LONG-TERM CARE ALLIANCES

Thriving in a Managed Care Marketplace

BY JADE GONG & SERGEI SHVETZOFF

While managed care is well established in other sectors of healthcare, many long-term care providers, including Catholic-sponsored organizations, have only recently acknowledged the impact that managed care could have on long-term care. This growing recognition that the status quo is no longer assured has motivated proactive long-term care providers to pursue market-driven strategies. The formation of alliances with other long-term care organizations is seen as a way to gain access to managed care contracts and achieve broader economies of scale. Such alliances with other values-based organizations are consistent with the vision and mission of the Catholic health ministry.

The passage of the Balanced Budget Act of 1997 (BBA) strengthened the rationale for long-term care providers to develop local and regional alliances. First, the managed care provisions of the BBA are expected to substantially increase overall Medicare enrollment in one of the Medicare+Choice plans, making it essential for long-term care providers to have a viable mechanism for securing managed care contracts.

Additionally, the BBA made PACE (the Program of All-Inclusive Care for the Elderly) a permanent program, offering the possibility of social HMOs becoming a Medicare+Choice option. Managed Medicare and Medicaid long-term care have gained greater acceptance and could spread across the nation.

Finally, the implementation of a Medicare prospective payment system for skilled nursing facilities (SNFs) will demand greater operational efficiency from long-term care providers. Through alliances, providers can develop more effective group purchasing, ancillary management, and comprehensive billing functions.

Providers may fear that joining an alliance will reduce their individual organization's autonomy, but the structure can allow each member organization to access managed care contracts while maintaining its unique identity and mission.
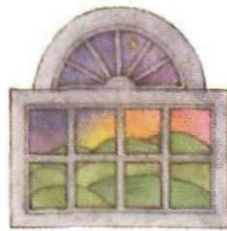
DEFINING A LONG-TERM CARE ALLIANCE

A long-term care alliance or network involves a partnership of 10 to 20 local or regional long-term care facilities serving patients in institutional and community settings. Such long-term care alliances are vertically integrated, but do not involve a merger of the organizations involved.

Each organization typically provides skilled nursing care as well as other community-based programs, such as meals on wheels, adult day care, home healthcare, and assisted living. Some organizations within an alliance may offer SNF-based subacute care. At present, the availability of subacute care is necessary in order to attract contracts with Medicare managed care plans.

The legal structure for a long-term care alliance can take many forms, such as a limited partnership or joint venture, depending on the specific circumstances. Our discussion of partnerships is applicable to all alliances, regardless of their specific legal form.

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UNDERSTANDING THE OPPORTUNITY

Over the past few years, there has been a steady growth in long-term care alliances across the country. An informal survey by the American Association of Homes and Services for the Aging (AAHSA) in 1998 reports that there are 53 alliances in 22 states, with the highest concentration of alliances in Pennsylvania, Ohio, and Illinois.

Interest in alliances is particularly strong among nonprofit long-term care providers that are seeking the economies of scale and contracting that have been available to larger, national (and usually for-profit) chains. However, larger regional chains also benefit from long-term care alliances.

To provide services needed by a variety of Medicare managed care plans, long-term care alliances seek members that are well established providers of SNF and subacute services. Medicare managed care contracts for SNF and subacute care supply revenue that offsets the administrative costs of establishing the alliance and creates a platform for expanding the range of services offered to aging and chronically ill populations.

However, proactive long-term care organizations view a successful alliance as the means to achieve the broader goals of improving the health and well-being of their long-term care patients. The Medicare and Medicaid systems have not encouraged the provision of primary care within the long-term care setting nor community-based care. By providing a capitation for primary, acute, and long-term care, managed care can encourage long-term care providers to take responsibility for the total healthcare needs of patients, including the provision of primary care, and provide community-based long-term care services such as adult day care or supportive in-home services in order to allow patients to remain in their own homes as long as possible.

Until now, there has been no real opportunity for long-term care providers to participate in managed care. Managed care financing may present the possibility of improving the care provided to long-term care populations if providers are willing to accept both the risk and responsibility.

RESPONDING TO A CHANGING MARKET PLACE

Most long-term care providers are not experienced in responding to managed care marketplace developments. An often-asked question is whether the local market is ready for a long-term care alliance. While it is necessary to conduct a market analysis for any proposed alliance, a convergence of managed care developments makes alliances a sound strategy for many independent long-term care providers. Medicare enrollment under Medicare+Choice options is expected to increase dramatically from its current level of about 12 percent to about 25 percent in a few years. Thus, one out of four of Medicare fee-for-service (FFS) patients will not be admitted to a long-term care facility if it does not contract with a Medicare managed care plan. Further, new payment formulas to calculate Medicare+Choice capitation rates were designed to increase payments in rural areas and reduce geographic variation, leading to greater penetration across the country. No doubt Medicare managed care enrollment will increase in the post-BBA era and Medicare managed care plans will enter many more markets.

