

Case management in the social health maintenance organization demonstrations

by Cathleen L. Yordi

In this article, case management departments and roles during the early years of the social health maintenance organization (S/HMO) demonstrations are compared. These organizations provide acute and chronic care services under a prepaid plan for the elderly. Eligibility criteria for case management and chronic care services at each site are compared,

followed by a description of the resultant case mix of members receiving chronic care benefits. Case managers principal activities are described, and a preliminary assessment is made about the strength of the linkages that have been developed between the case management component of these plans and the larger health care system.

Introduction

In 1980 the Health Care Financing Administration (HCFA), in cooperation with the Health Policy Center of Brandeis University, began planning a demonstration program to provide and finance long-term care services. This demonstration program uses a social health maintenance organization (S/HMO) to combine acute and long-term care services under a single prepaid health care plan for the elderly. S/HMO benefits include all basic acute and ambulatory health care services covered by Medicare as well as selected chronic care services. These services are paid for by Medicare on a capitated basis, along with a premium paid by the enrollee, or when applicable, Medicaid.

The demonstration was designed to address the health care and health insurance needs of both a severely impaired and a well group of elderly. Beneficiaries meeting their State's nursing-home-certifiable criteria at enrollment receive an adjusted Medicare capitated rate, which is higher than the adjusted average per capita cost (AAPCC) rate established for the well enrollees. Although all enrollees are eligible for basic Medicare benefits, only those assessed as nursing home certifiable or "at risk" of nursing home placement are eligible for chronic care benefits. The availability of long-term chronic care benefits, and the associated case management processes, distinguish an S/HMO from a health maintenance organization (HMO); these features plus the capitation payment distinguish an S/HMO from fee-for-service health care.

The demonstrations began in early 1985 and will continue for 7 years under the current terms of the program. The four sites involved include: Elderplan in Brooklyn, New York, sponsored by Metropolitan Jewish Geriatric Center; Medicare Plus II in Portland, Oregon, sponsored by Kaiser Permanente Center for Health Research; Seniors Plus in Minneapolis, Minnesota, sponsored by Group Health Inc. and

Ebenezer Society; and SCAN Health Plan in Long Beach, California, sponsored by Senior Care Action Network. Although under different organizational auspices, all S/HMO's share the common purpose of testing the ability of these health plans to attract members and to provide an expanded array of acute and chronic care benefits within a capitated budget.

HCFA has commissioned a comprehensive evaluation of the S/HMO's by a consortium of researchers. The prime contractor is the Institute for Health & Aging at the University of California; others include Berkeley Planning Associates, the Center for Demographic Studies at Duke University, and Westat, Inc. The evaluation has both quantitative and qualitative research components. It explores the cost effectiveness of each S/HMO demonstration model as well as internal operations and environmental factors affecting program outcomes. The evaluation investigates nine major issues:

- Selection bias in initial enrollment and in attrition.
- Utilization of specific acute and chronic care services.
- Public, third party, and out-of-pocket expenditures for acute and chronic care services.
- Factors associated with decisions to enroll or not enroll in an S/HMO.
- Health status and mortality rates among S/HMO members and nonmembers.
- Levels of informal caregiving and changes over time.
- Marketing efforts, the market area, and environmental conditions affecting each site's operations.
- Patterns of change in the organizational form, management, and financing at each site as the programs evolve.
- The effectiveness of case management in controlling chronic care service use and cost and assuring access to appropriate levels of care.

An interim evaluation report covers organizational and operational issues (Health Care Financing Administration, 1988). Current field work is gathering health status, health service utilization, and out-of-pocket expenditure data on S/HMO enrollees and the fee-for-service comparison group. The evaluation is currently scheduled to end in the spring of 1990.

