**Purpose**

The purpose of this Information Memorandum is to transmit to Area Agencies on Aging and HIICAP programs a workshop report concerning managed care and the Aging Network. This transmittal is part of an ongoing effort by this Office to provide information and technical assistance regarding managed care to the Aging Network.

**Background**

The 1996 Summer Conference and TNT-29: "Aging Concerns Unite Us," co-sponsored by the New York State Association of Area Agencies on Aging and the New York State Coalition for the Aging, was the setting for this workshop. An earlier conference session -- "The Basics of Managed Care" -- explored the definition of managed care, provided an overview of how managed care affects the elderly, and looked at some managed care models across the country.

"The Aging Network and Managed Care: Current Context and Challenges" was a workshop and discussion which covered critical managed care issues facing the Aging Network in New York State. The enclosed report summarizes the key points made at that session and includes many helpful insights and practical suggestions for emerging Aging Network roles in managed care.

**Further Information**

For additional copies of this report, contact Dave Murray at (518) 474-8147.
The 1996 Summer Conference and TNT-29: "Aging Concerns Unite Us," co-sponsored by the New York State Association of Area Agencies on Aging and the New York State Coalition for the Aging, was the setting of this workshop on June 19. An earlier session -- "The Basics of Managed Care" -- explored the definition of managed care, provided an overview of how managed care affects older persons, and looked at some managed care models across the country. That session was presented by Bob Mollica of the National Academy for State Health Policy and drew heavily on "Managed Care: Handbook for the Aging Network" published by the Academy.

This workshop -- "The Aging Network and Managed Care: Current Context and Challenges" -- covered critical managed care issues facing the Aging Network in New York State. The purpose of the session was to stimulate discussion of practical issues in undertaking active Aging Network roles in a managed care environment. The speakers emphasized the context for Aging Network involvement in managed care and noted practical steps which can be taken by the Aging Network. Nancy Hansen, Director, Cortland County Office for the Aging, briefly summarized the earlier session, introduced the speakers, and moderated the discussion which followed. The speakers were:

- Robert Mollica, Deputy Director
  National Academy for State Health Policy
  Portland, Maine

- Paul Tazbir, Deputy Director
  New York State Office for the Aging
  Albany, New York

- Nancy Hansen, Director
  Cortland County Office for the Aging
  Cortland, New York

- Ann DiSarro, Executive Director
  Senior Services Center of the Albany Area, Inc.
  Albany, New York
Mr. Mollica, who presented the earlier, well-received session on the basics of managed care, began this presentation with the thought-provoking question: "When you go back home after this conference, whom in your local Medicare HMO will you call? Will it be the marketing director? the CEO? the Medical Director? the utilization review staff? primary care physicians?" The answer depends on what you need to know to get started. First, you need to understand their product, their marketing strategy, their benefit package, and their long term goal. Do they seek geriatric providers? Are they doing anything special for older people that they might not do for other members? Whom you call depends on your current knowledge base. You might want to begin with the marketing staff.

Mr. Mollica suggested five key areas for an aging agency to consider before contacting an HMO and before considering a contract with an HMO.

- **Define Your Product**

  Just as you need certain information about an HMO, so, too, you need to understand your own product, marketing strategy, long term goal, etc. When you call the HMO, they are likely to ask you questions about what you do. Can you measure it and describe it? How would you sell it to someone, particularly an HMO?

  For an arrangement to work, you both need to meet each other's needs in a positive way. You need to know what you want to get from them.

- **Know Your Costs**

  Do you have data on services and costs (including where you might reduce costs)? These are essential for your financial success in dealing with an HMO.

- **Know Your Customer**

  Do you have data on your clients? Remember that HMO members will age over time.

- **How Will You Benefit the HMO?**

  You must know what you have to offer and how it will benefit them at the HMO.

  One challenge might be how well your geographic services delivery area matches that of the HMO. It is likely that your area will be smaller, and the HMO might want to serve its entire area. In addition, the HMO might not want to enter into numerous contracts. This means that you might have to consider joining with others in the Aging Network to create a
single entity to develop and market a product and be responsible for a single contract, coordinating services, and overseeing standards. In Massachusetts, the AAA association is developing an organization which will seek to contract with several HMOs to provide certain services.

