

Letters to the Editor

Medical Services in Social HMOs: A Reply to Harrington et al.

We are writing to respond to Harrington, Lynch, and Newcomer's article, "Medical Services in Social Health Maintenance Organizations," which appeared in the December 1993 issue of *The Gerontologist*. As the developers of the Social HMO demonstration at Brandeis University and the sites, we have a different perspective on the project's goals in medical care and how it should have been evaluated than do the authors, who were the evaluators of the project for the Health Care Financing Administration (HCFA). We also have a very different view of where the demonstration should be going in the second generation of sites. In addition, we think it important for readers of the article to know that there are serious methodological questions about several of the evaluation studies cited in the introduction to support the overall critique of the demonstration.

The most serious flaw in the "Medical Services" article is that, after the fact, the evaluators have redefined the demonstration's original goals in medical care and service integration. Since Brandeis first received HCFA support for the Social HMO in 1980, it was never a demonstration requirement in planning, legislation, or HCFA-approved protocols that the Social HMO restructure physicians' roles or develop a geriatric model of care (Leutz et al., 1985). In fact, one of the sponsors — Kaiser Permanente — was determined not to change physician practices, but rather to finance and integrate the delivery of a community care benefit into a medical care system.

We clearly have a different definition of "integration" than do the authors. To us, integration meant ensuring that access to benefits, delivery of services, and sharing of clinical information in the acute and long-term care (LTC) sectors were closely coordinated where the two systems intersected. We viewed integration essentially as a systems development issue. Just as much of the systems coordination that takes place in the acute care system is not managed by physicians, much of the integration of acute and LTC systems does not require using the limited time and special expertise of physicians as the key managers or linkage points.

Integrating acute care and LTC required setting up communications and referral arrangements between the new LTC benefit managers and key personnel in the medical care system, such as hospital discharge planners, nursing home admission and discharge staff, home health coordinators, nurses and social workers in medical clinics, and primary care physicians. The evaluators' own studies, such as the study by Kathleen Yordi (1991), cited in the introduction to

their article, support the fact that integration has been largely successful by this definition. So did a number of our studies of the question (Abrahams et al., 1989; Altman et al., 1993; Greenlick et al., 1988; Leutz et al., 1988).

In contrast, Harrington and colleagues appear to believe that the only way to create integration is to restructure the responsibilities of physicians by involving them extensively in LTC. Their study thus looked at primary care physicians' knowledge of the Social HMO's LTC component, physicians' participation in interdisciplinary meetings, and how often physicians and case managers talked to one another. By these measures most sites had made only modest progress at the time of the study, although Yordi (1991) reported that at least 19% of referrals to LTC case managers at the two HMO-based sites came from physicians' offices. Further, as our physician colleagues point out in a companion letter, a great deal of change in this direction has happened since 1989.

It is ironic that the one original Social HMO site that tried to develop a geriatric medical care group — Elderplan — ended up dissolving the group in 1990. The Elderplan group, led by the first geriatric fellow to graduate from the Cornell University Medical Center's Division of Gerontology and Geriatrics, was established to incorporate geriatricians and geriatric nurse practitioners (GNPs) as both medical care providers and members of the team that planned LTC services. As Harrington and colleagues point out, the group had very low productivity, difficulties with patient access, and large financial losses. What they do not point out is that this was a geriatric medical group, and that its intensive treatment orientation (long appointments, initial physicals for all new members, GNP home visits) appeared to be one source of its financial difficulties.

The authors' focus on changing medical care reflects their misunderstanding of what the Social HMO demonstration is about — and what the evaluation should have been about. They viewed the demonstration in the clinical trials model (p. 798). In other words, they hoped for a controlled change in medical care that should be evaluated in terms of its impact on patient outcomes and cost outcomes compared to a control group.

In fact, the Social HMO demonstration is nothing like a clinical trial of a medical intervention. It is a systems intervention that was designed to change the context of Medicare financing, benefits, service delivery, and marketing. The Social HMO changed

the system for Medicare providers by: (1) asking them to add prescription drugs, other ancillary services, and long-term care for community residents, to Medicare benefits; (2) requiring that they integrate delivery of the full range of services (as described above); and (3) paying them 5% more than standard HMOs using a disability-based payment formula as dual protections for taking on these risks. The Social HMO changed the system for beneficiaries by giving them the chance to choose these richer benefits in return for: (1) joining a managed care system; and (2) paying a monthly premium to cover the difference between Medicare reimbursement and provider costs.

