Nursing Facilities and Managed Care

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Abstract

Objective: **To examine the extent to which Illinois nursing facilities have developed relationships with other healthcare providers, particularly managed care organizations (MCOs).**

Study Design: **A cross-sectional survey of nursing facilities designed to determine: 1) relationship objectives; 2) obstacles to developing relationships; 3) currrently available services; 4) staffing for these services and; 5) nursing facility approaches to networking. The survey was sent to a census sample of 867 nursing facilities serving the elderly in Illinois. Descriptive and multivariate logistic regression analyses of relationships determined to be formal/risk-sharing were performed.**

Study Population: **The sample included 523 Illinois nursing facilities. A total response rate of 60% was achieved (523/867).**

Results: **Higher strategic goals, urban location, nonprofit ownership status, higher percentages of private pay and/or Medicare clients (vs Medicaid), and provision of home care and subacute services were all significant predictors of formal or risk-sharing relationships with MCOs.**

Conclusions: **Facilities with more relationships and higher goals have more formal/risk-sharing relationships with MCOs. Facilities in urban areas have more relationships, likely due to the fact that rural facilities have fewer options and operate in different markets. In addition, nursing facilities rely on Medicare referrals from hospitals, and these Medicare patients, especially those in urban areas, are increasingly controlled by MCOs.**

(Am J Managed Care 1999;5:737-746)

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This research was funded by the Retirement Research Foundation (Grant # 94-98). The opinions expressed are those of the authors and do not necessarily reflect that of the Retirement Research Foundation. Portions of the results presented here have been presented at the American Society on Aging Annual meeting (1996) and at local membership conferences sponsored by Life Services Network of Illinois and the Illinois Health Care Association.

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The delivery of healthcare has changed dramatically since implementation of the prospective payment system (PPS). PPS changed incentives for acute-care providers to decrease healthcare costs. Now, 15 years later, managed care is trying to reduce the costs of healthcare even further, primarily by achieving efficiencies among both services and providers. These efficiencies, in theory, stem from productive relationships between providers within a managed care organization (MCO) network. In large part, the success of managed care ultimately depends on how well MCOs integrate service delivery across providers and settings.

In the past, many nursing facility providers believed that these changes would bypass them. Unlike their acute-care counterparts, nursing facilities relied heavily on private-pay clients for many years. As a result, they have operated in a comparatively stable environment. Increasingly, however, changes in the financing of acute care (eg, the substantially larger role of Medicare, Medicaid, and managed care) are beginning to trickle down to nursing facilities.

Two recent dynamics, in particular, are making managed care important to nursing facilities. First, public financing is playing an increasingly important role in the financing of nursing facility care. Medicare reimbursements for skilled nursing facility care increased 25% in 1 year—from $12 billion in 1994 to $15.1 billion in 1995[1]—and public financing funded 61.1% of all US nursing facility residents in 1995.[1] Medicaid comprised 53.5% of this financing, and Medicare comprised 7.7%. Second, this trend is likely to continue because elderly consumers are switching from fee-for-service providers to MCOs (typically Medicare health maintenance organizations). About 70,000 Medicare beneficiaries are enrolling in managed care plans each month, and the Health Care Financing Administration is reporting record rates of health plans applying to participate in Medicare. In May, 1998, about 16% (or 6.3 million) of all Medicare beneficiaries were enrolled in HMOs.[3]

Because MCOs must provide the full breadth of services that are available to Medicare recipients, they need to develop relationships with nursing facility providers. Nursing facilities that can provide the geographic breadth and depth of services needed to meet the subacute and other healthcare needs of Medicare enrollees are particularly attractive to MCOs. Currently, little is known about how extensively nursing facilities have initiated relationships with Medicare MCOs. This paper helps fill that gap by presenting results of a census survey that examined the relationships between nursing facilities and MCOs in Illinois. The survey also assessed nursing facility providers' views about integrating with MCOs and other healthcare providers.

