



Facing the Final Frontier

Opportunities and Challenges of Managing
Long-Term Care for an Aging Population

by Howard Gleckman
The Urban Institute

A Passionate Voice for Compassionate Care

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ABSTRACT

States and the federal government are moving rapidly towards managed long-term supports and services (MLTSS)—a broad set of initiatives aimed at expanding managed health care to include personal assistance and other services for the frail elderly and younger people with disabilities. In many models, fee-for-service reimbursement would be replaced by capitated, risk-based arrangements where managed care organizations (MCOs) and their health and long-term care partners work together to control costs and improve outcomes through fully integrated care.

Currently, most MLTSS initiatives are focused on the Medicaid population, particularly those dually eligible for both Medicare and Medicaid. Fully integrated care has great, but largely unproved, potential.

The Catholic Health Association of the United States commissioned this paper to explore, for our eldercare members and others, the scope of current MLTSS initiatives, their potential impact on patients and providers, and the opportunities and challenges they present.

KEY TERMS

ACA: The 2010 Patient Protection and Affordable Care Act.

ACO: Accountable Care Organization, a formal risk-sharing arrangement among partner providers greatly expanded by the ACA.

FIDA: Fully Integrated Duals Advantage plan is New York State's effort to manage medical and long-term care for those receiving both Medicare and Medicaid benefits.

HMO: Health Maintenance Organization is a closed, staff-model managed care system.

LTSS: Long-term supports and services, also called long-term care.

MA: Medicare Advantage, also known as Medicare managed care or Medicare Part C.

MedPAC: The Medicare Payment Advisory Commission, which advises Congress on Medicare policy.

MCO: Managed Care Organization, which may be an insurance company or a health system.

MLTSS: Managed long-term supports and services.

PACE: Program of All-Inclusive Care for the Elderly—a capitated, fully integrated care system built around an adult day program and including home supports and medical care.

PPO: Preferred Provider Organization is a managed care system built on a network of independent providers.

SNP: Special Needs Plan is the generic label for many Medicare-based managed care programs. These include D-SNPs for people with disabilities, C-SNPs for people with chronic disease, and I-SNPs for people who need an institutional level of care.

BACKGROUND

Until recently, managed care was focused on medical care only. Staff-model health maintenance organizations (HMOs) have been a major care delivery model for the commercial market on much of the west coast of the U.S. for decades. More recently, states have moved aggressively to shift Medicaid medical care from fee-for-service to risk-based managed care, effectively turning over delivery of medical services for low-income adults and children to managed care organizations (MCOs). In 2011, 74 percent of Medicaid health care was delivered through managed care (Smith, 2013). States are taking this step in an effort to save money and improve quality.

Similarly, Medicare managed care, known as Medicare Advantage or Medicare Part C, has also grown significantly. In 2012, more than 12.6 million people were covered by MA managed care plans, more than double the enrollment in 2004. (Kaiser Family Foundation, 2013). This represented about one-quarter of all Medicare enrollees. About 10 percent of Medicare beneficiaries received care through Accountable Care Organizations.

However, while long-term supports and services—such as home health, transportation, and nutrition—are often a key element of care for those with chronic conditions—this assistance has been largely excluded from this model. A few integrated programs do include supports and services, including the Program of All-Inclusive Care for the Elderly (PACE) and certain Medicare Special Needs Plans (SNPs). But their reach has been extremely modest. For instance, while in 2012 there were 88 PACE programs in 29 states, enrollment was only about 25,000 nationwide (National PACE Association). Enrollment remains relatively low for several reasons, including the requirement that participants use only PACE physicians and what states have perceived as the program's high cost.

In recent years, policymakers have begun to expand managed care to include long-term supports and services for the frail elderly and younger people with disabilities¹. These are being developed through state initiatives under Medicaid waiver programs and provisions of the 2010 Patient Protection and Affordable Care Act (ACA). Many are designed as demonstrations targeting those who receive both Medicare and Medicaid benefits (known as dual eligibles).

As of 2012, about 400,000 people were receiving long-term supports and services through managed care programs (Paul Saucier J. K., 2012). This was four times the number in 2004, but still only a small fraction of potential enrollees.

In this period of disruptive change to the health and LTSS delivery systems, it is important to distinguish among several quite different managed care models. Some focus on care coordination

¹ This paper focuses on care for older adults only. However, many managed LTSS or fully integrated programs also cover the 39 percent of dual eligibles who are under 65 and whose care needs are often quite different from elders. For instance, almost three-quarters of those younger duals have developmental disabilities or mental illness.

only, such as transitional care or case management services. Others manage medical and post-acute care but not long-term services and supports. See page 14 for descriptions of the most common models.