Another reason to consider an alliance is to become part of a provider sponsored organization (PSO), a new entity created by the Medicare+Choice Program. A PSO is a state or federally licensed provider entity that can accept direct risk from the Health Care Financing
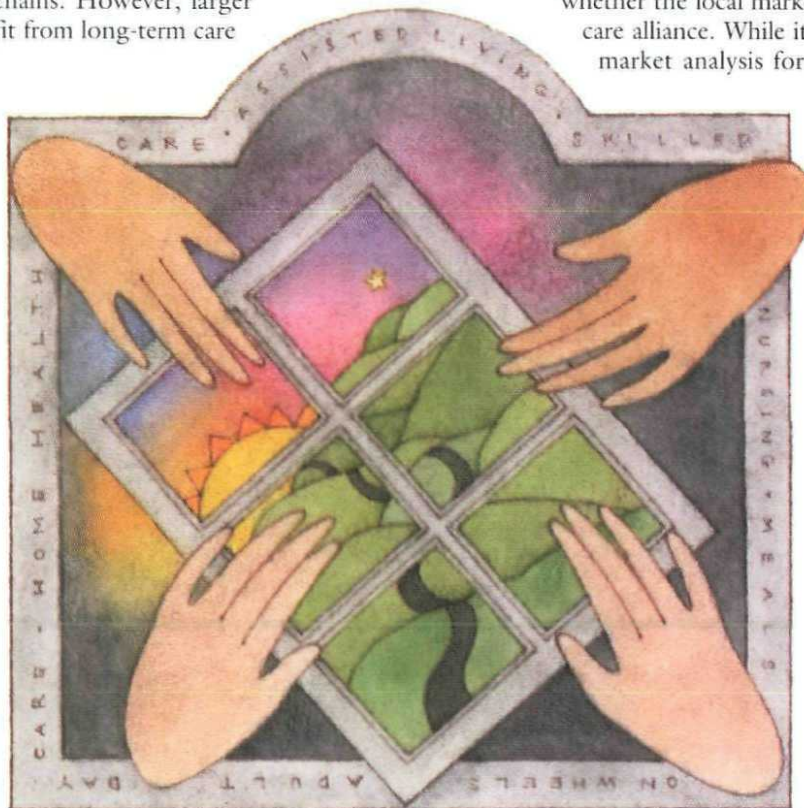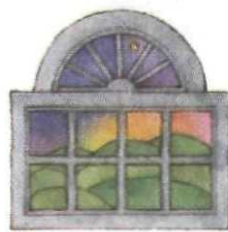
Administration (HCFA) for providing healthcare to Medicare patients. While post-acute or long-term care providers by themselves cannot meet the definition of a PSO, partnering with physicians or hospitals as affiliated providers would meet PSO requirements.

Although most managed care plans do not encompass long-term care benefits, a number of states, including Minnesota, Massachusetts, and Colorado, are experimenting with broader managed care approaches that combine primary, acute, and long-term care to beneficiaries dually eligible for Medicaid and Medicare. However, since these state programs require special waivers from HCFA, they are presently operating under demonstration status.

The flagship "dual eligibles" program is the Minnesota Senior Health Options program (MSHO), which has been operating in Minnesota since January 1997. The program places a single entity at risk for providing primary, acute, and long-term care (up to 180 days) to achieve the following benefits:

• A single coordinated program with a seamless point of access for all services, including long-term care

• A single enrollment plan for both Medicare and Medicaid

• Less duplication and administrative complexity

• Continuity of care wherever it is provided

• Better coordination of information among caregivers

• Additional opportunities for patients to continue care at home or in the community

• Access to specialized geriatric services

• A single set of oversight, complaint, and grievance procedures

ORIGINAL GOALS OF THE FAIRFIELD COUNTY ALLIANCE

• Maintain autonomy by partnering with other nonprofit or values-based organizations
  • Position for managed care
  • Develop integrated care processes
  • Develop new products and services
  • Secure savings from group purchasing
  • Prepare for accepting risk as an integrated service network

> To be successful, an alliance must offer services needed by the community and of interest to managed care plans.

Since its inception, MSHO has spurred the development of several long-term care networks serving its geographic area.