··· METHODS ···

Sample

Using the 1993-1994 Illinois Department of Public Health's Long Term Care (IDPH LTC) Survey, we identified 867 nursing facilities that primarily serve the elderly. Illinois has 3 levels of licensure for nursing facilities serving the elderly: skilled care, intermediate care, and sheltered care. Skilled nursing facilities provide 24-hour skilled nursing services for residents requiring them. Intermediate care facilities provide health services and some nursing supervision in addition to help with eating, dressing, walking, and other personal needs. Sheltered care facilities provide personal assistance, supervision, oversight, and an activity program with provisions for periodic nursing care as needed. All 3 facility types were included in the sampling pool.

Survey Development

Prior to developing the census survey, which we call Nursing Facilities in a Changing Health Care Market (NFCHCM), we conducted 5 structured interviews and 2 focus group interviews with Illinois nursing facility administrators. These interviews focused on various aspects of relationships that these facilities considered or already developed. Based on their responses, a draft survey was developed. Topic areas included: 1) objectives for developing relationships; 2) obstacles to developing relationships; 3) services currently available; 4) staffing for these services; and, 5) classification of nursing facilities' approaches to networking. The NFCHCM survey was reviewed by our advisory committee, pilot-tested by administrators at 16 facilities, and revised accordingly. A summary of this survey is available in the Appendix.

Using the Miles and Snow[4] typology for classifying how organizations deal with uncertainty, we also asked nursing facility administrators to classify their facility according to their own views of their facility now and in the future.

Response Rate

NFCHCM surveys were mailed to the facility administrators at the 867 facilities in April 1994. Of the 523 facilities responding, 55% (n=289) responded by mail. Due to this low response rate, we attempted to complete the remainder of the surveys via telephone. Nursing facility administrators who agreed to be interviewed by telephone were faxed a copy of the survey prior to the telephone interview. The total response rate was 60%.

Nonrespondent Analyses

To examine differences between our respondents and nonrespondents, we examined data from the IDPH LTC survey, our only source of data for nonrespondents. The analysis revealed that nonrespon-

dents had significantly more Medicaid patients ($\bar{x}$=64.7, SD±60.6 vs 51.4±52.87, P<0.001); a higher percentage of Medicaid funding ($\bar{x}$=80.5%±31.4% vs 75.3%±35.6%, P = 0.03); and a lower percentage of Medicare funding relative to total facility funding ($\bar{x}$= 12.9%±25.2% vs 18.7%±31.8, P=0.006) than respondents. About two-thirds of nonrespondent facilities were for-profit compared with about one-half of respondent facilities ($\bar{x}$=68% ±46.7% vs 48.7%±50%, P=0.0001). Implications of the differences for the external validity of our findings are discussed more fully under the limitations section.

Data Sources

The data sources for analyses conducted for this paper included responses to our NFCHCM survey, nursing facility information from the 1993-1994 IDPH LTC survey, and the US census.

