

# **Medicare/Medicaid Integration: What Do the Experts Say?**

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## **Abstract**

The environment for Medicare/Medicaid Integration Programs is examined from the perspective of selected health plan and provider experts known to have an interest in the integration of acute and long-term care. Twenty-nine respondents described their vision for integrated care and explained the operational issues they faced in developing programs for people “dually eligible” for both Medicare and Medicaid. Challenges in developing a new infrastructure in the context of an uncertain environment will need further government investment in demonstrations. Integrated care programs for all Medicare recipients, not just duals, could benefit from such an investment.

## **Introduction**

The integration of acute and long-term care has long been envisioned as one of the key steps necessary to bring long-term care into the mainstream of our health care system and improve care for those with complex care needs. Medicare is our nation's primary public source of funding for acute care and Medicaid plays the same role in funding long-term care. Given their impact on healthcare providers and health plans, these two programs together hold the potential to shape our health care system. The Centers for Medicare and Medicaid Services (CMS) estimates that there are 6.2 million people in the U.S. that are eligible for both Medicare and Medicaid.<sup>1</sup> Since many in this group have complex medical and chronic care needs that require lengthy stays in a variety of long-term care settings, states have been actively seeking to integrate Medicare's acute benefits with Medicaid's long-term care benefits to provide better services for these dually eligible beneficiaries.<sup>2</sup>

Unfortunately, the environment for accomplishing this vision has been even more difficult than expected. When The Robert Wood Johnson Foundation and the University of Maryland Center on Aging launched the Medicare/Medicaid Integration Program (MMIP) in 1996 it was well recognized that new programs for dual eligibles would need federal waivers from CMS to streamline administrative complexity and exempt states from duplicative activities.<sup>3</sup> These waivers had been notoriously time consuming to secure. Despite these obstacles, Minnesota had just successfully negotiated the necessary approvals and was ready to launch its innovative Minnesota Senior Health Options (MSHO) program. More states were looking to build on that momentum. Fueled by the strong interest at that time in public sector managed care, as many as 13 additional states

(CN, CO, FL, ME, MA, NH, NY, OR, RI, TX, VT, WA, WI) received MMIP support to do their own version of integrating Medicare and Medicaid for dual eligible beneficiaries.<sup>4</sup>

Shortly thereafter, the 1997 Balanced Budget Act unexpectedly changed the environment. A combination of provider payment restrictions and a backlash against managed care began moving providers away from integration and back to their “traditional” silos of care. Nonetheless, the MMIP states continued to work toward better systems of care for the dual eligible beneficiaries. This perseverance has recently prompted CMS to establish a new Technical Advisory Group (TAG) on dually eligible beneficiaries. The Dual TAG is the first of its kind that recognizes the critical role that Medicare decisions have on state Medicaid programs.

At least two ingredients are necessary for launching a dual eligible program in any state – a willingness on behalf of the state to facilitate the program’s development and work with CMS, and at least one committed provider or health plan that is interested in investing the necessary energy and start-up capital to get the program off the ground. In this article we will review where we are on integrating acute and long-term care for the dual eligible population from the perspective of selected key health plan and provider contacts who have been closest and most committed to its pursuit.

## Background

Work began on integrating acute and long-term care more than 20 years ago when two very different models fostered the notion that proper preparation for the health care needs of our aging population would require reconciliation of the separation (often

estrangement) between the social side of health care and the medical side. The On Lok model, and its replication Program of All-Inclusive Care for the Elderly (PACE) initiative<sup>5</sup>, along with the Social HMO experiments of the early 1980's<sup>6</sup> began to show the way. In very general terms these models -- along with the EverCare nursing home care management demonstrations<sup>7</sup> -- have set the stage for current efforts in Minnesota and Wisconsin that represent the new wave of state based programs that provide a broad menu of services for people eligible for both Medicare and Medicaid.

