Impacts of Managed Care/Health Care Reform on Aging Service Providers
by Provider Type

CCRC/CCRC look-a-likes

- Managed Care Organizations (MCOs) will assume responsibility for case managing their enrollees, determining whether and to what extent services will be authorized.
- Transfer decisions to another level of care (higher or lower) will be made by third party payers beyond the control of the CCRC.
- Coordination of health care for nursing home residents will be directed by physicians affiliated with the resident’s MCO.
- Residents will be discharged earlier from the hospital and may be sicker/need higher levels of care to meet their health care needs.
- If resident’s MCO does not contract with the CCRC, they may be discharged to another skilled nursing facility.
- Potential CCRC market may decrease. Customers may question need for a CCRC and multi-level of care if their enrollment in a MCO will reduce their future health care costs and provide the care they need.
- Extending services to non-residents may be necessary to help build and protect referral sources, which may increase the CCRC’s value to the MCO due to having a larger senior market.

Nursing Homes (NHs)

- NHs will need to help MCOs achieve goal of providing care at lower cost.
- MCO will want to negotiate the lowest rate for patient care with NHs in their network.
- NHs will need to reduce costs in order to remain a competitive alternative to other long term care settings.
- Staff will be expected to work to the top of their license.
- MCO will case manage NH residents, NH staff may need to adjust to different protocols to comply with the requirement of the MCO in which their residents are enrolled. This may pose challenges where the protocols vary among MCOs. Therefore, NHs should attempt to define the best practice protocols for care and targeted conditions in order to increase the ability of their staff to comply and produce better outcomes.
- Residents will be discharged earlier from the hospital and may be sicker/need higher levels of care to meet their health care needs.
- MCOs may ask NHs to “treat in place” instead of sending a resident to the hospital, for which the NH may be paid a higher rate to provide more intensive services.
- NHs will need enhanced information system capabilities and cost accounting competencies.
- NHs will need to measure resident care and outcomes.
- NHs will want to build alliances with other long term services and support providers (e.g., adult day services, assisted living) to expand referral sources, as hospitalizations are reduced more referrals may come from the community over time than the hospital.
• NHs may want to form alliances with other NHs to be attractive partners to MCOs, or physician/hospital organizations who are willing to assume risk for providing skilled care.

Assisted Living Facilities (ALFs)
• MCOs may want to contract with ALFs who will need to offer competitive prices and demonstrate quality.
• ALFs will need to help MCOs achieve goal of providing care at lower cost and may want to demonstrate when they are a more cost effective alternative to nursing home care.
• MCOs will want to negotiate the lowest rate for patient care with ALFs in their network.
• MCOs will case manage residents, ALF staff may need to adjust to different protocols to comply with the requirement of the MCOs in which their residents are enrolled. This may pose challenges where the protocols vary among MCOs. Therefore, ALFs should attempt to define the best practice protocols for care and targeted conditions in order to increase the ability of their staff to comply and produce better outcomes.
• ALFs will need enhanced information system capabilities and cost accounting competencies.
• ALFs will need to measure resident care and outcomes.
• ALF residents will be discharged from the hospital earlier and sent home needing a higher level of care that used to be provided by a nursing home. The MCO will determine the amount of care to be provided, which may be less than under fee-for-service.
• ALFs may see the demand for their services increase from the Medicaid and dual eligible populations if they are a lower cost option than nursing homes, as the emphasis in many of the state dual integration programs is on increasing care provided in home and community based settings.
• ALFs may want to form alliances with other long term care providers to deliver/expand services to residents.
• ALFs may develop/provide services on their own (e.g., day services, home care).