- **Make Sure Your Information System Produces Relevant Data**

To answer your own business questions and those of an HMO trying to buy value added services, you must have good data. Your services somehow must be cheaper for them. They will buy your expertise and your costs. (The danger is that they might learn that expertise or hire it away from you.)

**Summary**

When you meet with someone from the HMO, you need to know what it is they hope to achieve. Determine what you have in common, how to present your services to them, and how you measure your services. If you develop a contract, you will need to report to them so they can measure whether you achieved what they bought from you.

You will need to address two fundamental questions:

- **First, what is it that your agency can offer HMOs?** (For example, how do you define that and make it available to them?)

- **Second, how do you deal with the potential conflicts of specific work with HMOs (including contract arrangements)?** How do you balance those obligations with the requirements of the Older Americans Act to provide information and services and to treat people equally? How does a services contract with an HMO affect these? How does risk impact on us?

Once you have a handle on these questions, you may be able to "trade" services, access to the elderly, etc. You may be able to create opportunities for mutually supportive activities, such as health fair participation or information sessions or wellness activities, in exchange for the services of their nurse or primary care physician, especially if a large proportion of participants are their members.

**STATE PERSPECTIVES ON MANAGED CARE**

Paul Tazbir, Deputy Director  
New York State Office for the Aging  
Albany, New York

Mr. Tazbir began by noting that managed care is neither perfect, nor for everyone. Each older person must make his or her own individual decision about whether to enroll in a managed care plan. Therefore, the State Office encourages informed choice based on
individual need and personal preference.

**Medicare Managed Care in New York State**

The number of Medicare managed care plans available in New York State has increased, and New York State's elderly have more opportunities to enroll in managed care. In addition, more and more of New York State's elderly are joining Medicare managed care plans. However, not every Medicare beneficiary has a managed care option. Some parts of the State do not have even one Medicare managed care plan. But, those plans are coming, and nearly every older person will have a managed care option available to them. Therefore, there is no question that the Aging Network must be involved in managed care.

**Medicaid Managed Care in New York State**

The State has a proposed waiver with HCFA to expand its current, non-waiver managed care program. Both the current and the proposed programs focus on primary and acute care and are designed for children and families on Medicaid. Neither program requires the elderly to join managed care.

**Managed Long Term Care in New York State**

There are three Medicare-Medicaid demonstrations, including two Programs for All-Inclusive Care for the Elderly (PACE) programs and one Social HMO. More PACE programs are planned, but these serve a very limited number of people. In addition, Governor Pataki has proposed legislation to create a State demonstration program for Medicaid managed long term care.

The State Departments of Health and Social Services have funding from The Commonwealth Fund to develop and test partially capitated long term care programs. These programs will provide long term care for enrollees who are dually eligible for both Medicare and Medicaid. A request for proposals has been sent out, and about six sites will be selected.

In Broome County, the Office for the Aging, local social services district, county nursing home, and mental health department have jointly submitted a proposal to the State to establish a Medicaid managed long term care demonstration project. Clearly, the experience of the AAA has been recognized (and will be enhanced) in this process and will be very helpful to the whole Network as we develop and design managed care programs for the elderly.

**The Aging Network**

The State Office for the Aging has three broad roles regarding managed care: State policy and planning, public education, and support for the local Aging Network. The State Office has developed and distributed several papers on managed care and sent out several information memoranda with resource materials. We have conducted or participated in
training sessions and have produced numerous materials through HIICAP. We will continue to provide those kinds of information.

**Managed Care Fit With the Aging Network**

The concept of managed care is not foreign to the Aging Network. In fact, the concept of managed care fits well with the Aging Network's philosophy --

- that older people be served in the lowest cost, least restrictive setting with the least intrusive services required to meet their needs.

While our practices and those of managed care plans are not identical, we do share this very basic goal.