Still others provide for management of long-term supports and services but have yet to fully integrate medical care and LTSS into a single model. Florida, for example, is shifting all of its Medicaid long-term care enrollees into risk-based managed care. However, even though nearly all expected enrollees are dual eligibles, Florida will not include medical care in this model, at least as currently designed (see case study).

Finally, some states are attempting to combine both health care and long-term supports and services into a single, fully integrated system. For example, as of Nov. 15, New York was taking bids from MCOs to operate its Fully Integrated Duals Advantage (FIDA) program beginning in 2014. ArchCare, the health system of the archdiocese of New York, is one of the organizations aiming to participate in this project as an MCO (see case study).

This paper will focus on the latter two designs--managed supports and services and fully integrated health and LTSS.

Nationally, these models include:

- Medicaid Managed Long-Term Services and Supports (MLTSS)
- State Demonstrations to Integrate Care for Dual Eligible Individuals
- Other Medicare-Medicaid Coordination Initiatives such as PACE
- Medicaid State Plan Amendments under §1915(i)
- Community First Choice

As of September, 2013, 21 states were developing MLTSS programs and 26 states applied for dual eligible demonstration grants, though five have subsequently withdrawn their applications.

Seventeen are creating managed care programs under their 1915(i) state plans, and 10 through the Community First Choice program. Note that several states have applied to create managed care programs through multiple initiatives. Some are operational. Many of the most ambitious are scheduled to begin in 2014 (State Medicaid Integration Tracker- Sept. 2013, 2013).

There is, however, great variation among the states, both in ambition and level of progress. While states such as New York and Florida are moving aggressively, others, such as Maine and Maryland, have not yet opted to shift older adults to managed care.

The duals demonstration program has faced particular challenges. CMS has approved state initiatives in California, Illinois, Massachusetts, New York, Ohio, Virginia, and Washington State. However, Arizona, Hawaii, Minnesota, New Mexico, and Oregon have withdrawn applications for this program (State Medicaid Integration Tracker- Sept. 2013, 2013). California has delayed for at least

a year its plan to provide fully managed medical and long-term care for 500,000 dual eligible residents.

On May 30, Robin Callahan, the deputy Medicaid director for policy and programs in Massachusetts, told a group of state Medicaid officials that this demonstration was one of the most challenging she's seen in 20 years. Among the difficulties: balancing payment rates to providers while ensuring adequate benefits, and anticipating the needs of patients who have rarely received fully managed care (Adams, 2013).

THE MANAGED CARE MODEL

The scope of change cannot be overestimated. Many initiatives aim to replace the current fee-for-service system with a new model that includes two key components: a fixed payment design, based on either episodes of care or the full spectrum of ongoing care, and payment provisions that put MCOs and service providers at financial risk for both cost and quality.

In the fully managed care model, MCOs and their care networks would provide all medical treatment and long-term supports and services. This may include help with Activities of Daily Living (ADLs) such as bathing and dressing, Instrumental Activities of Daily Living (IADLs) such as transportation and nutrition, and significant care management. Individual case management decisions would be made by the MCOs with varying levels of consultation by providers, no longer by the state.

This is vastly different from the traditional financing model. In the current system, Medicaid payments are often insufficient but predictable. Medicare payments are more generous, though recently somewhat less predictable. Some analysts, such as Congress' Medicare Payment Advisory Commission (MedPAC), have concluded that Medicare payments for nursing homes, hospice, and home health are excessively generous (Medicare Payment Advisory Commission, 2013) while a study funded by the American Health Care Association estimates that costs exceed Medicaid payment rates for nursing homes (Eljay Inc., 2012).

The system is heavily rules-based and often top-heavy—frequently placing compliance with process standards ahead of patient-centeredness and even health outcomes. Yet, providers learned to live with the system. Organizations that provide both long-term and post-acute care maintain a viable business model only because of the cross-subsidy between Medicare and Medicaid.

In the new design, all partners in an MCO are at risk for costs in excess of the fixed payment rate but have the opportunity to increase margin when they deliver care for less than the capitated rate. MCOs may be insurance companies, integrated health systems, or Accountable Care Organizations. They may also be looser organizations operating with unaffiliated partners through bundled payment arrangements.

Typically, an MCO will build a network of providers, including senior service providers, and will negotiate payment arrangements with each. Because the MCO is at financial risk for cost and quality, it will almost certainly impose such standards on its downstream partners. Thus, the hallmark of these financial arrangements is likely to be some form of pay for performance.

For their part, consumers face three major risks: interruption of existing services during a transition to managed care, loss of access to current providers, and future reduction of services as managed care contractors seek to hold down costs (Paul Saucier, 2013).

A key design issue is whether Medicaid recipients are automatically enrolled in a plan (known as passive or mandatory enrollment) or whether they can select among plans or even choose to remain in fee-for-service.

For their part, providers must confront a significant change in the managed care business model.

Until recently, managed care came in two forms—staff-model HMOs such as Kaiser Permanente or structures such as the Preferred Provider Organizations (PPOs) offered by most commercial insurance.

