoided down the road. In addition, VNS CHOICE predicts that using social day care, assistive technology, home-delivered meals, and increased family responsibility will lead to fewer home health and personal care

²¹ In addition, the state sets separate capitation rates for those who are institutionally eligible for Medicaid (which entails a 36-month look-back on assets) and for those who are community eligible (which does not involve a 36-month look-back). Calculation of the latter rate excludes payment for nursing facility services.

visits and nursing home stays compared with use patterns by a similarly disabled Medicaid population. Similarly, SNH staff believe they are able to avoid or postpone hospital and nursing home stays through their active case management and creative service delivery.

All three programs have found that some of their cost experiences have been at variance with their expectations, although the directions of those differences vary. VNS CHOICE found early in the program, for example, that prescription drug costs far exceeded expectations, although such expenses have come more into line as enrollment has increased and the caseload's share of high users has gone down. Similarly, utilization was much higher than expected for dentistry and PERS, perceived as due to pent-up demand. VNS CHOICE staff believe that, although the program has not been able to gain efficiencies initially (e.g., through cluster care), as the number of enrollees increases, services can be provided at lower cost.

In contrast, Co-op Care has experienced lower utilization of services than expected, including lower use of pharmaceuticals, dentists, adult day care, and podiatry. This lower level may indicate that Co-op Care is serving a less disabled caseload than had been anticipated. Co-op Care's contracted payment with the state under the demonstration assumes a 65 percent SNF and 35 percent HRF case mix. In the first year, Co-op Care was serving a caseload with the opposite patient mix. In fact, all three plans have enrolled more HRF patients than expected. Co-op Care does not feel its current caseload of 87 patients is enough to adequately spread risk under the demonstration program. Its target number for adequate risk spreading is 200 to 300 beneficiaries. SNH is in a similar position, estimating the need for a target population of 300 enrollees to accurately spread risk under the demonstration.

New York State has announced plans to implement a new four-tiered rate system to account for HRF/SNF differences as well as differences in costs by age groups. Co-op Care and SNH reported that their payments would drop under those changes. Both plans were concerned that this change would decrease their ability to develop a reserve for serving the population as it ages and becomes more disabled. They also questioned the wisdom of the state's readjusting its payment methodology in the middle of the demonstration while the organizations are still learning the system.

All three sites indicated the desire to have full risk data as opposed to the partial risk data scenario under which they now operate. They feel that they could improve their care and cost savings if they had full information and responsibility for the patients. Furthermore, the three sites feel the financial incentives would provide a mechanism for

encouraging all the parties involved in providing care to the patient to work together. In addition, the sites would benefit from the (currently unrecognized) savings in reduced emergency room and hospital use resulting from the care they provide.

Although the capitation rate for the demonstration appears to be sufficient at the present time, all three sites are concerned that as people age and get sicker, the capitation rate will need to be raised. Even at the current time, the screening tool for eligibility and rate setting (DMS-1 form) does not adequately risk adjust for the patient population, since it does not distinguish well differences in resource consumption between HRF and SNF levels of need. Perhaps more important, the DMS-1 does not pick up the presence of dementia, which the plans have found to be more prevalent in their enrollee caseload than they had anticipated in designing their programs.

X. LESSONS LEARNED

With the aim of providing insight for future capitated long-term care programs, the study asked the projects what problems or surprises they have encountered thus far and what recipe they could give for an effective long-term care program.

Problems and Surprises

Time and costs. The sites indicated that they were surprised at how long it took to get the program started and how much it cost to do things right. Staff training (e.g., orientation to new program, negotiation skills) took considerable amounts of time. Designing and setting up new organizational systems and new information systems also consumed major personal and financial resources. Moreover, the amount of time elapsed between the conceptualization of the program and the date at which it could be implemented was substantial. This reflected, in part, organizational changes within each of the programs, as well as the need to adapt to external entities, such as the state and federal government. Some of the problems reflected time diverted to meet administrative and regulatory demands and sometimes changes in program rules. The cost of developing a management information system (MIS) was also underestimated; SNH expects to spend approximately \$100,000 to completely implement an MIS, because it was unable to find an off-the-shelf software program capable of meeting its needs. Although VNS CHOICE was able to adapt the extensive management information system used by VNS, additional screens, coding, and other features were required to add functionality.

Marketing issues. Without an existing pool of potential enrollees from which to recruit (as VNS CHOICE had), it can be very difficult to identify potential enrollees. It becomes necessary to invest resources into building relationships with a wide range of referral sources, because direct marketing to the patient community was not effective. Related to the need to build relationships with a number of referral sources is the need to educate the entire community about the new plan, because marketing the demonstration program successfully requires changing the perspectives and behavior of patients, caregivers, and providers.