**Opportunity for the Aging Network**

Managed care presents the Aging Network with a major opportunity to pursue our philosophy. The health care delivery environment is changing -- focusing on the least costly interventions, prevention, and continuity of care and pushing the level of care delivered to the lowest level required to meet needs.

We must focus on the fact that, although the Aging Network does not deliver health care services *per se*, among our many responsibilities, **we deliver services which significantly improve the health of older individuals.** At the very least: Better nutrition is better health; home and community-based care prevent nursing home placement; caregiver assistance reduces caregiver strain and exhaustion; senior centers improve quality of life, personal outlook, and self esteem. We need to recognize and promote our positive impact on the health of older people.

**Some Aging Network Strengths**

The Aging Network has many strengths which are directly related to managed care.

- We have a 30-year, positive history with older people, their families, and the community. No one can top that.

- We understand older people's needs and values. We know our customers, and we know them better than anyone else.

- We are well experienced with fixed, capped budgets. We always have had limited resources, and we are experienced with substituting lower-cost services.

- We have a solid and unique infrastructure in place to reach older people and their families and to deliver a wide range of health-improving services to them.

- We are accustomed to flexibility in services delivery and to responding to changing needs.
We involve families and informal caregivers, thus strengthening bonds and reducing costs.

As a general example, in New York City, the Department for the Aging is helping a licensed home care agency to develop design features and address many of the program development aspects of managed long term care. They are seeking to set up a long term care, managed care program that is centered around the worker-client relationship.

Clearly, the Aging Network has the experience to be active on behalf of the elderly in a managed care environment.

**Local Network Roles**

The Aging Network already is helping Medicare beneficiaries via HIICAP. Of course, we want to further strengthen the program.

We could enter into service delivery arrangements with managed care plans -- marrying our capabilities with their needs. This seems like a promising area for packaging, arranging, and case managing home and community-based care, since managed care emphasizes the lowest level of appropriate care and we have that experience. Other services which might be appropriate for such arrangements include nutrition services and health promotion.

We could advise managed care plans on how to do a better job of serving their older members. We also can monitor quality and outcomes -- not by some sophisticated and time consuming data gathering and analysis, but by being available, often through HIICAP, to hear whether managed care is meeting the needs of older people.

**Some Next Steps**

We need to continue to educate the Aging Network and older people. This will help supplement our experience with an improved knowledge base. We need to continue, and seek additional funding for, HIICAP. We need to provide specific technical assistance to individual Aging Network agencies. We also will begin work, in cooperation with the Aging Network, on a consensus document on the possible roles of the Aging Network in a managed care environment.

**AN AREA AGENCY ON AGING PERSPECTIVE ON MANAGED CARE**

Nancy Hansen, Director
Cortland County Office for the Aging
Cortland, New York

Ms. Hansen began with her observation that the speakers are presenting the same theme,
with variations. Managed care is here to stay, and managed care presents issues and challenges to the Aging Network. She noted that the cover story of Newsweek magazine features HMOs and ranks the top 40 managed care companies in the country and provides some guidelines on what to look for in the new managed care environment.

Issues and Challenges

The evolution of managed care presents both issues and challenges for our Network.

- The Network needs to understand managed care and how it will affect health care for older people. The Network needs to be able to respond to questions asked by seniors. There is great disparity within the State as to the location of managed care organizations. Most rural areas do not yet have managed care while there may be several in large metropolitan areas. In either case, the Aging Network will be called upon to provide specific information and counseling so that seniors can make informed choices.

- The Network needs to be aware of the rapid changes that are taking place, even without a managed care organization serving older people in the area. Provider networks are being created, physicians' organizations are being formed, and linkages are being developed between and among these entities and with hospitals.

- Where long term care may become part of a managed care organization, the Network has concerns about the potential over-medicalization of long term care. Will the emphasis on medical care lose sight of the importance of the social model?

Aging Network Experience

The Aging Network has expertise in several areas:

- **HIICAP.** Health insurance information and counseling has been available for many years, and managed care is an important element of this function.

- **Health Education and Wellness Activities.** The Network continues to promote good health through education and exercise programs.