The MMIP states are in various stages of planning, development, and implementation of integrated programs for the dual eligible. For example, Minnesota and Wisconsin are operating programs that are capitated for both Medicare and Medicaid – the programs are entitled Minnesota Senior Health Options program (MSHO) and the Wisconsin Partnership Program (WPP), respectively. Texas (Texas Star Plus) and Florida (Nursing Home Diversion Project) are capitating Medicaid and supporting care coordination with Medicare. Programs in Maine, Vermont, and Oregon have implemented managed fee-for-service strategies to better connect Medicare and Medicaid on behalf of their dual eligible populations. This survey includes experts from some of these programs, experts from other state Medicaid and Medicare efforts, as well as from private initiatives. Responses from these experts provides a view of the dual programs nationally, and can also help guide further program development activities in the Medicare/Medicaid Integration Program, and activities of other providers, plans, and states not currently focusing on the dually eligible population.

## Survey Methods

The survey was undertaken in January 2002. The MMIP (University of Maryland Center on Aging), along with the National Chronic Care Consortium<sup>8</sup> (Bloomington, MN), a provider membership organization, developed a list of potential survey participants who were program directors, chief executive officers, or medical directors from organizations across the country that had developed programs for dual eligibles. In addition, a list of was created of organizations that had special Medicaid or Medicare-only programs that moved toward a more integrated model of care, but had chosen not to develop a dual program. Many of the organizations that did not have special programs for duals served a small percentage of dually eligible clients in their other programs. All potential respondents were considered experts in that they had knowledge of the issues surrounding the dual population, and/or had demonstrated innovation around a more integrated model of care. These experts had familiarity with PACE programs (10), social HMO programs (4), and state sponsored or administered dual programs. In total, twenty-nine experts agreed to participate in the interviews (Table 1).

<b>Table 1: Snapshot of Respondents</b>	
<b>Title/Role of Interviewee</b>	<i>Number in Sample</i> <u>Total = 29</u>
CEO, Exec. Director, or Senior-level V.P.	10
Medical Director or Physician	8
Program Director or Manager	11
<b>Type of Organization</b>	
Health Plan	10
Provider	19

Before the interview, each participant completed and returned a consent form and a background survey form. The background survey form had three questions requesting information on the type of dual eligible program the organization had developed (if any) and the entity (state, federal government or other) that the participant believed was the most important driver in the creation of dual programs.

The interviews were conducted by telephone using a survey protocol. Of the 29 persons interviewed, there were ten chief executive officers or senior level vice presidents, eight medical directors or physicians, and eleven program directors. Nineteen interviewees were providers and ten were from health plans. Each interview took, on average, forty minutes, involved nine to ten open-ended questions, and was audio-taped. Each interviewee was asked to comment on their vision and their organization's vision for the integration of primary, acute, and long-term care and to indicate one or two key factors for moving ahead on their vision. They were, also, asked to identify the type of support that was needed by providers, plans, and states in developing dual programs and predict how dual programs will evolve within the next year to five years.

In addition, each interviewee from an organization that targeted the dually eligible as a special service group was asked to explain the operational issues faced in developing a dual program, the top internal and external barriers and catalysts to the creation of a dual program, and specific outcome measures for evaluating dual programs. Interviewees from organizations that did not target dual eligibles were asked why that population had not been targeted for special program consideration and their opinion was sought about the feasibility of serving the dual eligibles, given current marketplace and organizational dynamics. They were, also, asked about the pros and cons of developing a dual program

and the market advantages and disadvantages to serving this population (see Table 2 for an outline of the survey questions).