Enrollment issues. Based on early program experiences, it is prudent to enroll members at a gradual pace to allow for a longer adjustment period for new sites to be established. Although the planned patient-to-nurse case manager ratio is about 25 to 1 in all of the sites, this ratio might be too high for new patients because of a backlog of problems that need to be addressed when they first enroll.

Patient needs. Complexity of patient needs was a surprise, possibly because, unlike a home health program, these capitated projects are designed to address the total long-term care needs of its members. A specific condition that emerged was the greater than expected prevalence of depression and cognitive disorders, which resulted in the need for more social work and counseling services than anticipated, as well as more active case management. The plans were surprised by how poorly the assessment instrument (the DMS-1) predicts service utilization. DMS-1 does not measure cognitive functioning or family support, two major determinants of need.

Setting up the provider network. Even more time than anticipated should be set aside to establish the provider network before enrollment begins. Part of the problem is that between the time a provider signs on and the time a program starts, some providers forget their participation commitment. The plans recommend maintaining a deliberate effort to keep in touch with the new provider network during the long period between program development and the beginning of program operations. Establishing links with providers who were threatened by the parent organization was also a problem: some providers viewed both VNS and MVN as the “gorilla” in their markets.

Use of provider network. The capitation program implied a transition to a new type of health care system for many patients, especially regarding the need to use network providers. All three sites indicated they have had the most difficulty regarding patients’ use of out-of-network providers for pharmacy, podiatry, optometry, and dentistry. Education of patients and providers is an ongoing issue under the managed care programs.

Interaction with acute care system. Influencing practice patterns of community providers (such as hospitals and physicians) proved difficult as their services are outside the capitation rate. Investment of time was necessary to educate community providers about what the program is trying to accomplish (e.g., prevention, education). Plans have also been trying to establish an informal network of contacts within the hospitals and nursing homes, so that continuity of care could be enhanced when members are in acute care settings. Although being in a network reduces these pitfalls, the network can also constrain some of the options available for using non-network providers of specific services. In the future, as Medicaid and Medicare are integrated, this problem is likely to become even more complex.

Flexible design. Being flexible in program design and operations is important. All three plans reported changes in staffing arrangements, staff responsibilities, and program operations as their programs developed. The design of the program evolved as the plans learned more about the population being served and service delivery in a new environment.

Context issues. Two context issues raised by the plans were working with government agencies and the level of New York's general Medicaid home care program. Start-up was noted to be a long process due in part to state-federal regulatory and administrative requirements. Maintaining good relations with local governments also proved challenging at times, particularly if they operated home care programs and were competitors for the same patients. Timing of approvals for eligibility and referral of more difficult cases were also plan concerns.

When deciding whether to enroll in any of the three organizations, a potential patient must weigh New York's extensive Medicaid program against the services and case management of the demonstration. All three organizations reported complications in recruitment due to New York's existing fee-for-service Medicaid home care program. It is interesting, therefore, to highlight the services to which the enrollees are most drawn: case management and nontraditional services.

Policy and Program Considerations

The New York Evaluated Medicaid Long-Term Care Capitation Program is a relatively small demonstration in number of programs and enrollees. It represents an important step, however, in a much larger effort by New York State to improve delivery of public long-term care services. The state has already moved ahead with legislation to capitate another 24 organizations to deliver Medicaid long-term care services, and it envisions that Medicaid long-term care and all of Medicare will be integrated within the next few years.

Regardless of the eventual configuration of New York's capitated Medicaid programs, many of the same issues arise in developing managed care models that coordinate and manage the delivery of acute and long-term care under Medicaid and Medicare. Following are highlights of policy and program considerations based on this studies' findings.

- Up-front investment of staff and resources is essential. To begin a managed care plan for long-term care services, substantial amounts of start-up resources—both human and financial—are needed to build up the staff, network, and management information systems for accounting and quality assurance.
- Case-management is central. In addition to the array of problems that require both acute and long-term care services, disabled older Americans also require many social services that are not generally covered by Medicaid. Unlike the traditional fee-for-service program under Medicaid, capitated long-term care plans can provide “case management for life” to meet the World Health Organization's

definition of physical, mental, and social well being. The expanded scope of activities includes taking patients to doctor's appointments, fixing their bathrooms, providing case management and continuity of care while they are in nursing homes or hospitals, and facilitating receipt of food stamps, housing assistance, and other social services.