- **Advocacy.** The Network must make sure that consumer interests are represented and monitor the quality assurance component of managed care.

- **Programs and Services.** The Network sponsors many programs that will be of interest to MCOs, such as congregate programs, home delivered meals, adult day care, and in-home services. Where long term care services are integrated into MCOs, the Network’s experience with EISEP (which is a capitated program) should be of value because we know how to use limited dollars.

Next Steps
The Aging Network needs to be involved in managed care. However, since it is easier to say than to do, it raises the following questions:

• How does the Network let MCOs know what it has to offer?

• How do we negotiate service contracts with an adequate and fair fee structure?

• How do we balance the potential conflicts of counseling, advocacy, and services delivery?

• Finally, where do we go from here?

A SENIOR CENTER PERSPECTIVE ON MANAGED CARE

Ann DiSarro, Executive Director
Senior Services Centers of the Albany Area, Inc.
Albany, New York

Ms. DiSarro noted that one theme of these presentations is opportunity. Over time, there will be even greater HMO emphasis on prevention and as that occurs, HMOs will be more interested in Aging Network services. However, we should begin planning now for two particular opportunities: sponsorship arrangements and prevention/wellness.

Sponsorship Arrangements

HMOs already are becoming more interested in the Aging Network and the Medicare population. Therefore, the first opportunity might be sponsorship arrangements, such as health insurance fairs or special events. In addition, the HMO might support transportation for its older members or fund senior center membership as a means to reduce isolation, loneliness, etc.

Prevention and Wellness

Opportunity No. 2 is the HMO's realization that reducing sickness will improve their bottom line and that we can deliver services important to them. For example, some HMOs have acknowledged that home delivered meals will affect their bottom line, but they do not understand the quality, scope, or cost of these Aging Network services, even as they recognize that we have an established capacity. This HMO interest goes hand in hand with their need for education about the Aging Network. HMOs don't know what's available in the Aging Network, and we need to inform them.

Prevention and health/wellness promotion are perhaps the areas where the Aging Network might be able to do the most for HMOs. There have been some sophisticated responses by HMOs to health and wellness promotion -- perhaps more sophisticated than we are accustomed to providing. A Seattle senior center has an HMO contract to achieve improved health outcomes (not just to provide a program) in the areas of weight reduction
and smoking cessation (as examples) by helping seniors modify their behavior. Ms. DiSarro stressed that the HMO is looking for results. In Denver, an HMO (Kaiser-Permanente) sponsors informal lectures by health care professionals which provide information and mutual support for its members with a specific diagnosis (diabetes or arthritis, for example). They have found these cost effective because the increased information sharing and support decreases members' reliance on physicians.

This type of service could be provided by a senior center. HMOs recognize the problems of isolation and depression, and addressing these problems may be opportunities for us. We need to understand the diagnoses around which the HMO might want to have some interventions. We need to turn our thinking around to think about what we're doing that might help solve these specific problems for HMOs.

Readiness Checklist

Ms. DiSarro highlighted a checklist of 10 things we need to do to be ready for managed care, noting that many of these already have been referenced by other speakers.

1. **Know your costs.**

   We need to know our costs not only in the traditional way but also in a capitated way. If we contract with managed care, we must deliver within the amount paid. We need to become more comfortable with financial risk.

2. **Know your outcomes.**

   It's not easy to know our outcomes. We have to demonstrate not just that we deliver meals, but for example, that after six months of our meals, our clients' conditions improved by a documented amount (weight gain, fewer physician visits, etc.). This will prove that meals not only are delivered but also that they have a positive impact.

3. **Know your environment.**

   This includes thinking beyond the boundaries of the county, even though the AAA service area usually is county based. HMOs are not organized by county. Therefore, our interest in HMOs might lead to partnerships and coalitions.

4. **Look for new partnerships and collaborations.**

   How does the Aging Network, and its different parts, come together? Who are our partners and potential partners with whom we should work as we talk with HMOs?

5. **Know your customers.**

   We do know our customers because we have talked with them for years. But we also need solid assessment information so we can document their values and personal preferences, for example. We know them intuitively, but we need documentation to back
us up and prove our knowledge to HMOs.