Housing
• Delivery of services in housing will be increasingly important in meeting the needs of residents. On-site services may be part of MCO network.
• Housing residents will be discharged from the hospital earlier and sent home needing a higher level of care that used to be provided by a nursing home. The MCO will determine the amount of home and community based services to be provided, which may be less than under fee-for-service.
• Residents in MCOs may be required to use only certain providers requiring the housing provider to open their doors to multiple providers serving multiple health plans.
• Residents may seek guidance from the housing manager on whether to join a MCO.
• Residents may seek the housing manager’s help in advocating with the MCO on their behalf.
• Housing providers may want to form alliances with other long term care providers to deliver/expand services to residents.
• Housing providers may develop/provide services on their own (e.g., day services, home care).
• MCOs may want to contract with housing and service providers who will need to offer competitive prices, demonstrate quality and may be asked to provide additional services in their settings.

**Adult Day Services (ADS)**

• Medicaid MCOs may purchase adult day services (ADS) requiring the ADS provider to offer competitive prices and demonstrate quality.

• MCOs may look to ADS centers to function as delivery sites for health care services either through contractual arrangements or other providers.

• Care coordination will be increasingly important as MCOs look to ADS programs to coordinate medical and social needs of participants.

• MCOs may not look to ADS or other home and community based care providers unless they can accommodate 24 hour admission/discharge services as nursing homes.

• Medicaid reimbursement may be provided through the Medicaid MCO. ADS programs will need to be part of contracting networks or have separate relationships with several MCOs to insure an adequate volume of participants.

• ADS programs will need to find ways to garner a larger private pay market to provide financial stability. This could include marketing to employer groups as a service for employee caregivers and retirees.

**Home Care**

• MCOs will be paid a fee for providing a bundle of services that may cause them to limit the amount of Home Care services provided. However, many state dual integration and managed Medicaid LTC programs seek to incent MCOs to provide more services to consumers in the community than institutions. As such, demand for home and community based services is expected to be high.

• MCOs will determine the tipping point at which nursing home care becomes more cost effective than the provision of the required amount of home care services for an individual.
General Impacts of Managed Care/Health Care Reform on Aging Services Providers
(Notes from CliftonLarsonAllen PowerPoint Presentations)

Define Your Organization’s Value Proposition
Aging Service Providers will need to demonstrate their value proposition, how they can help MCO lower total costs. You’ll want to share how your organization can/will:

- Reduce admissions...eliminate avoidable admissions/readmissions
- Improve patient-centered care/experience
- Improve care transitions
- Share/exchange health information
- Enhance prevention/wellness...eliminate potential preventable conditions (e.g., never events, health care acquired conditions)
- Manage chronic care
- Lower total cost of care through reduction/elimination of duplication, improved coordination
- Be a needed partner in the provision of quality, cost effective care

Aging Service Providers will want to Bend the Cost Curve to play in today’s managed care environment. It is important to remember that while one part of bending the cost curve is lowering per unit costs, the other part of the equation is changing how your organization delivers care so that higher cost services are reduced or eliminated (e.g., hospitalizations, readmissions). In other words, “think globally” about the total care needs of the individual, but “act locally” to improve the care.

- Provide cost efficient care
- Eliminate duplication
- Reduce/eliminate unnecessary care
  - Hospital readmissions
  - Health care acquired infections
  - Improve care transitions/care coordination
- Provide same service in lower cost setting
- Use best practices consistently
- Manage chronic conditions
- Reduce/eliminate medication errors, preventable conditions

Measurement Matters:
Tools to Track and Trend Data
- To become value-based providers, we must develop platforms for both capturing and trending outcome data
  - Surveillance tools to monitor readmission issues, identify high-risk patients and establish protocols for intervention
  - Effective surveys or consumer interfaces to gather real-time (or near-to-real-time) data about patient perception of care and quality
  - Systems that can measure and report actual patient improvement from admission to discharge: functional status improvement
**Readmissions**

Readmissions and “avoidable hospitalizations” are key measurements

- Tracking and avoiding acute readmissions/unplanned hospitalizations is an urgent strategy for all long term and post acute care (LTPAC) providers.
- MedPAC estimates that 28 - 40% of such admissions might be reduced through higher quality SNF care
- Readmission rates for 5 preventable conditions have been increasing
  - Electrolyte imbalance
  - Congestive heart failure
  - Respiratory infection
  - Urinary tract infection
  - Sepsis