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The focus of this article is on case management roles and activities across the four S/HMO demonstration sites. The information presented is drawn from data gathered during site visits in 1986 and from progress reports during the first 2 years of operation of the S/HMO's, which began enrollment in 1985. Throughout this article, emphasis is placed on the 1986 data, which represent a more stable program period and are less susceptible to variations experienced during the initial startup period. It is important to note that the S/HMO is an evolving form, and as such, there have been some important changes in case management and its activities since this article was prepared. The information provided here describes S/HMO case management as it functioned at the close of the second year of the demonstration and does not reflect changes made as the plans assumed full financial risk.

Case management's mandate

At each S/HMO demonstration site, the case management component was given responsibility for managing the non-acute, long-term care services. In the S/HMO, the role and authority of the case manager was envisioned as much broader than in earlier long-term care demonstrations (Leutz et al., 1985). In most earlier demonstrations, the case manager role focused primarily on screening and assessment and the coordination and/or authorization of community-based care (Austin, 1983; Berkeley Planning Associates, 1985; Health Care Financing Administration, 1988; Zawadski, 1984). In the S/HMO, the case manager was to have primary responsibility for authorizing all long-term care services, responsibility for monitoring the chronic care services and budget, and final authority over chronic care resource allocation. Beyond this, it was hoped that the case management component would also be able to establish new norms of practice regarding linkages with other components of the health care system. It was also hoped that these norms would lead to care of a consistently high quality that would simultaneously maintain chronic care costs at budgeted levels.

Within these broad goals and objectives, each demonstration plan was permitted flexibility in developing its case management model. As implemented, no two case management models were alike.

Service eligibility criteria

Eligibility criteria for chronic care services and case management differed among sites. There were no restrictions placed on the plans by HCFA as to which members should be eligible to receive the expanded long-term care benefits. During the planning phase, there was debate about the advisability of limiting services to the severely impaired versus providing services to less impaired members as a preventive measure. Ultimately, eligibility criteria were based on

level of functional impairment. In addition, because the plans were reimbursed at a higher capitated rate for members assessed as meeting their State's nursing home certification (NHC) criteria, it was decided to link eligibility for the chronic care services, at least in part, to nursing home status.

Although each plan paralleled its State NHC form and guidelines to qualify a member for chronic care benefits (and a higher reimbursement rate), the NHC criteria were different among the four demonstrations. (Forty-five variables were used for certification and only 11 were common to all plans.) Each plan also expanded eligibility criteria beyond NHC, allowing at least some services to members who were not nursing home certifiable (henceforth referred to as "certifiable"), but who were considered to be "at risk" of future institutionalization by case management staff.

The final determination of eligibility for chronic care services and/or case management was determined by interrelated factors: the stringency of the State's nursing home criteria and the plan's application of these criteria; the extent to which the plan permitted provision of chronic care services to less impaired members; and the extent to which the plan provided case management services to members who did not qualify for chronic care services.

The eligibility criteria of the four plans can be placed on a continuum ranging from the most restrictive to the least restrictive. Medicare Plus II used the most restrictive criteria, followed by Elderplan. Seniors Plus and SCAN Health Plan were much less restrictive, electing to provide preventive services to moderately impaired members.

Case mix

At all of the sites, the case management department was the single entry point into the chronic care service component of the S/HMO. Each plan used two standardized screening and assessment forms. Initially, every new enrollee received by mail a baseline health status form (HSF). If this form, or a followup telephone screening to review HSF responses, indicated that the person might be impaired, a case manager conducted an in-person comprehensive health assessment. Telephone screenings and comprehensive assessments could also be triggered by referrals from S/HMO medical staff and other service providers. Following the comprehensive assessment, a final determination was made about eligibility for chronic care services.