6. Use technology.

Technology can help to collect data for satisfying an HMO and making your case. Computerization efforts will be helpful here. We must collect the appropriate data and quickly give information to those who contract with us.

7. Appropriately compensate staff.

This is very difficult to do. If we want to sell a specific service to an HMO (for example, meals or preventive health services), do we have the staff to make that contract work? Can we pay them adequately?

8. Use a diversity of revenue and services.

As we look at what we provide in relationship to the coming demand for those services and their fit with managed care, some services will be more relevant than others to managed care. As a result, we might want to shift resources.

9. Consider the need for capital.

In a risk contract, financial needs are different. One challenge for the Aging Network is that we have been organized into many small agencies. An agency might need a budget of $1,000,000 to $3,000,000 or more to be viable as a managed care contractor and able to take on managed care contracts. Collaborations might give us strength in this area.

10. Marketing and communication.

Clearly, we have not done enough in the areas of marketing our services to older people and communicating their value to the public. We have been hiding our value, and in particular we must say we're cost effective.

Conclusion

In New York City, an HMO did a nutrition assessment and identified its high risk, older members. They put interventions in place and saved money as a result of reduced physician and hospital utilization. What was the intervention? The home delivered meals and congregate meals in the community -- OUR PROGRAMS. Had they considered paying for those meals for their members? No (yet, due to a lack of funding, only a small proportion of older people who need meals are getting them).

We need to convince HMOs that we're the guys they need to be in business with and that they should be paying us directly, not counting on our continuing existence or capacity to serve their members.

New York State HMOs are not necessarily ready for us. Therefore, we have an
opportunity now to get ourselves ready for them, so we can help them determine how to work with us. HMOs have begun to be aware of our services; they are part of the way there.

We all can look forward to new partnerships with a wide range of community based providers.

DISCUSSION HIGHLIGHTS

Ms. Hansen opened up the session to questions and comments from the audience, which raised excellent questions and issues. The discussion was wide ranging and touched on a number of areas, including the needs of older people, questions about HMOs, and activities of the Aging Network.

Older People

A complaint has been that there are many changes in personal physicians. It's difficult for older patients to establish a relationship. Response: This has happened in some HMOs more often than in others. An individual must compare to what he or she is used to having. Some people might be accustomed to using clinics or outpatient departments for care and not seeing the same doctor. So the availability of a specific physician might not be a problem for them. Some people might like the drug benefit and lower costs (for example) and be willing to forego having one primary care physician.

Regarding access, some people assume that older people have the ability and/or desire to manage their own care. In rural counties, older people may be reluctant to ask for the help they need to make informed choices.

If we are going to sell ourselves to HMOs, we need to know what we’re selling to seniors.

Managed Care

In managed care, where do the savings come from? Response: The savings come from efficiencies in the delivery of (sometimes less, but appropriate) care. "Telemedicine" offers an opportunity for more efficient care in both rural and urban areas by reducing home visits, physician visits, etc.

Managed care means less care, and this should be stated up front. Preventive care is great, but people over aged 75 need more care, not less care. Response: Managed care is not necessarily less care; it attempts to deliver appropriate care. To help determine that locally, look at the provider network in terms of who is available, particularly a specialist for a certain condition, and where providers are located.

Managed care might be fine for healthy persons; what about those who are sick?
What about the old, old?  **Response:** With older members, HMOs have to expect to spend more, and they do get more funding from Medicare. You might ask an HMO if it has an age and/or chronic condition profile of its membership. Some HMOs will impress you with their quality, commitment, and approach to serving the elderly, but others will leave you wondering if they are ready.

Is there a limit on the funds that a Medicare HMO can spend on administration, marketing, etc.?  **Response:** HCFA does look at these costs, particularly the "Adjusted Community Rate," which includes spending. HCFA calculates the difference between fee-for-service and HMO costs. The HMO can put the extra money into a stabilization fund, return it to HCFA as savings, or put it into additional benefits for enrollees.