Independent Variables

- *Relationships Index Score.* We used data from the NFCHCM survey to construct an index to measure the extent of facility relationships with other providers. Respondents received a list of 19 provider types—including other nursing facilities, residential facilities, community and acute care providers, and MCOs—and were asked to indicate if a relationship existed with each provider type. Respondents were also asked to classify the intensity of existing relationships as follows: 1 (no relationship), 2 (informal relationship), 3 (would like to establish a more formal relationship), 4 (formal relationship), 5 (formal relationship involving financial risk sharing), and 6 (related part of system/organization). Relationship index scores were computed by summing across 17 of the provider types and were weighted according to intensity. Thus, higher scores represent more relationships, including more formal and risk-sharing relationships. We excluded hospice providers and MCOs from the index scores. Hospice providers were excluded based on feedback from the pilot survey, which revealed that all respondents had formal relationships with a hospice organization. The MCO score was used as the dependent variable.
- *Goals Index Score.* Our survey asked respondents to evaluate 32 possible strategic objectives for developing relationships with other providers, including costs and reimbursement issues, geographic coverage, need for linkage or desire for acquisition (eg, networking vs merging), and/or enhancement of clinical or technical expertise. These objectives were rated by importance as "high," "medium," or "low." Goals Index Scores were computed as a simple sum of the 32 items and were weighted by importance. Therefore, the higher the goals score, the more objectives the respondent identified. The goals score was also weighted according to importance.
- *Services Provided.* Respondents were asked to indicate which of 34 services they provided. Because many nursing facilities provide only traditional services, facilities providing home care or subacute services are, almost by definition, more progressive. Therefore, we used these 2 variables as predictors of a formal or risk-sharing relationship with an MCO.
  - HOME CARE SERVICES PROVIDED. The NFCHCM survey list of possible home-care services included: personal care, occupational therapy, speech therapy, physical therapy, high-tech infusion therapy, homemaking tasks, chores/housekeeping, dietary/nutrition services, respite care, adult daycare, transportation, meals, personal laundry service, companion services, telephone reassurance, and hospice services. The total number of home-care services per nursing facility was summed.
  - SUBACUTE SERVICES. Subacute care services on the NFCHCM survey included: intravenous (IV) therapy, ventilator, oncology, Alzheimer's unit, respiratory care, infectious diseases, postambulatory surgery, and orthopedic and neurological rehabilitation. The total number of subacute services per nursing facility was summed.
- *Payor Mix Variables.* Payor options included Medicare, Medicaid, other public payors, and private payors. IDPH survey data were used to compute each type of reimbursement as a percentage of the overall reimbursement per facility.
- *Ownership Type.* Ownership was classified as nonprofit (including church-related and other public funding, ie, city, county, etc.) or proprietary. This information was obtained from the IDPH LTC survey.
- *Environmental Characteristics.* We expected factors outside the facility to influence the number of relationships. One such factor was the percent of the total population in the county that was urban. This information was obtained from the 1990 US Census Bureau.[5] Values were obtained by linking the facility's zip code with its appropriate county-level information.

Dependent Variable

As stated earlier, we used the MCO relationships index score as the dependent variable, with 1= "formal or risk-sharing relationship with an MCO"

and 0 = "no relationship or informal relationship with an MCO."

Analysis

Sample means were substituted for individual nursing facilities with missing data for single independent variables (<2%, n=10). Bivariate and multivariate logistic regression analyses were used. Only variables that were statistically significant in predicting a formal or risk-sharing relationship with an MCO were retained in the final regression model.

··· RESULTS ···

Table 1. Comparison of Overall Mean Values for Selected Independent Variables (n=521)

Independent Variables	Overall % or Mean	Formal/Risk-Sharing Relationship with HMO	No Relationship with HMO
Percentage urban	68.6	86	64.3
Percentage with membership in a system or network	60.7	73.8	57.4
Percentage not-for-profit organizations	41.5	47.6	39.9
Percentage describing their organizational philosophy as "pioneers"	11.5	21.3	9
Percentage overall funding:			
Medicare	18.6	37	14
Private Pay	2.8	8	2
$\bar{x}$ Relationship Index Score (Range: 36-180, 4 point scale, 17 items)	41.9 (16.1)	55.9 (16.8)	38.6 (13.9)
$\bar{x}$ Goals Index Score (Range: 13-96, 3 point scale, 32 items	63.1 (14.7)	71.8 (11.8)	60.9 (14.5)
$\bar{x}$ Number of:			
Medicare beds	13.7 (18.8)	26.9 (24.5)	10.4 (15.5)
Medicaid beds	93.1 (77.9)	97.2 (92.5)	92.1 (73.9)
Total beds*	116 (72.7)	130.7 (84.7)	112.5 (69.1)
$\bar{x}$ Number of services provided:			
Home Care (Range 0-16)	4.2 (5.3)	5.4 (5.6)	3.8 (5.1)
Subacute (Range 0-9)	4.2 (2.6)	5.4 (2.2)	3.9 (5.6)

HMO = health maintenance organization.
Data given as mean (SD). All values P <0.01 except for those marked with asterisk (P=0.02).

Descriptive Results

Comparisons of means (or percentages) for selected survey variables are summarized in Table 1.

Relationships. Eleven nursing facilities (2.1%) reported no current relationships; of those, only 7 expected that this would remain the case in 2 years. Of those facilities reporting at least 1 relationship (97.5%, n=510), the average facility reported 10 relationships (±4.84, range: 0 to 17). On the average, 4 of the 10 relationships were classified as informal, 3 were classified as formal, and 2 were classified as with other providers within their system. Facilities also indicated that there is at least 1 provider, on average, with which they would like to develop a more formal relationship in the future.