<b>Table 2: Survey Structure and Questions</b>	
<p>The opening questions on the Survey pertained to:</p> <ul style="list-style-type: none"> <li>• The individual’s and organization’s vision for the integration of primary, acute and long term-care, including home and community-based services</li> <li>• One or two key factors for moving ahead on the vision</li> </ul>	
<p>First branch: For those organizations that had developed a program for the dually eligible, the questions included the following.</p> <ul style="list-style-type: none"> <li>• Some details/description on the organization’s program</li> <li>• Identification of 1 or 2 significant internal operational issues that the organization faced in developing the dual program</li> <li>• The top internal and external barriers to the creation of a dual program</li> <li>• The top internal and external catalysts to the creation of a dual program</li> <li>• How to evaluate the success of dual initiatives—identification of outcome measures</li> <li>• Identification of the type of support, if any, that providers, plans, or states need in getting dual programs off the ground</li> <li>• A forecasting or prediction of how the individual sees dual initiatives evolving in the next year, or next 5 years.</li> </ul>	<p>Second branch: For those organizations that had not developed a program for the dually eligible.</p> <ul style="list-style-type: none"> <li>• An explanation of why they thought their organization hadn’t targeted the dual population for special program development</li> <li>• Their opinion about the feasibility of serving the dually eligible given current marketplace and organizational dynamics</li> <li>• The pros and cons of developing a dual program</li> <li>• Market advantages and disadvantages of serving this population</li> <li>• Identification of the type of support, if any, that providers, plans, or states need in getting dual programs off the ground</li> <li>• A forecasting or prediction of how the individual sees dual initiatives evolving in the next year, or next 5 years.</li> </ul>

The majority of interviewees (25) were from organizations that had targeted the dual eligibles for special consideration and, therefore, were asked the first set of questions involving operational issues, barriers to the creation of a dual program, and measures to gauge the success of their programs, in addition to the questions involving a vision and futuristic predictions for the program. There were four interviewees that indicated their organization had not targeted dual eligibles for program consideration that were asked the second set of questions involving why their organization had not targeted the dual eligible. Because the questions were open-ended and appeared similar in some cases, interviewees were allowed to give similar responses to different questions.

## **Vision of Integrated Care**

The majority of respondents indicated that their vision of integrated care included a full continuum of coordinated services with supportive financing and a shared information highway. This involved integrated Medicaid and Medicare programs that pool finances, have one set of rules, and coordinate medical and social services across all delivery of care systems. Some interviewees believed that the PACE program embodied this vision. Other interviewees said that the PACE model could represent this vision if providers revised that model, which only serves a small number of clients, to serve a larger number of clients.

While the majority of respondents did see the integration of Medicare and Medicaid client information and financing as a way to fulfill their vision of integrated care, several other important nuances were noted. One interviewee emphasized that integration of services should involve mental health and substance abuse services.

Mention was also made of finding clinicians who want to deliver care in a different way, streamlining regulations, and creating consumer demand for an integrated care approach. A client/patient-centered system of care and financing that supports disability prevention were also cited as key aspects of truly integrated care

## **Catalysts**

Interviewees described many catalysts that motivated them to implement programs to serve the dual eligible population. Some of the top responses included support from the CEO and the Board of their organizations. These were internal

champions that brought strong commitment and energy to a vision of integrated care. Support at the state level was also mentioned. Other responses included support from the National Pace Association and from consumer advocacy groups. Another major catalyst was the demographic imperative. This included the fact that the “baby boomers” are aging and the current capacity of long-term care services will be insufficient. In addition, the “boomers” will demand more options for care at home, greater flexibility, and more input in care and treatment decisions.

A few interviewees mentioned that their catalyst was the obvious improvement in care management and perceived outcomes due to the care coordinator in the program who was able to provide innovative services to clients that helped keep these clients in the community. This service could be as small as providing a refrigerator or an air conditioner. One interviewee commented that, after the program had been around for awhile, “people saw this as a valuable choice and the word is getting out.” Members of the program, also, begin to see it as valuable and embrace its approach to their care. Other interviewees found that their geriatric clinicians (geriatricians, nurse practitioners) were committed to the program and this served to keep the program viable. Some also said that there were other health plans and agencies (such as state health departments) working with them in a cooperative manner that was gratifying, and served to enable the program to run more smoothly.

In general, the interviewees saw the programs in which they worked (e.g., PACE, MSHO, WPP) as exemplifying a viable vision of integrated care and as being the catalyst for motivating them to continue to refine program efforts. Some interviewees believed that their programs should be expanded to include additional categories of seniors (e.g.

Medicare beneficiaries who do not yet qualify for Medicaid) and the younger, physically disabled population.