 Most seniors have no idea how Medicare HMOs get their money. When you calculate the amount of money the HMO is getting and realize that many healthier seniors are enrolling, you wonder is Medicare saving or losing money and whether they are looking at different ways to set the payments?  **Response:** Medicare is losing some money because healthier people are joining and because the current payment methodology does not adequately reflect actual HMO costs. Healthier-than-average people cost less than the capitation rate. However, even the best adjusters being tested do not account for much of the difference in utilization. So it's a very difficult thing to do. Risk adjustment is a problem in insurance; how do you anticipate and account for risk?

Are there not-for-profit organizations going into the HMO business?  **Response:** Yes, but these organizations face strong competition from for profit HMOs and generally find it more difficult to access capital for taking risks.

**Aging Network**

AAAs often find that, even though they are widely supported, various funding sources often don't want to pay for our services. As a result, AAAs can't get into managed care unless payment mechanisms include both Medicare and Medicaid. When seniors come to us, they often can't identify what funding stream might apply.

If the Aging Network takes on a provider role, we need to be sure we get an amount of payment which matches the amount of effort we're putting in. This has not been the case thus far with HIICAP which has only covered about 20 percent of the AAA's actual insurance counseling costs.

Look to the West, where HMOs are better established, for ideas. Some commercial HMOs offer health club memberships; they might consider the same for senior center membership. We can find some clues for serving the elderly based on services for commercial groups.

**SUMMARY**
There is no question that the Aging Network has necessary and legitimate roles in a managed care environment. Medicare managed care is growing rapidly, and Medicaid managed care for the elderly is in the future. Furthermore, the concept of managed care fits well with the philosophy of the Aging Network: that older people be served in the lowest cost, least restrictive setting with the least intrusive services required to meet their needs.

Traditional Aging Network roles which are applicable to managed care include I&R, advocacy, counseling, and services delivery. The Aging Network has a 30-year, positive history of helping and serving older people and their families in a productive and cost-effective manner with a wide range of services and supports. Furthermore, the Aging Network already delivers services which significantly improve the health of older people.

As a provider of services under contract with a managed care organization, an Aging Network agency must have a clear understanding of how such a contract fits with its own mission and goals, as well as those of the managed care organization or HMO. Furthermore, the Aging agency must know its products; it must have a complete definition of its services, a precise understanding of its costs, a careful insight about its clients, and an in-depth knowledge about how it can benefit the HMO. The Aging agency must be able to overcome any HMO resistance to paying for a service which it might perceive as "free." In this respect and others, we cannot overstate the value and importance to success of relevant data about costs and benefits. In services delivery, senior centers have been gaining positive experience in prevention and wellness services. HMOs appear willing to support those services if proven effective and to lend help with community-minded events which help older people.

Although it is clear that the Aging Network has many roles regarding managed care -- including information and assistance, protection and advocacy, and services design and delivery, for examples -- unanswered questions remain about implementing those roles in order to advocate for, facilitate, and support improved managed care services for the elderly. Among those questions:

**Older People.** Should the primary Aging Network role be advocacy to improve the managed care system and should that advocacy include both general, system-wide advocacy and advocacy on behalf of individual older people? Should the primary role be information, assistance, and education for older people, through HIIICAP and other means of reaching older people?

**Managed Care.** How can the Aging Network become more knowledgeable about managed care and better prepared to meet the needs of the elderly in a managed care environment? How does the concept of managed care both promote and inhibit the delivery of needed care for the elderly? How can HMOs and the Aging Network work together to improve the health of older people and the delivery of health care services?

**Services Delivery.** In terms of working with HMOs, should the Aging Network focus initial efforts on wellness promotion, illness prevention, and post-acute services? Should the Network seek to promote community-based long term care services with HMOs?
Further steps need to be taken to sort through these and other questions. It is clear that Aging Network agencies and the elderly themselves must become more knowledgeable about managed care. Current managed care needs of the Aging Network include the need for more detailed information about how HMOs work and their effects on the elderly, as well as specific technical assistance in creating working relationships, including contracts, with HMOs.