Most non-HMOs built the widest possible networks to attract and maintain enrollees. However, payment constraints and growing demand for high quality care is rapidly changing this model. Today, many insurers have embraced a strategy of “narrow networks.”

In this model, MCOs partner only with providers that deliver the best value—that is to say, high quality combined with low cost. MCOs are betting that consumers will accept limited choices (even if they must change doctors or hospitals) in exchange for lower premiums and other out-of-pocket costs—as long as those providers are highly rated. The model anticipates growing transparency that will make it easy for consumers to easily access quality information on in-network providers.

These narrow networks are appearing in health insurance offered through the ACA’s health exchanges. The same model is playing out in Medicaid, where states are similarly demanding value for their dollar from MCOs that provide medical care to low-income households.

Narrow networks are likely to proliferate as managed care integrates medical care with LTSS. In these models, MCOs will include only those nursing homes, assisted living facilities, and home health agencies that deliver value.

THE CASE FOR MANAGED CARE

Managing care for older people has great potential. This population has high rates of chronic conditions and often some level of cognitive impairment. Two-thirds of seniors with three or more chronic conditions visit at least 10 doctors per year. More than half of those admitted to the hospital take at least seven prescription drugs. Of those taking five medications or more, half take them

incorrectly (Gleckman, 2009). Ideally, this population should have access to a delivery model that fully integrates medical care, personal assistance, and other supports and services.

Achieving such a level of integrated care is especially difficult in the traditional fee-for-service environment. This payment system encourages individual providers to maximize diagnostics and treatments and provides no compensation for organizing care.

These challenges are greater for dual eligibles. Among people 65 and older, one-quarter of those fully eligible for both Medicare and Medicaid benefits (full duals) have been diagnosed with three or more chronic conditions compared to 10 percent of the non-dual Medicare population. Fifty-four percent require long-term supports and services.

In 2009, average per capita spending for the 7.1 million full duals exceeded \$33,000—divided almost equally between Medicare and Medicaid. Total per capita spending for all other Medicare beneficiaries averaged just \$8,300—or one quarter as much (Congressional Budget Office, 2013).

A growing body of research finds that well designed coordinated medical care for older patients with chronic conditions can improve outcomes and perhaps reduce costs—although evidence of cost savings remains weak. Unfortunately, most research tends to concentrate on medical care only, rather than on fully integrated health and long-term care models (which are too new to be assessed).

A 2013 review of academic research on the cost and quality effects of integrated medical delivery concludes that such models do improve quality of care. Most studies surveyed found that integrated care reduces the level of service utilization, and thus may lower cost of care. However, there is wide variation in these results, with declines in utilization often dependent on the exact model of care, the nature of the targeted population, and even geographic location within the same model (Wenke Wang, 2013).

Still, those medical designs do provide some clues to the potential benefits of well-integrated care.

One example is the Care Transitions Model developed by Dr. Eric Coleman, a series of relatively modest steps aimed at better managing care for patients over 65 following hospital discharge. This design includes a patient-centered medical record, follow-up physician visits, and assistance from advanced-practice nurse transition coaches. In a randomized controlled trial, it was found to reduce hospitalizations and rehospitalizations, and to shrink mean hospitalization costs at 180 days from \$2,546 to \$2,058 (Coleman EA, 2006).

Another example is the Geisinger Health System—an open managed care system that serves both 330,000 plan members as well as non-members in central and northeastern Pennsylvania. By fully integrating health services, it appears to have improved outcomes and reduce costs, as least for some conditions.

For instance, monthly claims for participants in Geisinger's diabetes disease management program averaged \$394.62, compared with \$502.48 for non-participants. Hospital admission and lengths of stay declined. Participants had more primary care physician visits but fewer costly trips to the emergency room (Sidorov & Robert Shull, 2002).

The question is whether the lessons of coordinated medical care can be translated to fully integrated health and long-term care. Interestingly, despite Geisinger's deep experience in managed medical care, it is not yet participating in any demonstration programs for dual eligibles.

MANAGED LTSS: THE EVIDENCE SO FAR

Because most MLTSS is so new, there are limited data to support its efficacy. However, there appear to be significant opportunities to address inefficiencies in the existing model, which suffers from two severe design flaws.

The first is fee-for-service itself, in which providers are paid by volume rather than quality outcomes. The perverse incentives of this system drive patients to the highest-cost providers--such as hospital care rather than skilled nursing, or physicians rather than physician assistants--even where there is no difference in quality.

The second flaw is that nearly all dual eligibles receive care through two largely disconnected payment streams. Medicaid, funded by both the states and the federal government, pays for supports and services but not medical care. Medicare, funded entirely by the federal government, pays for medical costs but not long-term supports and services.