Finally, the BBA enacted a SNF prospective payment system (PPS), beginning July 1, 1998, with the specific transition date depending on a facility's cost-reporting periods. Under the SNF PPS system, each SNF will receive a fixed per diem payment for routine and ancillary services. Given the end of cost-based reimbursement, SNFs face pressure to reduce the costs of serving Medicare patients. Alliances can offer independent long-term care providers some of the economies of scale that have been available to national chains by virtue of their size and scope of operations.

NEED FOR FLEXIBILITY

If an alliance is to be successful, it must ultimately be greater than the sum of its parts. It must offer services needed by the community and of interest to managed care plans. The alliance itself, or in partnership with other healthcare providers, should provide a continuum of care. Properly structured, an alliance can maintain mission and autonomy and prevent a merger or sale to another organization.

On the other hand, an alliance will not be successful if its governance structure is too cumbersome to allow flexibility in the marketplace—for example, if its governing board is too large or there is excessive day-to-day management control. Finally, the alliance must be sufficiently capitalized over a two-to three-year development period.

Depending on the specific managed care marketplace, alliances are pursing a variety of approaches. The following two case studies present strategies for two different managed care environments, Connecticut and Minnesota.

THE FAIRFIELD COUNTY ALLIANCE

Environment In Connecticut, managed care is penetrating all sectors of healthcare, including long-term care. Managed care has achieved moderate penetration within the employed population and most nonelderly Medicaid populations are enrolled in managed care. However, Medicare managed care presence varies across the state, with greater penetration in Hartford County than Fairfield County. Medicare managed care plans continue to enter Connecticut aggressively, and hospital affiliations and consolidations are occurring.
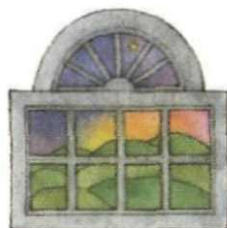
For several years, the state had been participating in a six-state New England consortium to plan a voluntary statewide managed care program for dual eligibles that incorporated long-term care benefits. However, in early 1998, the state withdrew its waiver application and decided instead to pursue PACE programs. PACE programs are substantially limited in size and scope and will not have a statewide impact on long-term care delivery and financing.

Strategy In the midst of the state's plans to pursue a statewide managed care program for long-term care, 9 not-for-profit organizations representing 14 nursing homes, including more than 2,100 beds and other aging services, began discussing whether they should jointly pursue a countywide alliance in anticipation of a managed long-term care program. All the organizations invited to participate in alliance planning were not-for-profit, and some were religiously affiliated (see **Box**, p. 48).

The Fairfield County Long Term Care Alliance was incorporated as a limited liability corporation in October 1997, and included seven of the nine organizations. Three of the alliance members were diocesan long-term care facilities managed by one umbrella organization.

When the state withdrew its dual eligible waiver request in early 1998, the members of the Fairfield County Alliance decided to merge into an existing alliance of not-for-profit long-term care organizations in nearby Hartford County. The focus of this alliance will be on contracting with Medicare managed care plans rather than county-based contracting for meeting the long-term care needs of dual eligibles. Given the state's more modest plans, the members of the Fairfield County Long Term Care Alliance felt that joining forces with an existing alliance would be most cost effective and achieve the necessary goal of moving each organization forward with managed care contracting. At present, the three diocesan homes have not yet elected to join the new alliance.

THE ACCESS ALLIANCE

Environment Minnesota has shown leadership in the development of innovative managed care programs and was the first state to receive HCFA's approval to operate a managed care program for elderly dually eligible persons. MSHO builds on networks developed for the state's prepaid medical assistance program and is available in the seven-county area surrounding Minneapolis-St. Paul.

Minnesota is also considering proposals to modify its Medicaid long-term care system, including expansion of MSHO to other counties, expansion of MSHO to encompass a two-year risk for the long-term care services, and proposals to allow counties to take risk for providing care to Medicaid populations.

Strategy In 1996, Health Dimensions, a member organization of the Benedictine Health System, and the Evangelical Lutheran Good Samaritan Society began exploratory conversations to determine how these two organizations might work together within a dynamic managed care marketplace. Both organizations had identified new and evolving opportunities for progressive long-term care organizations. What emerged was an alliance between these two organizations, which have operated as a joint venture since November 1, 1997. The Access Alliance is limited to Minnesota and includes 90 facilities that are managed or owned, which represent a market presence of about 15 percent of beds statewide, in both urban and rural areas.

This new organization has been created to take advantage of market opportunities presented by managed care, rather than out of concern that managed care would erode the current census. The desire to achieve savings from group purchasing or other operational considerations is of secondary interest (see **Box**).