Table 2 shows the most common types of relationships. About 20% (n=103) of respondents described having a formal or risk-sharing relationship with an HMO. These respondents were also more likely to report risk-sharing relationships with other providers, and most tended to concentrate on an average of just 1 risk-sharing relationship at a time. These providers also had more relationships of every type, with a mean of 14.25 total relationships (±4.0).

Formal relationships were most common between nursing

facilities and medical vendors (eg, rehabilitation therapy companies) (46%), hospice providers (46%), physicians in solo (vs group) practice (22%), and HMOs (15%). Providers most sought after for more formal relationships included rehabilitation hospitals (26%), HMOs and physician groups (24%), and acute-care hospitals and adult day-care programs (23%). Overall, nursing facilities were most interested in developing financial risk-sharing arrangements with home health agencies, HMOs, and medical vendors, likely because nursing facilities do not view these organizations as direct competitors. Relationship index scores ranged from 18 to 105, with a mean of 44.5 (±16.81). Cronbach's alpha for the relationship index was 0.87.

Goals/Objectives for Developing Relationships. The most common goals/objectives for developing relationships with other providers included enhanced cost effectiveness (61%), strengthened market position (56%), and new referral opportunities (54%) (Table 3). High on the list of objectives desired within the next 2 years was the need to strengthen relations with local hospitals (70%) and increase referral opportunities with providers (69%) with whom they are already linked (Table 3). The mean Goal Index Score across all respondents was 63.1 (±15; range: 11 to 96).

Obstacles to Developing Relationships. Most facilities (84.8%) identified at least 1 obstacle to establishing relations with other providers. On average, facilities said they perceived 5.72 obstacles (±4.29). When we excluded the 15% of facilities perceiving no obstacles, the mean number of obstacles per facility increased to 6.75 (±3.85). Among facilities reporting at least 1 obstacle, the top 3 obstacles included: difficulties meeting ongoing responsibilities (50%), past history/politics as an obstacle to integration (48%), and worries about the costs of integrating (43%) (Table 4).

Because factors may present as obstacles at different times, we asked respondents to indicate when these obstacles were most prevalent. Respondents indicated that during start-up, concerns about meeting ongoing responsibilities (26%) topped the list. Obstacles before start-up tied for second place included past history/politics (24%) and uncertainty about what integrating means [for their organization] (24%). Other obstacles most likely to be encountered during start-up included changing others' views of the facility (13%), costs (10%), need for technical expertise or resources (10%), and perceived competition with other providers (9%). Obstacles impeding further progress included

Table 2. Most Common Types of Relationships Nursing Facilities Currently Have with Other Providers (%, n=523)

Provider Type	Formal Relationship	No Relationship
Medical Vendors	46	23
Hospice	46	18
Individual Physicians	22	18
HMO	15	64

Table 3. Objectives of Developing Relationships (%, n=523)

Objectives	Now	In 2 Years
Enhanced Cost Effectiveness	61	80
Enhanced Quality Control	56	75
Strengthen Market Position	56	73
Improved Reimbursement Strategies	56	74
Add New Referral Opportunities	54	72
Strengthen Relations with Local Hospitals	53	70
Increased Referral with Same Providers	48	69

Table 4. Top 3 Obstacles to Developing Relationships with Other Providers (%, n=523)

Meeting ongoing responsiblities precludes consideration of integration (staff is stretched too thin)	50
History/politics hinder integration	48
Worries about the costs of integrating	43

costs (12%), and inadequate technical assistance and access to resources (12%).

Services Provided by Facilities. Respondents provided an average of 14±8.3 of 34 possible services. Physical therapy (94%), speech therapy (87%), skilled nursing (79%) and occupational therapy (79%) were among those services most frequently provided. Among nursing facilities indicating that they offered subacute services, IV therapy (66%) was the most frequently provided, followed by orthopedic rehabilitation (58%) and respiratory care (50%). The most common community-based services included respite (29%), dietary (26%), meals (25%), and physical therapy (25%). Community-based social services most frequently offered by nursing facilities included information and referral (42%) and recreational activities (28%). The mean number of home-care services provided was 4.12 (±5.4; range: 0 to 16), while the mean number of subacute services was 4.23 (±2.7; range: 0 to 11).