One perverse outcome of this bifurcated payment system: States must share the cost of enhancing Medicaid services and supports. However, to the degree these delivery reforms reduce hospitalizations and other medical costs, savings are credited only to Medicare, with no financial benefit to the states. Thus, they have little financial incentive to expand Medicaid-funded personal care to reduce costs of Medicare-funded health care.

Because the existing system is so inefficient, it opens the door to reforms that may save money with equal or better outcomes. Whether the new delivery models can achieve that, however, is uncertain.

Until now, there have been only a few exceptions to the traditional model. The best known may be PACE. Jointly funded by Medicare and Medicaid, it combines medical care, adult day services, and in-home supports and services for dual eligibles aged 55 and older with extensive care needs.

Outcomes are quite positive. One study (partially funded by PACE) finds that preventable hospitalization rates among PACE participants are half that of other dual eligibles living at home and about 40 percent that of nursing home residents. Thirty-day all-cause readmissions are about 19 percent for PACE compared to 23 percent for dual eligibles aged 65+ and hospital stays are shorter (H. Temkin-Greener, 2012).

By keeping people out of hospitals and nursing homes, PACE was also found to be associated with improvements in quality of life (White, 2000).

However, cost savings are uncertain. Some studies have shown that while PACE can reduce Medicare costs by avoiding hospitalizations, it may increase Medicaid costs. Estimates of the net cost of PACE are highly variable and most research is based on data that are now quite old--often from the late 1990s and early 2000s. Studies that compare PACE participants to nursing home residents find that PACE may reduce Medicaid costs (Darryl Wieland, 2013), while those that measure PACE against non-PACE participants receiving home-based care find it may increase costs (Leslie Foster, 2007).

Special Needs Plans are another integrated model. SNPs are a form of Medicare Advantage Plan available for people with significant care needs. They include plans for dual eligibles (D-SNPs), for those who require an institutional level of care (I-SNPs), and for those with severe chronic conditions (C-SNPs).

Studies have found a wide variation in level of services and quality of care provided by these managed care programs. Some achieve very little improvement in cost or quality and others show notable benefits relative to non-SNP participants (Medicare Payment Advisory Commission, 2013).

In general, I-SNPs appear to do a better job of integrating care and reducing hospital admissions and perform well on other quality measures. C-SNPs tend to perform relatively poorly, according to a survey of current research by the Medicare Payment Advisory Commission (MedPAC) (Scott Harrison, 2013).

International integrated care models provide additional evidence of the potential and limitations of fully managed care.

Beginning in 2009, the consulting firms RAND Corporation and Ernst & Young engaged in a careful analysis of 16 integrated care pilot programs in the United Kingdom. Many included medical care, case management, and long-term supports and services, and several were aimed specifically at a geriatric population². The joint study, done for the UK Department of Health, reached five major conclusions, all somewhat ambiguous (RAND Europe, Ernst & Young LLP, 2012). It found these integrated care pilots:

- Led to increased use of care plans and better use of care staff.
- Reduced planned hospital admissions and outpatient care but not emergency room visits.

² Two pilots focused on care for dementia patients, one targeted end-of-life care, one provided care for people at high risk of falls, and five were aimed at populations at high risk for readmission. One, in the community of Durham Dales, specifically included care initiatives for older people, such as improved transportation, access to mental health care, and community-based medical care.

- Can improve the quality of care “if well led and managed” but “improvements are not likely to be evident in the short term.”
- Did not save money in the short run, although case management may lead to a reduction in certain medical costs.
- Did not improve patient attitudes about their care.

Of course, this study was based on the medical care model of the UK’s National Health System, thus its results may not be applicable to the US.

THE RISKS OF MANAGED CARE

Despite the potential benefits of care coordination, transitioning from today’s fee-for-service model carries with it risks and challenges for the managed care entities themselves, consumers, and providers.

MCOs will take full financial risk for patient care. Because managing both health care and long-term supports and services is complicated and relatively untested, they must be very careful in negotiating reimbursement rates with payers as well as payments to their various partners. Some may negotiate very aggressively with Medicare and Medicaid, thus winning business but risking unsustainably low returns. This may be especially true in a fully capitated system.

Of course, lower margins to the MCOs may result in lower-than-expected payments to their network providers.

Concerns are more than financial. Mission-based providers and patient advocates also worry about what integrated systems will mean for the quality of care. For instance, will MCOs at full risk for a patient’s costs skimp on services? This may be a particular concern for extremely high-cost patients who are nearing the end of life.

Another critical challenge will be delivering community care for indigent people who have no families and few informal supports. In the current fee-for-service system these people would likely be living in a nursing home. Most managed care models will include strong incentives to deliver care to this population at home with the help of professional case managers. However, it is not certain whether it will be possible to develop appropriate systems of care, given the likely financial constraints of the managed care systems and the difficulties of caring for this population.