A Readmission Surveillance Tool should be used daily

- Integrate as key component of patient care management protocol
- Should be used in evaluating any patient considered for hospital admission
- Ideally employed “in-situ” to capture most reliable and meaningful data
- May also require implementation of evidence-based tools for patient assessment and management – like Interact II

**Readmission Causes Vary**

- Readmission Issues in the SNF may have multiple root causes:
  - Nursing staffing levels, nurse skill set and turnover
  - Implementation of assessment and management protocols
  - Physician/APRN coverage and support
  - Affiliation with acute organizations
  - Geography
  - Time of day, day of the week
  - Hospital length of stay prior to discharge

**Strategies for addressing readmissions:**

- Avoid generics with narrow-therapeutic index medications
- Develop strategic plans of care for each patient diagnosis
- Use algorithm for nurses to ensure assessment and interventions are complete
- Require weekly family meetings and pre-admission family meeting with hospital case manager
- Employ liaison to serve as transition point of care between SNF and acute
- Require medical director on-site 4 days/week
  (Source: Case Management Monthly, January 2010)

**Resident Satisfaction**

Resident input is a critical measurement to track. Resident perceptions equate to reality for residents.

- If we listen (i.e., document) to resident concerns, we can learn a great deal – staff interaction, impressions of service, perceived outcomes.
- Satisfaction is not the same as quality of life.
- HOW you ask the questions matters.

- Utilize short-stay discharge surveys, rather than the annual satisfaction survey alone
  - Use a small tool – only 15-20 questions with simple rating scale (i.e., 1 to 5, excellent-good-poor)
• Simplicity is key for two reasons:
  o Ease of patient completion
  o Ease of data entry and management for staff
• Tool should be employed on the day of discharge as part of standard discharge practice

Functional Status Improvement
Measure improvements in functional status by looking at resident status at admission and again at discharge to “measure” what you have accomplished
• Variety of different measurement scales (i.e., Functional Independence Measurement scale primarily used within inpatient settings, but has been adapted for use by some rehab-intensive SNF organizations)
• Providers can develop their own measurements and benchmarks:
  o Patient’s need for assistance by number of ADLs
  o Patient’s capacity for mobility or self-ambulation – get out of bed, toileting, etc.
  o Patient’s ability to ambulate a certain distance
  o Patient’s ability to manage care
• Many proprietary organizations are already marketing to outcomes, preparing for VBP

Rate of Community Discharge
Measure/monitor the percentage of short-stay (Medicare) patient discharged to the community (home or community-based care setting)
• Monitor potential acute returns if SNF discharge is less than 30 days after acute discharge
• Also, monitor potential acute returns if SNF discharge is less than 90 days after acute discharge, given proposed Hospital Value Based Purchasing rules for FY2014
• Continued management of patients after discharge will play an important role
  o Home health/assisted living
  o Care transitions intervention or health coaching

Building Stronger Relationships
- Relationships are mandatory going forward, providers need to grow new relationships and not operate as an island in the future
• What is the role and function of business development in your organization?
• How well do you really KNOW your major referring organizations? Who really holds the relationships?
• Are there other providers with whom you can collaborate or partner?
• With whom are you willing to share risk?

Grow Clinical and Patient Management Skill
• Develop clinical pathways for common patient types, like CHF, COPD, pneumonia, stroke and other diagnoses
• Increase or evolve current physician strategies to support around-the-clock coverage
• Adopt evidence-based protocols, like INTERACT II, to better manage high acuity patients
• Evolve to or partner to provide post-discharge management: care transitions, health coaching or geriatric care management

Detailed understanding of operating costs and expenses will be essential for potential risk-sharing or gain-sharing relationships with ACOs, hospitals and MCOs.
LTC will be particularly challenged when it comes to individual costs of patient care

- Can your current financial system support expense management at the patient level?
- What are your costs for a typical hip replacement or a CHF patient?