Membership in a System/Alliance. Just over 60% of the facilities in our sample indicated that they are members of a healthcare system, defined as "2 or more healthcare organizations sharing a common form of ownership." Another third said they belonged to a provider network or alliance, defined as "formal relationships not including ownership."

Orientation Toward Change. Most administrators identified their facilities as analyzers (32.7%), followed by defenders (30.9%). About 12% of respondents identified their orientation as extremely progressive.

Regression Results

The most important predictors of formal or risk-sharing relationships with an MCO were: a higher number of formal relationships with other providers, higher goal scores, urban location, higher percentages of private pay and/or Medicare clients, and provision of number of home-care and subacute services (Table 5).

Table 5. Logistic Regression Results: Factors Explaining Formal or Risk-Sharing Relationship with MCOs (n = 521)

Independent Variables	Mean ± SD	ß	Standard Error	*P* value	Odds Ratio
Relationship with Other Providers					
Relationships Index Score (17 items, score 0 = "No relationship" to 5 = "Formal relationship with financial risk sharing," continuous)	41.99 ±16.12	0.0492	0.0106	.0001	1.050
Goals for Developing Relationships					
Goals Index Score (17 items, score: 1 = "low," -3 = "high," continuous)	63.1 ± 14.67	0.0451	0.0119	.0001	1.05
Services Provided					
x̄ Number of Home Care Services Provided (Yes/No, 16 items, continuous)	4.15 ± 5.3	–0.0833	0.0302	.0001	0.92
x̄ Number of Subacute Care Services Provided (Yes/No, 9 items, continuous)	4.23 ±2.6	0.1559	0.0625	.0001	1.17
Payor Mix					
% Medicare Reimbursement (range 0-100, continuous)	19%	0.9826	0.4264	.02	2.67
% Private Pay (range 0-100, continuous)	3%	3.8089	1.1831	.0013	45.10
Environmental Characteristics					
% urban (county-level measure, 0-99, continuous)	68.60	0.0308	0.0064	0.0001	1.03
Intercept		-9.8318	1.0432	.0001	

In Table 6, we compare the odds ratios for the first and third quartile values of independent variables.* The single strongest predictor of a formal or risk-sharing relationship with an MCO was a higher goals index score. Facilities with goals scores of 73 (at the 3rd quartile, just 10 points above the mean) were almost 17 times more likely to have developed a formal or risk-sharing relationship than those with goals index scores of 52 (1st quartile).

Geographic location was also an important predictor. Facilities in counties with a population that was 97% urban were 12 times more likely to have developed a formal or risk-sharing relationship than facilities in more rural areas (47% urban population).

Facilities with relationship index scores of 51 were almost 8 times more likely to have a formal or risk-sharing relationship with an MCO than a facility with a lower score. Facilities with higher percentages of Medicare reimbursement and private pay were also more likely to have developed a formal or risk-sharing relationship with an MCO. Finally, while provision of subacute services was a positive significant predictor of a formal or risk-sharing relationship with an MCO, provision of more home health services was negatively associated with such relationships.

··· DISCUSSION ···

This census survey of nursing facilities in Illinois shows that facilities with more relationships and higher goals—as measured by higher goal scores—and objectives have a larger number of formal or risk-sharing relationships with MCOs. While it was somewhat surprising that facilities providing more home health services were less likely to have relationships with MCOs, this may be due to the fact that MCOs often have separate subcontracts with existing home health agencies.[6] It is unclear if the payer mix variables reflected differences in case mix or if facilities with more private pay and/or Medicare patients are truly more aggressive in trying to develop relationships to achieve financial success.

Our finding that facilities in urban areas have more relationships may reflect 2 factors. First, geographic proximity enhances the possibility of relationship development. Second, urban facilities may simply have a larger pool of non-nursing facility providers with which to become involved. This finding may illustrate the disadvantage that rural facilities face in terms of accessibility to other providers, or it may reflect market differences. In addition, nursing facilities with Medicare patients rely on referrals from hospitals, and MCOs increasingly control those patients, especially in urban areas.