Our goal was to create changes in the ways Medicare relates to health care providers and beneficiaries and then to see how both responded. Over time the intervention has changed as providers have seen what works and what does not, as competition has changed, as reimbursement levels have outpaced or fallen behind cost increases, and as the memberships have aged. We assumed that the central role for evaluation in this type of intervention is to track how the intervention changes, and to feed evaluation information back to the program to help improve the intervention. Thus, an evaluation that sees the model as a static intervention not only misunderstands what it is looking at, it is not at all helpful. This is the case with this article, which comes out four years after final data collection, which was never shared with the demonstration sites, and which leaves the uninformed reader with the erroneous impression that the demonstration ended in 1989.

Harrington and colleagues set up a scenario that the failure of Social HMO sites to change medical care was the source of a larger failure of the demonstration. Part of the authors' case that the Phase I Social HMOs have failed is based on a series of evaluation papers (cited as Manton et al., 1993a, 1993b, and 1993c in their article) that appear to contain methodological errors. Although these articles are not given much discussion in their article, it is important to understand their flaws, since their negative findings are the underpinning of the proposed changes in the Social HMO.

The first error is that the evaluators (Newcomer and Harrington were co-PIs) created a different Health Status Form (HSF) to screen the comparison group population (Durako, 1987) than was used for Social HMO members (Greenberg & Leutz, 1987). The comparison group HSF asked more expansive questions concerning functioning and health status than were asked on the Social HMO HSF. For example, on each of seven Activities of Daily Living (ADL) and mobility questions, comparison group members were asked whether they needed the help of another person or a device to perform the activity. Social HMO members were only asked about human assistance. Thus, Social HMO members who could get to the bathroom with a walker would respond that they were independent while similar comparison group members would respond that they were dependent.

Expanded wording was also used for four health

conditions. For example, the Social HMO health screener asked members if they had a "stroke," while the comparison group was asked if they had "stroke, Parkinson's Disease, or other neurological conditions." In all 11 of these questions (all of which were used in the Manton analyses), the differences in wording always expanded response options for the comparison group. These problems cannot be fixed, and it is difficult to estimate their impact on the health status weighting of the Social HMO and comparison groups. The evaluators, however, have never properly acknowledged the problems in their reports and papers, and we have seen no evidence that they tried to compensate for them.

Beyond using biased underlying data without acknowledgement, the papers compound the bias against the Social HMOs with another even more questionable approach to data: They weight the health status of the comparison group with responses to five questions that were not even asked on the Social HMO members' HSF — osteoporosis, depression, arthritis, hip fracture, and severe memory loss. This is analogous to doing a farm productivity study by counting wheat and corn in both test and comparison farms but adding counts of oats and barley only in comparison farms. We would question whether a finding of higher productivity in comparisons farms was really valid, and we similarly question whether Social HMO sites really had favorable selection on health and disability status (particularly since the findings contradict the evaluators' first Report to Congress (HCFA, 1988).

Additional methodological questions can be raised concerning the evaluation paper on differences in health outcomes (cited as Manton et al., 1993a in their article). The finding of this paper is that, compared to fee for service (FFS), there was both a higher incidence of disability among Social HMO members and a higher mortality among the Social HMO disabled. The paper concludes that Social HMOs did worst with the frail subgroups they were designed to help most, apparently because they failed to integrate acute and LTC, and also because they deprived members of numerous geriatric interventions available in FFS. The problem with this analysis is that this paper's methods fail to account for the fact that Social HMO members were nearly twice as likely as the comparison group to receive a disability assessment, which is the result of new disability being identified in different ways in the Social HMO and the comparison sample. On the one hand, newly disabled Social HMO members are routinely identified and moved into the disabled status by the integrated Social HMO service system. On the other hand, newly disabled comparison group members were identified only through an annual telephone screen. Sometimes newly disabled members die fairly soon, especially if the event that triggered the assessment was a hospitalization. Thus, the higher incidence of disability in the Social HMO may actually have been the result of the system's working well: The more the Social HMO chronic care screening and referral network did its job in such identifica-

tion, reclassification as frail, and service with LTC, the worse Social HMOs came out in the evaluators' analysis.

Finally, having tied the shortcomings of the Social HMO identified in other studies to the failure of Social HMOs to restructure physicians' practice, Harrington and colleagues propose the geriatric model as the solution. It includes asking sponsors to change appointments systems, bring primary care physicians into team meetings, buy substantial administrative time for a geriatrician medical director, hire other geriatric professionals to fill a variety of new roles, establish geriatric assessment and management systems, and expand the number of members case managed to include medical case management of chronic conditions. The recent HCFA request for proposal (RFP) for second-round sponsors (issued in June 1994) follows the evaluators' recommendations and asks for a wide array of geriatric interventions and personnel in new sites.