### **Operational Issues**

The majority of respondents indicated that primary operational issues involved building the necessary infrastructure for delivering care to the dual eligible. One respondent said, “our challenge has been transforming a home care agency into a managed care organization.” There were, also, concerns with training staff, and with managing growth. A lengthy internal approval and development process and the need for a large up-front capital investment were other operational issues/barriers. In addition, developing adequate information systems, convincing clients to enroll, and educating the public about the program were significant issues. One respondent indicated that dual programs are different from other programs in so many aspects, including unique contracts and unique procedure codes that entail specialized training and staff capabilities.

### **Barriers**

Some of the answers to program barriers were similar to the answers to operational issues, however, they tended to be in greater depth. The frequent answers to barriers to setting up integrated programs included fragmented financing and entrenched delivery systems with multiple and conflicting regulatory requirements. Medicare and Medicaid have separate narrowly defined benefits for which these programs reimburse with no bridge or transition into the benefit areas that the other program covers. In addition, there

is a lack of integrated information and a centralized medical record accessible to all providers serving the patient. It is difficult to convince providers to participate in the program and requires, at least, training for providers to understand the requirements of serving this population. Another issue is that families and dual eligible clients do not understand integrated care – therefore there is no ready-made consumer demand for it. This demand has to be created person by person, as individuals in a given community learn the benefits through experience with the program.

A few responses referred to a need for additional resources for this population, in particular, affordable housing. Some respondents also mentioned that it is difficult to find a champion within senior management who believes in the program and is willing to take the risks. Another respondent said that the dual program can be seen as competition to other support service providers in the area. This may mean that these support services are reluctant to refer to the dual program. Additionally, other programs and community agencies fear that the dual program will base delivery of care decisions on medical needs and not allow clients the freedom of independent decision making. Another response included “finding a model where people who have a more medical approach and a more psychosocial approach can come together and talk the same language”. A few responses indicated that cultural and diversity issues can be barriers.

### Measuring Integrated Care

Most respondents commented that satisfaction surveys should be used to measure the success of the dual program. Surveys should be designed to evaluate how the seniors

perceived their health before enrolling in the program and after enrollment in the program, including questions regarding whether or not a senior would recommend the program to other seniors. Respondents, also, mentioned analyzing specific outcome measures such as the number of emergency room visits, the hospital admission rates and length of stay, nursing home admission rates and length of stay, rate of physical decline, and rate of movement across settings. These measures could be obtained for members in the dual program and comparison groups and/or could be viewed longitudinally, comparing seniors before, at the time of, and some period of time after enrollment. Other measures mentioned included measuring the success of prevention efforts, the success of specific disability prevention efforts or disease management models, and the financial result or cost effectiveness of the program.

Infrequent responses included measuring the number of disenrollments from the program over time, with fewer disenrollments indicating program success, and measuring the number of prescriptions per member per month, with more prescriptions, possibly, meaning more success at preventive care. A few respondents believed it was difficult to perform any program outcome measures as dual eligible clients do not improve in health, per se. Some interviewees indicated there should be a general measure for quality of life. This, however, is a subjective measure and difficult to determine. One respondent stated that some of the selected outcome measures that are used in the first year of a program should be different than the second year of the program, as experience is gained.

## Need for Support

All respondents said that providers, plans, and state governments need support in getting integrated programs for the dual eligible population off the ground. Some respondents indicated that states need assistance from the federal government in developing common agendas, understanding the waiver process, and blending the payment system. Health plans and states also require assistance in developing demonstration projects and writing RFPs. In addition, some health plans with no Medicare experience will need technical support to learn the requirements of this federal program. Other respondents indicated that the type of support providers needed included freedom from some of the Federal fraud and abuse regulations so that they could experiment with various approaches to delivery of care (particularly linking specialized providers to improve continuity of care and decision-making). Providers need a supportive work environment where they can be empowered to use innovative approaches. Providers also required training on how to identify and work with the dual population, to create a supportive work environment.