Our informal discussions with administrators indicated that most feel tremendous pressure to develop relationships with other non-nursing facility providers. However, because the Illinois market, including the Chicago metropolitan area, is still in the early stages of full capitation, this view and the strategies associated with it are not absolute. Some administrators disagree with the emerging common wisdom that nursing facilities must become more attractive to MCOs by developing relationships so they can provide more comprehensive services. Some administrators told us that they did not plan to change their strategies, regardless of external pressures to do so.

Table 6. Comparison of Odds Ratios (OR) for 1st and 3rd Quartile Values for Continuous Variables

Independent Variables	1st Quartile Values	1st Quartile OR	3rd Quartile Values	3rd Quartile OR
Relationships with Other Providers	30	4.35	51	12.17
Goals for Developing Relationships	52	10.38	73	26.71
Home Care Services Provided	0	1.00	8	0.52
Subacute Care Services Provided	2	1.37	6	2.55
Percent Medicare Reimbursement	0	1.00	18	1.19
Percent Private Pay	0	1.00	1.88	1.07
Percent Urban	47	4.10	97.2	18.47

*Typically, odds ratios are presented for mean scores. However, because we believed that they were more intuitive, we presented scores for the 1st and 3rd quartiles.

The increased dependence on government financing has sheltered nursing facilities from many developments in the acute-care market. While it is common for facilities with a large number of Medicaid patients to complain bitterly about poor reimbursement rates, the sheer reliability of Medicaid payments may have led to a sense of complacency and a belief that relationships with other long-term care providers, especially risk-sharing relationships, are not necessary. This inaction may be reinforced by a historical view of other providers as competitors rather than as potential collaborators.

In sum, our results confirm that many nursing facility administrators in Illinois have some understanding of the effect that managed care may have on their facility and the industry, and most administrators here readily admit that the need for change is imminent. While acknowledging the need to change is difficult, achieving change is even more difficult. Even when administrators are committed to change, it is not easy to know how best to accomplish it. Many administrators who completed the survey by telephone said they were uncomfortable that they had not made more progress preparing their facility (ie, their staff and/or their board) for the future. These comments suggest that providing some routine training for administrators on what managed care is, how managed care is organized, and how managed care financing works may be a necessary first step toward motivating nursing facility administrators to develop new strategies.

Limitations

This study used a cross-sectional census survey design to reach a larger number of nursing facilities. While this strategy produced useful information regarding current and future nursing facility activities, cross-sectional data are limited with respect to causal modeling.

In addition, our design did not allow us to verify actual nursing facility activity. A survey always represents a compromise in terms of how much detailed information can be obtained. Subsequent structured personal and telephone interviews with 30 survey respondents, however, indicated agreement between survey and interview responses.

Finally, there may have been response bias among proprietary providers. It is unclear if some administrators at proprietary facilities perceived survey questions as overly intrusive or whether they declined to participate because of fears regarding how their facility might be perceived by others. At least 1 nonrespondent indicated that his company's corporate policy prohibited participation. In general, however, nonrespondent analyses were consistent with our expectations, eg, nonrespondents had fewer overall patients and a higher proportion of Medicaid and a lower proportion of Medicare funding, characteristics similar to those respondent facilities with fewer overall relationships.

Recommendations for Future Research

This study focused on the MCO-nursing facility relationship, from the viewpoint of the nursing facility. A comparable study from the MCO viewpoint would help to round out the picture. Future research needs to focus on factors that help predict success in developing and maintaining relationships with other providers. Specific issues to be addressed include: (1) Should organizational strategy focus on development of strong relationships with a small number of MCOs or across many MCOs, (2) Are MCOs more interested in facilities that provide a smaller number of specialty care services or those that provide a more comprehensive set, and (3) Which services are MCOs most interested in obtaining from nursing facilities? The effect of regional factors—such as HMO penetration rate, competition among providers, and state regulations—on these relationships also needs to be considered. Variation in the degree of risk-sharing versus risk-shifting reimbursement arrangements should also be assessed.