- Key to service delivery is improving coordination of services. Coordinating acute and long-term care services is a daunting challenge under any circumstance, although this is the heart of the "seamless care" goal. Ensuring adequate transportation and aide support reduces the burden of missed appointments for physicians, while installation of mechanical aids to reduce risk of falls, providing social supports, and monitoring of combined medical and chronic care conditions all are expected to lead to more efficient use of public resources. Although no single methodology has been developed to do so, various demonstration programs continue to contribute to the knowledge base on effective coordination strategies.
- Program flexibility creates cost savings. Cost savings can be derived in a number of ways, including the use of social/environmental services in lieu of personal care, preventive care to reduce the risk of future acute and long-term care episodes, economies of scale in service delivery, and flexibility in use of funds. In addition, with a capitated program, case managers can address urgent concerns without prior authorization, producing better care more efficiently.
- Creativity is needed to measure quality of care. As data are not available to evaluate the quality of care impacts of these managed care programs, this study has focused on processes rather than outcomes. Existing statistics indicate, however, that disenrollment from the programs is low. Anecdotal evidence also suggests that the plans in the demonstration have succeeded in getting people to doctor's appointments, following them through hospital and skilled nursing facility stays, and better coordinating acute and long-term care services. Satisfaction surveys are difficult to implement for this population because of health status and demographic diversity. In some cases, patient focus groups tended to be a more effective means of eliciting opinions about quality of care.
- Settings affect program design. The coordination model works in many different settings, as witnessed by the variety of plans in the Commonwealth demonstration. Settings, however, do affect the design and operations of the program. For example, a plan that is nested in an integrated health system can more readily

coordinate acute and long-term care services than a stand-alone plan. Service areas with dense populations foster economies of scale in service delivery (e.g., staff specialization, cluster care). Rural areas may be more amenable to the use of adult day care because of prior familiarity with plan members. Rural areas may also require greater use of environmental and home modification services because most elderly persons live in single-family houses.

Conclusions

New York's Commonwealth-funded Medicaid Long-Term Care Capitation Program differs from integrated acute and long-term care programs (such as PACE and S/HMO) in that it capitates only long-term care and is required to coordinate with Medicare acute care rather than fully integrating financing for all patient care needs. This capitation and coordination may help to alleviate concern that full integration will shortchange the long-term care portion of the program, and it may also help to encourage enrollment. At the least, given that only two states have managed to integrate Medicare and Medicaid entirely, partial capitation may be the more practicable option for some states.

Although complete integration of financing and service delivery may be simpler administratively, the relatively high enrollment at the Commonwealth project sites speaks to coordination's appeal. A drawback of fully integrated programs has been that enrollees are asked to give up their current primary physician in favor of the program's staff doctor. At the Commonwealth sites, this is neither a requirement nor a problem, and patients presumably do not feel that they are making sacrifices in order to enroll.

The capitated Medicaid Long-Term Care Program is also an improvement over the standard public home- and community-based care in New York. The plans' ability to provide extensive family counseling, normally uncovered (but necessary) psychosocial services, and case management while individuals are institutionalized, for example, represents an expansion over the relatively generous levels of care available under New York's Medicaid program. Moreover, such "add-ons" can readily be determined and provided without undergoing elaborate, prior authorization procedures.

Whether one program design is better than another for patient outcomes remains to be seen. The Commonwealth-funded program, however, appears to be on its way toward enrolling patients in significantly greater numbers than many predecessor programs. Assuming the higher enrollment continues, the partial capitation, coordination model offered at these sites may prove to be a strong challenger to the integrated service and financing model. If so, lessons from the earliest sites will prove all the more valuable.

In anticipation of the continued enrollment growth at the Commonwealth sites, it is reasonable to begin considering ways to assess the plans' accomplishments. There are some key questions:

- What impact do the plans have on the health outcomes of program beneficiaries? Do they improve or delay declines in functioning? Do they reduce unnecessary hospitalizations? Do they postpone nursing home entry? Do they lead to greater patient satisfaction?
- Does the capitation approach to Medicaid long-term care services reduce Medicaid expenditures? Does it reduce Medicare expenditures?

To explore the impacts of the Commonwealth-funded plans on patient outcomes and program costs, quasi-experimental methods are needed. Outcomes and costs under the demonstration must be compared to outcomes and costs in other settings that provide reasonable estimates of what would have happened in the absence of the pilot programs—in other words, a “counterfactual” for the demonstration is needed. Because of the plethora of models under which Medicaid covers long-term care services in New York, some combination of those service models could be compared to the demonstration plans. With the selection of comparison programs and sites, the impacts of the demonstration on both interim outcomes (e.g., functional status, hospital use) and longer-term outcomes (e.g., quality of life, program costs) can be assessed. To accomplish that goal, consistent data on service use, costs, and satisfaction are needed for both program participants and the comparison group. This will require that the data collection activities in place at the demonstration sites be extended to the comparison sites.

Along with impact studies, further elucidation of the demonstration sites' ongoing efforts to refine the structure and operations of their programs, such as staff skill development and coordination of care across settings, is needed so that lessons can be shared with nascent plans in New York and in other states. In general, learning from the experiences of the Commonwealth-funded plans as they continue to develop their programs will contribute to advances in the field, as well as provide a clearer notion of the particular interventions that are being tested in the impact studies. In sum, a continuing flow of information about the programs as they evolve will help ensure the development of a clear understanding of the viability of capitated, managed care as an option for providing long-term care services under Medicaid.

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