In theory, enhanced quality measures are aimed at mitigating against these risks. The dual demonstrations, for instance, include provisions to withhold payment for managed care entities that fall short of quality standards. MCOs participating in New York’s managed care demonstration will be subject to gradually increasing financial penalties if they do not meet 69 quality benchmarks. These include falls prevention, reductions in hospital readmissions, and improvement in activities of daily living.

However, many metrics measure process, not outcomes. And few are truly patient-centered, focused more on easily quantifiable measures, such as falls, rather than on harder-to-measure quality of life. These standard benchmarks, combined with an ingrained focus of many MCOs on health care, leaves many providers and policy analysts worried that managed care partnerships will “medicalize” social supports and services.

MANAGED CARE BEYOND MEDICAID

So far, most efforts to coordinate both medical care and long-term supports and services through full-risk managed care have focused on the Medicaid population. However, a number of MCOs have begun exploring whether it is feasible to expand this model to the broader Medicare population through Medicare Advantage-type plans.

For now, these models remain on the drawing board. Premiums would likely be higher for such MA plans, and insurance plan marketing executives doubt consumers would be willing to pay for such an added benefit. The negative consumer response to the loss of low-quality, low-premium individual market health insurance policies under the ACA suggests this concern is legitimate.

One potential solution would be to make supports and services a basic benefit in all MA plans. However, there is no current effort to take that step. Thus while insurers are exploring ways to incorporate supports and services into MA plans, it may be some time before they offer this combined coverage.

THE ROLE OF CHA’S SENIOR SERVICE PROVIDERS

CHA member senior service providers face enormous financial and delivery challenges in any new managed care environment. However, the shift to an integrated, capitated payment model also opens major new pathways for organizations that deliver high value and can be nimble in a difficult payment environment.

How can CHA senior service providers navigate this new environment?

First, they should become aware of upcoming state initiatives and become engaged in the initial design of managed Medicaid LTSS.

Second, once programs are operating, they must decide what role they will play in this new delivery system.

Some may act as MCOs themselves, organizing care provided by others. This requires scale, access to a provider network, and experience managing both care for complex enrollees and business relationships with other providers. It is an ambitious undertaking but not beyond the capability of some CHA members. For example, ArchCare is attempting to win New York designation as an MCO (see case study #2).

There appears to be room for non-profits to compete. In 2012, four national for-profit MCOs dominated the market for managed LTSS. However, private not-for-profits played a significant role, with about one-third of market share (Paul Saucier J. K., 2012). This suggests there are potential opportunities for mission-based systems.

Other systems may fill a key niche by providing exclusive case management services for an MCO. The Miami Jewish Health System, for instance, is leveraging expertise developed through PACE and other home- and community-based programs to serve this role for one MCO in its region (see case study #1).

Many CHA members, however, will likely serve as downstream providers operating under contract to MCOs. This may be a more comfortable role for many smaller organizations, but it brings its own challenges.

These providers may benefit by sharing resources such as electronic medical records with larger health systems. In addition, building a close managed care relationship may drive substantial referral business for both post-acute and long-stay patients.

As networks narrow, MCOs will eventually deliver volume to their remaining contract providers. But overall enrollment in managed care may build slowly, thus limiting opportunities to increase volume at first. Regardless, providers are likely to face intense pressure from MCOs to accept lower payment even as they must meet tougher quality standards.

Some refer to this as the Walmart phenomenon, where suppliers face ongoing pressure to reduce cost and maintain quality as the price of preserving their supplier relationship. David Pollack, president of Molina Healthcare of Florida, has this message for downstream providers: “You have to be able to provide quality in an efficient manner. Rates will be adequate to earn margin but you have to provide quality services at an appropriate price. If you [can’t], you are going to have a tough time (Pollack, 2013).”

Thus, a major business challenge for providers will be to strike the right balance between compensation and network participation.

However, CHA members will not be without leverage. They often have a powerful local brand where a national managed care company may not. This relationship with seniors and their families can be a powerful point of negotiation.

Many Catholic providers also have experience delivering care across the senior service continuum. Few MCOs have this expertise since their business model has, until now, focused primarily on medical care. Case management may be at a particular premium.

Long-stay nursing homes may face the biggest challenges in this new environment since a relentless drive for cost-saving is likely to push more services to home or assisted-living settings. For instance,

Florida's managed Medicaid LTSS program includes strong financial incentives to care for participants in the community rather than in nursing homes. Increasingly, nursing facilities may be providing post-acute skilled nursing, rather custodial care for long-stay residents.

Quality will be another key area for negotiation between downstream providers and MCOs. For instance, will providers have the flexibility to maintain successful quality initiatives of their own or will they be required to adapt to top-down models that MCOs bring to the relationship?