Policy Implications

Several policy implications arise from this study. First, the impetus for developing MCO relationships seems to rest mainly on nursing facilities. Currently, Medicare HMOs are mandated to provide the same benefits that are available under fee-for-service plans and are not at risk for non-Medicare costs. Although many HMOs have begun to send nurse practitioners (some trained in geriatrics) to regularly examine enrollees in nursing facilities with which they have contractual arrangements, there are few or no incentives for MCOs to develop creative or shared care management strategies with nursing facilities. Without the financial stake that risk-sharing brings, HMOs may exercise less discrimination over the types of members involved, the quality of the enrollment, and the coordination of administrative systems. Managed care has the potential to be most effective when significant parties are appropriate stakeholders and all are working together in a coordinated fashion to provide the best care.

Until long-term care services constitute a larger piece of the overall business for any 1 MCO, it may not be reasonable for MCOs to actively seek long-term care partners who are willing to apply the aggressive strategies developed for acute care business. Particularly in markets with low managed care penetration, it may not make good business sense for MCOs to put too many resources into achieving cost savings from such a small percentage of their overall business.

Our findings reflect how dramatically the world is changing for nursing facilities. For the most part, long-term care providers have come to rely heavily on government reimbursement for their services. This reliance has clearly delayed nursing facilities' desire to develop strategies for dealing with the changing environment. The recent introduction of the Resource Utilization Groups-based PPS for nursing facility care, along with an increasing consumer preference for community-based residential care (eg, assisted living), has dramatically altered incentives for nursing facilities. These incentives at once move nursing facilities toward patients with higher acuity care needs (eg, subacute) and away from patients with lower acuity care needs (eg, assisted living, residential).

One goal of the Medicare-Plus-Choice program, expanded as a result of the Balanced Budget Act of 1997, was to dramatically increase the numbers of beneficiaries cared for by MCOs. Dissatisfied with reimbursement rates, however, national managed care plans have been dropping out of markets that they view as unprofitable. Thus, nursing facilities now face a world with dramatically new incentives. Our results confirm that the response to these changes in Illinois resembles something like a normal distribution; that is, a certain percentage of facilities are vying to be on the cutting edge, while the majority of facilities are waiting to see what happens to these risk-takers.

It seems apparent that the nursing facilities in our sample are reacting to the high degree of uncertainty in the environment. As more care moves out of the hospital, the demand for additional information about how to maximize outcomes for postacute care is higher than ever. Furthermore, as the sites in which care is delivered move further away from the hospital, and as the baby boom generation ages, it is likely that the boundaries between acute, postacute, and long-term care will become even more blurred.

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Please see Appendix on next page.

Appendix. Summary of "Mission of Nursing Facilities in a Changing Health Care Market" Questionnaire*

Domain	Areas Covered
Establishing Relations with Others	Asks if a facility is presently affiliated (or will be in 2 years) with a health-care system, provider network or other organization (eg, hospital, physician group, other nursing facilities), using a 6 point scale ranging from "no relationship" to "informal relationship" to "already part of our system."
Goals/Objectives for Relations with Others	Asks why a facility has (or will pursue within 2 years) a relationship with other organizations. Respondents indicate high, medium or low importance regarding such factors as enhanced managed care contracting power, expansion of services, strengthening training or technical expertise, etc.
Obstacles to Relations with Others	Asks facility to indicate the obstacles to developing relationship with others and when they were encountered ("getting started," "during start-up," "prevented them from going further" and "not an obstacle"). Choices include: competition, history, costs, culture differences, no perceived need, etc.
Services Available Through Your Facility	Asks facility to indicate availability of services now (and in 2 years) and how the services are provided (employees, contracts inside and outside network), including: *Traditional* (skilled nursing, physical therapy); *Subacute* (intravenous therapy, ventilator); *Home Care* (personal care, low tech); *Social Services* (counseling, case management)
Classifying Your Facility's Approach to Networking	Asks facility to classify their organizational culture now (and in 2 years) using Miles and Snow[4] typology for classifying how organizations deal with uncertainty: defender, analyzer, settler, progressive.

*A copy of the full survey is available from the authors. Please contact us at the address(es) at the beginning of the article.