The Access Alliance is operated by a management council, with equal representation by both organizations. Day-to-day work is carried out by four standing committees. Although alliance activities may eventually expand to other states, no merger of assets is anticipated.

At present, the Access Alliance has entered

> Minnesota has shown leadership in the development of innovative managed care programs.

INITIAL GOALS OF THE ACCESS ALLIANCE

- Create a shared research and development group to tackle operational and management issues
- Create care models that will bring together primary care and institutional care
- Show leadership in care management by developing "exportable" models

LONG-TERM CARE ALLIANCES

into an agreement to operate as a "care system" in Scott County, one of the seven counties participating in the state's MSHO program. The Access Alliance will be accepting global risk for the total healthcare needs of its enrolled population, and expects to accept its first enrollee in the summer of 1998. The Access Alliance is currently planning its priorities over the next three years and seeking ways to raise the necessary capital from its organizations.

LESSONS LEARNED

Experience in creating alliances shows that developing a long-term care alliance is a sound strategy in the right circumstances. However, as these two case studies demonstrate, the structure of the alliance will differ depending on the vision of its members and the reality of the marketplace. Providers in Connecticut, where there is moderate penetration of managed care, opted for a more measured approach, while providers in Minnesota, comfortable with managed care approaches, pursued a more comprehensive and proactive approach to take advantage of immediate opportunities.

Several common lessons emerge:

• The trust that emerges from a similar sense of mission and values is essential to forming an alliance.

• Substantial development time is necessary to agree on common goals and gain comfort with the risk and uncertainty of such a major undertaking.

• Leadership rather than consensus is necessary to move an alliance from concept to reality.

Although long-term care alliances are a "work in progress," Catholic sponsored long-term care providers might consider partnering with other values-based organizations as a means of flourishing during these times of transition. □

BUILDING TRUE COLLABORATION

social service resource information to the Mercy Health Partners database, and Mercy Health Partners supplied a laptop computer so CSS case workers could connect to the database during home visits.

AN ONGOING PROCESS

As organizations reach this point on their journey to collaboration, one or both partners often begins to ask, "Where is the payoff?" In projects such as the Wilkes-Barre effort, the healthcare partner may wonder when it will begin to see the additions to its database reflected in its revenues. All four Neighborhood-Based Senior Care Initiative projects feel financial pressure. Since grant monies from the Retirement Research Foundation underwrite only the study of interagency collaboration, program funds for the actual project must be found locally.

If organizations give in to these performance pressures and cut back on their resource contributions too soon, they put their collaboration in jeopardy. Collaboration is a process to which organizations must commit time and resources. Above all, they must resist pressure to leapfrog the process in order to produce an immediate "product" before they establish a strong working relationship that can support the product.

Nine months into the Wilkes-Barre project, Mercy Health Partners and CSS decided to develop a Program of All-Inclusive Care for the Elderly (PACE). The partners are currently working through the regulatory approval process.

The PACE model was first developed to meet the financing and care needs of elderly residents of San Francisco's Chinatown (see "PACE: Innovative Care for the Frail Elderly," p. 41). It focuses exclusively on the frail elderly, emphasizing their independence and dignity. An interdisciplinary team of providers manages a comprehensive package of services. Financing is based on capitation rather than fee-for-service.

The PACE model fits well with the mission of both CSS and Mercy Health Partners, who are committed to serving frail at-risk elderly persons through community-based programs. PACE is also congruent with managed care efforts within the community because financing is based on capitation.

Collaboration does not occur overnight, but develops gradually as organizations move along the continuum from cooperation to collaboration. The Wilkes-Barre site has, in fact, developed at a relatively rapid pace compared with other collaborations of the initiative. Once the partners in the Wilkes-Barre project succeed in creating a viable PACE site, they will have achieved a true collaboration, because they will have created a new entity which draws from all partners, but belongs to none. □

WHAT MAKES COLLABORATION WORK?

Researchers at the Amherst H. Wilder Foundation in St. Paul have determined that organizations most likely to succeed as collaborative partners are part of a community with existing models of successful collaboration; have a shared vision; trust and respect their partners; see the proposed collaboration as in their self-interest; share a stake in both the process and the outcome; communicate openly and frequently among themselves and with people outside the group; are willing to commit to concrete, attainable goals and objectives; and have an adequate, consistent financing base that supports their operations.

For more information, see *Collaboration: What Makes It Work: A Review of Research Literature on Factors Influencing Successful Collaboration,* by Paul W. Mattessich and Barbara R. Monsey, Amherst H. Wilder Foundation, 1992.