How will financial risk for quality shortcomings be allocated? For instance, if a patient is discharged from a hospital to a nursing home and then readmitted to the hospital, which entity will be responsible? Similarly, if readmissions are reduced, how will cost savings be shared?

CHA members should be aware of the competitive environment they are facing as they make these choices. For example, the national for-profit system Kindred Healthcare is repositioning itself to compete in the managed care setting by focusing on 21 markets where it operates a fully integrated continuum of services—except for acute-care hospitals. It is doing so, in part, by abandoning more than 7,000 nursing home beds in markets where it does not have critical mass. Its goal: Position itself to partner with Accountable Care Organizations in those markets where it is positioned to deliver managed care.

CONCLUSION

In an ideal world, care for people with chronic conditions would be fully seamless and integrated. Medical treatment would be accessible when appropriate. Similarly, supports and services would be provided when needed. Distinctions based on payer (Medicare-funded hospital care vs. Medicaid-supported home health, for instance) would be broken down so patients would receive the right care at the right time.

In this world, process-based rules would be unnecessary. Payment would be based on bottom-line value—the most appropriate and cost-effective care as defined primarily by the patient and her family.

Fully integrating care for frail elders with multiple chronic conditions, as well as younger people with disabilities, carries with it the potential for achieving these goals. But, at least today, it does so with significant uncertainty and some risk to patients and providers.

Notwithstanding those challenges, the drive towards managed LTSS in its various forms is accelerating. As CHA members decide how they will participate in such systems, they must consider the interconnected variables of cost, quality, and control. They will have to do so at a time of uncertain rules and unpredictable payment rates. But these changes are too important to ignore.

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WHAT ARE THE MANAGED CARE MODELS?

States participate in several managed care initiatives for the frail elderly and younger people with disabilities. Most operate through Medicaid and may involve either Medicaid-only enrollees or people who are dually eligible for both Medicaid and Medicare. These programs include:

Medicaid Managed Long-Term Supports and Services (MLTSS): A broad variety of arrangements where state Medicaid programs contract with private managed care organizations (MCOs). In return for a fixed per-patient payment, known as a capitated rate, each MCO is fully responsible for all long-term supports and services for its enrollees. Some MLTSS programs provide long-term care only, others fully integrate with medical care through the same MCO, and still others include less formal links to separate medical managed care.

State Demonstrations to Integrate Care for Dual Eligible Individuals: These models, known by the shorthand “duals demos,” aim to fully coordinate Medicaid-funded long-term supports and services with Medicare-funded medical care. Some are designed as capitated systems, while others would operate under a modified fee-for-service model. These demonstration programs are funded in part by grants from the Medicare-Medicaid Coordination Office at the federal Center for Medicare and Medicaid Services (CMS).

PACE: The Program of All-inclusive Care for the Elderly is a fully integrated health and social service system for people 55 and older jointly funded by Medicare and Medicaid. The program began in San Francisco in the 1970s and has since expanded to 29 states. PACE is a capitated system.

Medicaid Sec. 1915(i) State Plan Amendments: These allow states to provide medical care, such as skilled nursing, as well as long-term care for Medicaid beneficiaries living at home under the Home and Community-Based (HCBS) waiver program. In general Medicaid pays only for supports and services for people living in a nursing home. However, under various HCBS waiver programs, states may provide care for the elderly and people with disabilities who live in the community. Amending its Medicaid plan through Sec. 1915(i) of the Social Security Act is one of several ways a state can begin to integrate medical care with LTSS.

Community First Choice: This ACA-created program gives states more flexibility, as well as an additional federal Medicaid payment to encourage them to provide services aimed at helping people with disabilities to live at home. Most people eligible for home attendant and other benefits under Community First Choice would otherwise be living in nursing homes. While Community First Choice does not require integrated care, states may use it as part of a more coordinated system of home-based services.

CASE STUDY #1

BON SECOURS ST. PETERSBURG AND MIAMI JEWISH HEALTH SYSTEM PREPARE FOR FLORIDA'S MANAGED LTSS PROGRAM

In August, Florida began to shift the long-term care of all its Medicaid-eligible seniors to private managed care. The transition, which is expected to be completed in the spring of 2014, will profoundly affect both payment and delivery of care by senior service providers.

The state has contracted with a limited number of managed care organizations (MCOs) to provide Medicaid services only. Unlike New York (see case study), Florida is not yet integrating Medicare-funded medical services into this program. While some Florida dual eligibles are enrolled in Medicare Advantage plans, even they will not be coordinated with Medicaid managed care.

For Medicaid LTSS services, the state will pay each MCO a fixed, capitated rate. For instance, in the Miami area, MCOs will receive \$1,361 per member, per month for enrollees living in the community and \$5,210 for each nursing home resident. The nursing home payment covers all Medicaid services but not Medicare post-acute care or rehabilitation. MCOs will have broad flexibility to provide needed services and supports for people living in the community, including transportation, meals, and even home modifications, as well as case management.