## **Predictions for the Future**

There was a general sense of concern about the potential for progress with dual programs over the next year because of budget constraints and a realigning of priorities after the September 11 disaster. There was some hope expressed for the evolution of these programs over the next five years, especially if there is payment and program design reform in Medicare and Medicaid. Some respondents indicated that development of these programs over the next five years depended on the willingness of the states to

move forward and to cooperate with providers. Some interviewees believed that there would be a proliferation of PACE programs and other programs that will serve a broader population of the disabled and seniors.

Other respondents believed that pressures from a growing population of older adults requiring long-term care services will force the evolution of the dual programs but the federal government will continue to hold programs accountable for outcome measures. It will become imperative to learn what outcome measures are the most relevant for determining program success. However, some respondents felt that these programs may not advance because of the continuing limits of available financing.

### **Summary Discussion**

To review the results we will first focus on the perspective of the four interviewees who indicated that their organization had not targeted the dual population for special program consideration. Three of these did agree that there were good reasons for having dual programs in that it is generally the mission of their organization to deliver care to the underserved, greater system coordination reduces duplication, and, particularly when considering the PACE program, there is a high level of patient satisfaction and improved quality of care. However, the negatives include the concerns about payment, the need for upfront investment of capital and time, and the difficulty in marketing to this population. Another barrier is fact that it would take additional staff to meet the quality assurance requirements of both Medicare and Medicaid for these programs. One interviewee indicated that their organization was looking at the feasibility but couldn't decide what model of care they would use, PACE or another model.

Another reason for not targeting the dual population was the difficulty in targeting and tracking one special group at a physician's office. The amount of activity in a physician's office on any given day makes it difficult for the staff to remember the different payers and payer requirements for each patient. Other reasons included the prejudice that would develop in targeting one group for special consideration when there are other persons that are in the pre-dual stage and don't have the resources to obtain necessary care.

Regarding the feasibility of serving dually eligible, given marketplace and organizational dynamics, three interviewees indicated that programs should be implemented for persons before they are enrolled in Medicaid to save money. Once persons are enrolled in Medicaid it is harder for the programs to be cost effective, unless there is the ability to restrict benefits. Restricting benefits is not a popular concept, given that Medicaid is an entitlement program.

Regarding the market advantages and disadvantages to serving the duals, the general responses included that it is critical to develop a plan that addresses the fact there will be an increase in the elderly population in the market in ten to fifteen years which will impact on our resources, and a desire to serve all elderly not just one special group because of the negative image this would project in the marketplace. Also, respondents noted the difficulty in communicating with dual eligible beneficiaries because their poverty level makes them prone to other priorities such as where their next meal comes from and how they pay their bills. Other comments included fear of the growth of demand for these programs and inability to control the growth and quality of the

program. One interviewee indicated that having a dual program would help to control where persons got their care, e.g. in their home versus the hospital.

Unlike many of the interviewees that had targeted the duals in their organization, those that enrolled dual eligibles only as part of their general population either did not have a specific vision of integrated care or believed that their vision of integrated care was for all seniors, not just the dual eligible. Regarding the future of dual initiatives, these respondents, either believed these initiatives will be “placed on the back burner” because September 11th changed this country’s priorities, there will be a decline in participation because of Medicare requirements, or they just did not know how these initiatives would evolve over time. They also indicated that, if these initiatives did happen, they will be for all seniors, not just for the duals.

To complete our summary review we focused on the nine senior level managers, nine program directors or managers, and seven medical directors from organizations that targeted the dual eligible. Responses are compared on questions related to their vision for the integration of care and operational issues/barriers involved in creating dual programs. The senior level managers and program directors shared similar visions for integrated care. They viewed integrated care as coordination of services across care delivery systems, including interdisciplinary teams that look at all the competencies of an individual, both social and medical. Integration of care also included a centralized medical record for each patient that was accessible to all providers of care and information systems that transmitted data across delivery of care. Some of the managers described integrated care as a model of intensive case management and a seamless

delivery of care system, from the point of entry through the primary care provider. Several saw PACE as matching their vision for integrated care.

