Long Term Care in a Managed Care System

Idaho Health Care Association-
Idaho Center for Assisted Living

Long Term Care Providers

Today's Nursing Home

- Rehabilitation and return to home is the focus.
- Many individuals have a stay of 30 days or less.
- An efficient care model in terms of quality and cost when compared to hospitals.
- Federal regulations dominate care model.
- Quality of care has vastly improved.
- Sizable population of Dual Eligible individuals.

Assisted Living

- Similar clientele to yesterday's nursing homes.
- High customer satisfaction rate.
- Lack of Federal regulation supports a more cost efficient model for care for those not needing constant nursing care.

Access to Care is Critical

- A successful managed care system
  - Achieves access and quality improvements
  - integrates proven care models.
  - measures a balance in outcomes:
    - cost efficiency
    - quality patient outcomes
    - wellness.

Geographic Challenges to Maintaining Individual Choice

- The rural nature of Idaho presents unique challenges compared to other states.
- Example: Pennsylvania had optional managed care in its rural counties, and mandatory managed care in urban counties. They have since gone to an entirely optional managed care system.

How Savings for Managed Care is Measured

- Claims savings under managed care
- The administrative expenses MCOs incur as a result of their efforts to coordinate care and achieve savings
- Represents approximately a 10% increase in overhead.

Is there true savings after all factors are included?

Savings in Managed Care through Skilled Nursing Facility Services

- With integration of the "medical home" for the individual, long term care facilities provide the physician with:
  - Integrated case management and disease management services
  - Education to the individual to promote utilization of preventive services and healthy behaviors
  - Measurable quality outcomes

Reduce both Medicaid and Medicare expenses in Long Term Care

- Managed Care Companies have an incentive to reduce costs.
- Give incentives to providers who prevent decline and hospitalizations.
- Give incentives to providers who more quickly discharge to lower level of care. (opposite incentives exist today)

Required Hospitalization

- In order to utilize Medicare Part A SNF benefits an individual must be admitted and complete a three midnight hospital stay. The requirement is an artificial barrier to high quality, seamless and cost effective care.
- By eliminating the three-midnight stay requirement, rehabilitation services can be initiated quicker, thus reducing costs. **We should seek to reduce hospitalization lengths of stay, not require them.**

Coordination

- It will be important in a coordinated plan to ensure that both Medicare bad debt and the SNF provider assessment be addressed so that the state and the provider are adequately protected.

Coordination (continued)

- **Providers are very concerned about having multiple- consecutive "Molina" issues causing payment delays and confusion.**
- For every managed care contractor there will likely be new billing systems.

- Currently the state is looking at additional managed care contractors for behavior/mental health, dual eligible's and others in the future.

Lessons from North Carolina

- Physician groups are the center of care management, not insurance companies or hospital.
- Cost reports are utilized by nursing homes.
- The long term care community is generally supportive of their system.

Regulatory Issues

- Many states allow MCO contractors to exclude providers for failure to meet quality or performance criteria
- Idaho should ensure that providers are not subject to duplicative surveys (and adverse incident reporting) by multiple MCOs in addition to H&W. State survey should be sufficient.
- Or- can we ask CMS for a waiver from costly survey requirements if the managed care companies quality measurements are satisfied?

Save on Place not Price

- The current cost/acuity based SNF reimbursement system manages expenses. If a provider exceeds direct or indirect caps costs are not reimbursed.
- Replacing the current reimbursement systems with a capitated price based system could:
  - Unintentionally increase other program costs.
  - Increase MCO profits but not decrease Medicaid costs.
  - Decrease access and choice to consumers.

Looking Forward..

- IHCA-ICAL supports innovate, efficient models of care. Managed care is typically more receptive to specialty programs than traditional cost based reimbursement.
- If a patient can safely reside in an assisted living instead of another more expensive facility they should be allowed and encouraged to do so.
- If a nursing home can keep an individual from requiring hospitalization, there will be cost savings.