Approved MCOs are authorized to market in each of 11 regions. Each is responsible for building a care network, for authorizing services, for utilization review, and for monitoring of both services and providers. They are at risk for costs that exceed the capitated rate. In addition, they will face a penalty of up to two percent for failing to meet state quality metrics, which are still being developed by the state in consultation with MCOs.

MCOs, in turn, contract with individual providers for service delivery, including nursing and assisted living care, home care, and case management. Those providers will be at partial financial risk in the first year of the program but fully at risk in subsequent years. They will also have the opportunity to share from cost savings.

The Florida model bases the state's payment on a member's care setting at the beginning of the plan year. Thus, an MCO would receive a substantial financial benefit for moving a resident from a nursing home to lower-cost assisted living or home care. Similarly, it would incur a significant financial penalty for moving a member into a higher-cost setting. The decision about appropriate settings is in the hands of the MCOs, based on advice of their case managers. Participants do have the right to appeal these decisions.

Two mission-based providers are taking aggressive steps to adapt to this new system. They see both challenges and opportunities. They see risks to seniors along with the potential to better organize their care and improve their health.

The Bon Secours St. Petersburg Health System (BSSP) operates the full continuum of senior services. BSSP has contracted with all of the MCOs in the St. Petersburg region to provide nursing home and home health care, as have many of its competitors. Initially, managed care networks will be wide open and Medicaid nursing home payment rates will be protected.

Even these rates are difficult to manage. BSSP receives an average daily rate of \$219 for a Medicaid bed—about \$40 less than it costs to care for a resident. While the MCOs will be required to continue to reimburse at that rate for the first year, BSSP expects payments to decline in a managed care environment.

In coming years, the MCOs are likely to narrow their networks by contracting only with providers who accept lower rates and maintain high quality standards. However, as networks narrow, participating providers can expect to receive more referrals from partner MCOs. But volume does not help if margins are negative. Thus, BSSP will have to develop more efficient delivery systems to share in the potential cost savings achieved by the MCO.

This model is familiar to BSSP. In recent years, it has engaged in managed care through its Medicare-funded skilled nursing services for post-acute care and rehabilitation. It also provides skilled nursing services for a local PACE program (funded jointly by Medicare and Medicaid) and partners with Evercare, a for-profit integrated care model for skilled nursing facilities.

It is also developing a new “post-acute alliance” with local hospitals and physicians. In this bundled payment model, BSSP would serve as the skilled nursing and home health provider of choice for its partners.

However, all these relationships (except for PACE) are built on managed medical care. As BSSP celebrates its 50th anniversary, CEO Karen Reich is looking to adapt lessons from these Medicare models to managed Medicaid LTSS. “We are looking into the future with a broader range of options—different ways of positioning ourselves as a service provider (Reich, 2013).”

A key issue for Bon Secours and other mission-based providers will be finding ways to deliver appropriate levels of care for participants who would have been living in a nursing home under the old fee-for-service model but now are likely to be residing in the community. This may be a particular challenge for indigent seniors who have no family and few informal community supports but who will be receiving care under the steep cost constraints of the Florida system.

In Miami, another faith-based senior service provider is developing its own strategy for the managed care environment.

Miami Jewish Health Systems serves seniors and others in Miami-Dade and Broward counties. Like BSSP, Miami Jewish provides a full continuum of post-acute care as well as long-term services. Operations include a 462-bed nursing facility, home health, and assisted and independent living. They also include an ambulatory clinic, a PACE program, and, importantly, extensive Medicaid case

management. Two-thirds of its nursing home patients and 90 percent of its home care patients are not Jewish.

Initially, Miami Jewish considered bidding as an MCO. Then it partnered with a managed care company in joint bid, but the proposal was not accepted by the state.

As a result, Miami Jewish will serve as a downstream provider to each of the seven MCOs in its region. However, it is specifically leveraging its Medicaid case management expertise to develop a different relationship with one MCO, Molina Healthcare of Florida. Molina's parent, Molina Healthcare Inc., is a for-profit MCO with 1.9 million members nationwide.

Rather than simply providing home health or nursing home care, Miami Jewish will provide all case management for Molina enrollees in its region, whether they are using other Miami Jewish services or not.

Cliff Bauer, senior vice president for operations at Miami Jewish, believes the relationship can help both organizations. Miami Jewish brings a respected local brand and a built-in patient population, as well as its case management experience.

"It works for both sides," agrees David Pollack, president of Molina Healthcare of Florida. "We bring national experience and managed care discipline. Miami Jewish has been doing case management for 12 years, and we both have a mission to work with low income and financially vulnerable populations (Pollack, President, Molina Healthcare Florida, 2013)."