Given the differences in the eligibility criteria and processes at the four sites, it was not surprising to find that different proportions of the total membership were being permitted access to chronic care services. In Table 1 one can see the numbers and proportions of the S/HMO membership who were certifiable, of the members who were receiving chronic care services, and of the members who were receiving case management services only during the fourth quarter of 1986. Also shown, where available,

Table 1
Case-mix comparisons of selected types of members of four social health maintenance organizations: Fourth quarter of 1986

Plan and type of member	Fourth quarter 1986		
	Number	Actual membership	Projected membership
		Percent	
Medicare Plus II			
Total membership	4,300		
Nursing home certifiable members	289	6.7	5.0
Members receiving chronic care services	195	4.5	5.0
Members receiving case management only	176	4.0	—
Elderplan			
Total membership	2,502		
Nursing home certifiable members	103	4.1	5.0
Members receiving chronic care services	73	2.9	13.8
Members receiving case management only	65	2.6	—
Seniors Plus			
Total membership	1,688		
Nursing home certifiable members	122	7.2	4.3
Members receiving chronic care services	185	11.9	8.5
Members receiving case management only	139	8.2	—
SCAN Health Plan			
Total membership	2,061		
Nursing home certifiable members	114	5.5	4.0
Members receiving chronic care services	250	12.1	10.0
Members receiving case management only	162	7.9	—

SOURCES: Elderplan, Brooklyn, New York; Medicare Plus II, Portland, Oregon; Seniors Plus, Minneapolis, Minnesota; SCAN Health Plan, Long Beach, California: Data from their respective S/HMO demonstration quarterly reports, Oct.-Dec. 1986.

are plan projections of case mix made during the planning stages of each S/HMO.

Medicare Plus II projected that only 5 percent of its membership would be certifiable and only those enrollees would receive chronic care services. By the fourth quarter of 1986, the S/HMO had 4,300 members; 6.7 percent were certifiable, but only 4.5 percent (67 percent of the certifiable group) were receiving chronic care services. Another 4 percent of members received case management services only (i.e., periodic monitoring). The proportion of certifiable members was larger than the proportion of members receiving chronic care services for two reasons. First, the informal caregivers of some certifiable members provided all needed services. Second, during the first 24 months of the demonstration, there was an anomaly in the State of Oregon's NHC criteria that resulted in several incontinent Medicare Plus II members being evaluated as certifiable, although they

did not actually need services.

At Elderplan, the actual number of functionally impaired persons receiving chronic care benefits was considerably lower than that projected in its demonstration protocol. Elderplan projected that 13.8 percent of its members would be impaired and using chronic care services at any given time. Of the four plans, Elderplan had the highest projected use of chronic care benefits. By the fourth quarter 1986, this S/HMO had 2,502 members; 4.1 percent were certifiable, and only 2.9 percent were receiving chronic care services (i.e., approximately 71 percent of certifiable members were receiving chronic care services). Another 2.6 percent received only case management services.

Seniors Plus projected that 4.3 percent of its members would be certifiable, but that 8.5 percent of enrollees would receive chronic care benefits. This reflected this plan's orientation toward using chronic care services as a form of third-level safeguard to forestall further deterioration of the condition of moderately or severely impaired members at risk of becoming certifiable. By the fourth quarter of 1986, the S/HMO had 1,688 members; 7.2 percent of enrollees were certifiable; 11 percent of the members were receiving chronic care services; and an additional 8.2 percent of members received case management services only.

SCAN Health Plan also followed the Seniors Plus strategy of preventive use of chronic care services and projected that a larger proportion of its membership would receive those services (10.0 percent) than would be certifiable (4.0 percent). As was the case for Seniors Plus, the actual membership was more impaired than was anticipated. By the fourth quarter of 1986, SCAN Health Plan had 2,061 members; 5.5 percent were certifiable; 12.1 percent were receiving chronic care services; and 7.9 percent received case management monitoring only.

These data indicate that at the end of the second year of the demonstration, two of the plans were providing chronic care benefits (either case management or chronic care services) to a large proportion of the membership who were assessed by case managers as "at risk" of institutionalization but who did not meet their State's NHC criteria. At SCAN Health Plan, only 28 percent of those receiving chronic care benefits were certifiable; at Seniors Plus, the percentage was only slightly higher—35 percent. In sharp contrast, at Elderplan and Medicare Plan II, at least three-fourths of the chronic care recipients were certifiable. These differences are noteworthy because as the plans assumed full financial risk in year three, SCAN Health Plan, citing fiscal reasons, petitioned HCFA and changed its eligibility criteria, offering chronic care services only to members who were certifiable.