The medical directors envisioned integrated care in a manner that was specific to patient and physician care issues. From their perspective, integrated care included the primary care doctor engaging immediately in patient care. Integrated care included avoidance of unnecessary hospitalization for the patient and the building of better quality of care, including the medical and social components, for patients at the end of their life. Some medical directors describe integrated care as involving better communication and closer relationships between health plans, clinics, physicians and patients. Building a system of education, prevention, and early detection was cited as essential to reducing the demand for acute services.

The major operational issues that senior level managers identified related to training staff, and managing growth. Some of these managers were previously in programs that only handled specific aspects of patient care, such as home health, or they were social service agencies. For them, the challenge was in building the infrastructure to handle all the medical and social components of care for the dual eligibles. Significant barriers included identifying the dual eligible and convincing these persons to enroll in the program, having consistent state and federal regulations relative to reporting requirements and eligibility criteria, and problems with rate setting methodology. Other barriers included handling diversity, investment capital, obtaining the commitment from physicians to participate, and establishing adequate information systems.

The program managers and medical directors had many similar concerns to the senior level managers but their concerns, operationally, placed more emphasis on

developing an internal management structure and recruiting and retaining qualified staff. Their concerns also included space allocation and the details of matching claims to authorizations as well as getting their claims paid on a timely basis. Several were concerned with having adequate resources to handle patient needs in the community who could not depend on supports from their family. These included the need for housing, nursing homes, and transitional and subacute units in institutional settings. The lack of transitional housing was seen as a barrier to creation of a dual program in addition to many turf issues and competition from other programs and agencies in their community.

## **Conclusions**

States with the help of CMS and MMIP have taken the lead in developing programs that integrate long-term care into the mainstream of the health care system. This study was undertaken to help identify issues that could affect efforts to get Medicare and Medicaid working better together on behalf of dual eligibles. Health plans and providers are interested in this issue because it represents a learning opportunity in preparation for the much larger and rapidly growing market of Medicare beneficiaries that will need a full array of acute and long-term care services.

Some conclusions from the survey are the following. There is a fondness and respect for all of what the PACE program has and will accomplish as a model of integrated care but its focus is more limited than what is needed for fully integrated care system development since it can only serve the dual beneficiary who is already certified to need a nursing home level of care. The increased flexibility of the Wisconsin Partnership Program, which does not require the day care clinic and staff physicians of

PACE, is seen as one positive step because it allows for easier growth in market potential. However, the WPP still has the issue of focusing the enhanced home and community care benefits only on those who are “nursing home certifiable.” This may be too late an intervention or only part of the solution. The MSHO program and its sister option for the younger disabled (Minnesota Disability Options, MNDO) cover both the person eligible for nursing home care and those who are still relatively healthy and living in the community.

There is also recognition that states need to find ways to intervene before people become eligible for Medicaid so they can help people delay or avoid that costly transition. Health plans and providers see this as an important step toward developing systems of care that are relevant to the Medicare-only population who will be paying for their long-term care themselves directly or through insurance.

The MMIP states have worked through many challenges and an array of different integrated care strategies have emerged. Whether a state’s approach is fully capitated pooled financing or operating through focused care coordination of fee-for-service benefits, the intent is the same; to have Medicare’s acute care benefits and Medicaid’s long-term care benefits work well together on behalf of those patients who need those services.

To reach this goal will require further support and investment in demonstrations of the array of approaches and strategies that have emerged from the MMIP states. It is important for states and the Federal government to view these efforts as an investment in the future of our health care system and the time to make that investment is now while there is still time to work through the learning process.

Only when the demonstration approvals have been accomplished can health plans and providers feel comfortable working on the clinical changes that will be necessary for success. The new CMS TAG on dual eligible beneficiaries is a very positive development. The lessons learned from the MMIP efforts to integrate the missions of Medicare and Medicaid are just beginning and further investment is needed.

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<sup>8</sup> For more information on NCCC go to: [www.ncccconline.org](http://www.ncccconline.org).