We think it would be wonderful if new Social HMOs could do all this: It sounds like an ideal, perhaps utopian, system for elders. We strongly support the idea that more extensive geriatric systems should be tested in managed care settings. However, we question on one hand whether the Social HMO setting will yield a fair test of geriatrics in managed care, and on the other hand whether it is good policy to use the Social HMO demonstration for this test.

The Social HMO is a weak setting to test the geriatric model because the program structure and service resources do not exist to conduct the clinical trials that the authors suggest. The RFP does not specify an intervention structure, but rather asks sites to do as much as they can from a list of geriatric components much like those outlined in the article. Although HCFA may indeed find three qualified sponsors, it seems unlikely that the varied interventions they provide will constitute a definitive test of a comprehensive geriatric model. For example, if the new sites fail to prosper, will it be possible to say whether the geriatric model or the underlying Social HMO vehicle was at fault?

Furthermore, new sites are expected to add geriatric capabilities without receiving an increase in Medicare revenues. To help pay for geriatrics, several mandatory Phase I ancillary benefits (e.g., hearing aids, audiometry, eyeglasses, optometry, dentures) are no longer mentioned as requirements; and the minimum level of LTC benefits is reduced to 5% of the value of Medicare reimbursement, which is about half the level of most current sites' spending on LTC during Phase I. Thus, the first casualty of the more "integrated" geriatric Social HMO model may be LTC and ancillary benefits for members.

Redefining the Social HMO as a geriatric intervention is bad policy, since it has been built on discrediting and ending the test of the highly successful model developed in the first-round sites. In effect, the evaluators (and HCFA policy makers) may have made the ideal the enemy of the good. In pursuit of the geriatric ideal, they have rejected an expanded test of a model that adds long-term care, prescription

drugs, preventive services, and other ancillary benefits to Medicare without increasing public costs; that has proven its attractiveness to members across a wide price range; that has survived more than 9 years at all four original sites through a turbulent period in health care markets; and that may be more attractive than a geriatric model to numerous HMOs that want to improve benefits for members without major overhauls in medical systems and personnel (Leutz, Greenlick, & Capitman, 1994). We will continue to work to improve care at the current four sites and to seek a wider application of the successful, budget-neutral Phase I approach to bringing comprehensive benefits and integrated acute and long-term care to Medicare beneficiaries.

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Medical Directors' Response: Medical Services in the Social HMO

We are writing to respond to Harrington, Lynch and Newcomer's article "Medical Service in Social Health Maintenance Organizations," which appeared in *The Gerontologist* in December of last year. As the medical directors of two of the Social HMO programs, we have a different view about what happened in our programs before, during, and after the period covered by the researchers from UCSF and presented in this article. We are concerned that readers of the article may get the impression that the current SHMO programs have done little over the last 9 years to improve the way care is provided to our geriatric patients. We feel that nothing could be further from reality.

The truth is that the authors of the article collected data and visited our sites between 1985 to 1987. They also made brief phone calls to our programs during 1988 and 1989. Since that time, there has been no formal contact between the demonstration sites and the authors to provide updated information on the current systems of care which operate within our programs. It is unfortunate that the authors chose not to be clear about their data collection period and this lack of current information in their article greatly reduces the value of the information that they do present. There are two important messages readers should note: first, that the article has numerous factual errors in describing the programs and activities during the time the sites were studied; and second, that we have all moved on — far beyond the activities and limitations described in this article.

The authors also contend that our systems lack integration and have therefore failed to achieve the goal of the demonstration. The truth is that what they describe is a snapshot of the four programs during our early years of development — years in which we were only beginning to work toward the goal of integration. It is much like looking at a black and white photo of ourselves many years ago and comparing it to the wide-frame, full color photos which we

see today. A current photograph would show health plans that are providing coordinated and integrated geriatric medical care in many ways. For example, we provide comprehensive outpatient geriatric assessment clinics, inpatient geriatric consulting, multidisciplinary care pathways for geriatric specific conditions, ongoing integrated case management for frail seniors, and other targeted team approaches that focus on those already frail as well as those that are at risk of becoming frail within our population.

It is important to go back and look at old black and white photographs of ourselves, as it provides a reference point to measure how far we have grown since the picture was taken. However, taking a new photo of how we look today is really a better recording of our appearance. We thank the authors for allowing us and your readers the opportunity to pull out the old photos and realize how far we really have come. The Social HMOs have grown and changed based on what we have learned during our early developmental period and we will continue this process far into the future.

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