Primary case management roles

In large part, the roles, responsibilities, and authority given to the case management component of

the demonstration plans were determined by their organizational model—whether the plan's principal sponsor was an established HMO or a long-term care provider that created a newly formed HMO. The organizational model was also a key determinant of case management department linkages to the larger S/HMO delivery system. Indeed, the organizational model often determined whether the case managers had direct control over a service or whether the case manager's role was primarily that of coordinating with another health care provider.

The major difference in case management practices between the established HMO and long-term care organization S/HMO models is found in the degree of involvement of S/HMO case managers in monitoring acute care utilization. The two S/HMO's affiliated with established HMO's (Medicare Plus II and Seniors Plus) chose to leave primary responsibility and control over acute care utilization (i.e., hospital and post-hospital, skilled nursing home, and home health care) to their respective HMO utilization review and discharge planning staff. The S/HMO's founded on preexisting long-term care organizations (SCAN Health Plan and Elderplan) attempted to gain control over acute care utilization by assigning part of the utilization review and discharge planning responsibilities to the case management component of the S/HMO. Both plans experienced considerable difficulty with the original providers when they attempted to place case managers in these new roles. For example, at one site the case manager role was a source of contention with the regular hospital utilization review and discharge planning staff, who maintained that the job could be done more efficiently and effectively in-house. A more detailed discussion of organizational factors influencing hospital and nursing home utilization is presented in the interim congressional report (Health Care Financing Administration, 1988).

Other case managers' roles were similar across all plans, reflecting traditional case management functions (e.g., assessment, care planning, and service arrangement). At all sites, the case managers were responsible for coordinating the fairly comprehensive array of institutional and community-based long-term care services that constituted the chronic care benefit package. Much of each case manager's time was spent arranging chronic care services. In addition, case managers routinely contacted non-S/HMO service providers to obtain information or refer members for services not covered by the S/HMO, such as legal help, social security assistance, shared housing, friendly visitors, and senior centers.

All plans emphasized involving and supporting informal caregivers. Face-to-face meetings or telephone calls were conducted with caregivers to negotiate care plans, explain benefits and copayments, clarify client needs, help the family accept client disabilities, facilitate family interaction, identify tasks family members could reasonably perform, and support family caregiving efforts. All plans had written guidelines specifying that no chronic care

services could be authorized without first exploring the availability of potential help from informal caregivers.

At each of the sites, resource allocation was a primary role of the case manager. In most cases this required the development of a long-term chronic care service utilization plan to prevent clients from exhausting their benefits. Additionally, the plans had somewhat different benefit periods and cost-sharing arrangements (Health Care Financing Administration, 1988).

It is important to place in perspective the actual dollar amount available for a case manager's use in developing a chronic care plan. An impaired person's S/HMO chronic care budget was not large. For example, SCAN Health Plan offered a fairly generous \$7,500 annual benefit, yielding an average monthly benefit of \$625. If an elderly person with Alzheimer's disease needed day care 3 days a week (at \$27 per day) and a home health aide to assist the family with the member's personal care needs for 2 hours (at \$8.75 per hour) on the days when day care was not attended, the weekly cost would be \$151, which would exceed the budget. For members with short-term or time-limited chronic care service needs, benefit limits usually posed no problem. For a highly impaired person requiring services on an ongoing basis, services had to be carefully allocated to maximize member benefits.

To date, it appears that the case managers have been able to monitor and maximize benefits with considerable success. For example, during the fourth quarter of 1986, the plans reported that only a small number of members had exhausted their benefits—less than .01 percent. During the fourth quarter of 1985, even fewer members exhausted their benefits.

Service integration

By the end of the second year of the demonstration, plans varied considerably in the extent to which the acute and long-term services had been integrated to provide an effectively coordinated continuum of care for impaired elderly.

In general, at Medicare Plus II, S/HMO case management was a fairly insular unit functioning with a reasonable, although not a high, degree of coordination with the larger Kaiser system. Most physicians and providers generally did not know whether a member was in the Medicare Plus II program. The larger Kaiser system remained responsible for acute hospital care, medical care, and Medicare-covered home or nursing home care. The S/HMO case managers were only responsible for the expanded chronic care services and budget.

At Elderplan, there was little evidence of an integrated service system. It appeared that the S/HMO could have benefited from stronger ties and coordination between the medical/hospital service components and the case management component responsible for long-term care. A large number of medical specialists operating independently of the

S/HMO were responsible for acute hospital care. The primary care physician group was under contract to the S/HMO but was not closely linked to the case management component. In an attempt to gain control over hospital utilization, a case manager was assigned the utilization review and discharge planning functions, but did not have the power or authority to influence practice patterns. Further, working relationships between key personnel in the principal acute care hospital and the case managers were not strong. Long-term institutional and in-home care were the sole responsibility of the case managers, with little input from the medical component.

In contrast to Elderplan, Seniors Plus appeared to effectively integrate the S/HMO case management department with two strong preexisting service providers—Group Health, Inc. and Ebenezer Society. At each level of health care—acute hospital, outpatient clinic, nursing home, community-based services, and in-home services—there were well defined, closely coordinated working relationships between the case managers and the other service providers. In turn, the other service providers recognized that when a S/HMO client required chronic care services, the case managers then had control over chronic care service use and cost. Continued coordination between the acute care and long-term care service teams was evidenced in the case conference meetings attended by the medical director, select physicians, the home care service director from Ebenezer, the geriatric nurse practitioner who managed nursing home care, and the S/HMO case managers.

In the SCAN Health Plan, a large number of health care providers could be involved in a member's plan of care. Even though the SCAN program had a number of years of experience working with many of the providers in the multipurpose senior services program (MSSP), the S/HMO case management department faced a tremendous challenge as it attempted to coordinate this diverse group of service providers (more than 100) into a comprehensive continuum of care for the impaired S/HMO members. Each type of health care was provided by a different vendor under contract. With the assistance of the SCAN Health Plan medical director, the role of the case management department was to coordinate this array of service providers. At the end of the second year of the demonstration, based on service provider interviews, it appeared that some of the linkages needed to be strengthened and better coordinated—especially between the S/HMO case managers and the primary care physicians, the medical specialists, and the hospital discharge planning unit.

A detailed description of the acute and long-term care service delivery systems at each site at the end of the second year of the demonstration is provided in the congressional report (Health Care Financing

Administration, 1988). This report also provides information on the health care environment and the market in which each of the plans was implemented.

Research agenda

This preliminary review of the case management component of the S/HMO demonstrations has identified a number of issues and questions to be examined in subsequent analyses. In addition, the ongoing research agenda contains specific questions about S/HMO members who are eligible for and are receiving chronic care benefits.

- How do the health and functional limitations of members receiving chronic care services and case management vary across plans?
- To what extent do plans provide case management to persons determined not to be nursing home certifiable? What are the implications of this for State nursing home criteria, plan resource allocation, and beneficiary satisfaction?
- How do services differ between members assessed as nursing home certifiable and members assessed as "at risk" of institutionalization?
- What is the potential impact on client case mix and program revenues of standardizing nursing home certification criteria?
- What are members' covered chronic care service needs and unmet needs?
- How do case managers affect family involvement in chronic care?
- What are the quantitative and qualitative differences in each plan's approach to case management for members with the same primary diagnosis?
- What out-of-pocket costs are incurred for noncovered long-term care services?
- Can case managers remain within chronic care budgets as the membership ages and frailty advances?
- Should case managers participate in hospital utilization review and discharge planning?
- What impact will multiple vendor agencies have on case management work load and member satisfaction?
- Will case managers be able to develop formal chronic care standards and protocols for issues such as normal usage, equity of service allocation, and quality of care?
- What similarities and differences are evolving between case management in the S/HMO's and earlier long-term care demonstrations?
- What aspects of the S/HMO case management approach are transferable to other prepaid health care settings?

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