The key, Bauer says, will be getting people to the right care, in the right place—and being willing to accept a risk-based environment. "We've got to manage the risk that's associated with providing those services and that is a challenge," Bauer says. "But we strongly believe that's the future of reimbursement (Bauer, 2013)."

Karen Reich, Cliff Bauer, and David Pollack all see Florida's Medicaid managed LTSS initiative as an interim step. Soon, they expect, dual eligibles will receive fully integrated medical and LTSS care. Breaking down that last wall may be the way providers can realize true cost savings and patients can receive really well-managed care.

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CASE STUDY #2

ARCHCARE AND NEW YORK'S MEDICAID MANAGED CARE INITIATIVE

ArchCare, the health system of the Archdiocese of New York, is in the midst of a remarkable transformation. It is evolving from a provider of medical and social care to something quite different—a managed care organization (MCO) that not only delivers services but also coordinates care provided by others.

For decades, ArchCare has operated skilled nursing facilities and long-stay residential homes for underserved populations with complex social and medical needs in the New York City area. While it is not abandoning that role, it is taking on a new one-- built around the still-controversial idea of fully integrating medical care with long-term supports and services.

Today, ArchCare provides managed care services for about 3,300 New Yorkers through three managed care models that serve Medicare and Medicaid beneficiaries. Now it is applying to become an MCO. As such, it would participate in an ambitious New York State demonstration program aimed at eventually enrolling all Medicaid beneficiaries into a fully integrated medical and long-term care system. New York plans to begin delivering care through this model next summer.

Eva Eng, ArchCare's senior vice president for program standards and development, says providing coordinated care for these populations "is the right thing to do." But, she adds, "The pace of change is intense" (Eng, Senior Vice President for program Standards and Development, Archcare, 2013).

New York is one of several states looking to shift its senior Medicaid population from a fee-for-service model to full risk-based managed care. Under a three-year demonstration program, called Fully Integrated Duals Advantage (FIDA), participating MCOs would integrate all medical and social care for their dual eligible members.

MCOs would be paid a fixed monthly amount per participant (a capitated rate) to provide full medical care and supports and services. They'd take financial risk if costs exceed the payment but also enjoy financial benefits if they keep costs low. They also will be subject to financial penalties for failing to achieve more than 60 quality measures. These include falls prevention, reductions in hospital readmissions, and improvement in activities of daily living.

As an MCO, ArchCare would provide case management but deliver only a relatively small share of actual care. The rest would come from partner providers, such as doctors, hospitals, nursing homes, or home care agencies. MCOs will have the flexibility to provide a broad range of services and supports including transportation, meals programs, and home modifications.

As of late November, 2013, two dozen MCOs were seeking state approval to compete for business, including local non-profits such as ArchCare as well as national for-profit insurance companies. Of

those applicants, New York will authorize perhaps 10 to enroll about 170,000 people through the demonstration.

ArchCare's goal is to enroll up to 5,000 participants over the next few years. As a mission-based system, it comes into this effort with some important advantages but also with some significant handicaps.

One drawback is its relatively small size and limited geographical reach. It does not have the same financial resources to absorb start-up losses as a large insurer. And, unlike those competitors, ArchCare does not have a ready-made provider network. It has addressed that issue by leasing the network of the managed care company EmblemHealth.

However, ArchCare starts with two major advantages. It has a highly respected brand in New York City and, crucially, has substantial experience in managing care of the frail elderly and younger people with disabilities. This is in sharp contrast to many MCOs that may have experience managing medical care but little history integrating health with social supports and services.

ArchCare's first managed care initiative came through its PACE program. It currently operates two centers—one in the Bronx and one in Harlem—and is about to open a third on Staten Island.

Its PACE programs provide fully integrated medical and social services for 300 dual eligibles, built around an adult day program. The Harlem facility provides a full suite of medical and social services for a diverse population of seniors.

Enrollees all live at home, but participate in day programs and receive a broad range of medical and social services including transportation, occupational and physical therapy, and case management. The Harlem center, for instance, includes an on-site medical staff of two registered nurses, a nurse practitioner, and a primary care doctor that provides a full range of out-patient services. The program partners with several local hospitals for in-patient care.

New York pays ArchCare about \$7,000 per month for each participant to provide all medical and social services. While that seems expensive, it is less costly than housing participants in a long-stay nursing facility. New York Medicaid pays almost \$7,500 per month for such a nursing home stay, while Medicare pays additional medical costs.

ArchCare also provides full medical and social services for about 1,400 people in its Medicare Institutional Special Needs Plan (I-SNP). All are nursing home eligible though some live at home. In addition, it provides care for an additional 1,600 in a separate New York managed long-term care demonstration for which it is paid a partially capitated rate.

ArchCare is already using extensive case management for its PACE and SNP patients. For example, it uses computerized patient data to identify which enrollees are most at risk for hospitalizations or acute episodes so it can intervene early. It has also built an extensive medication management system

that has already reduced costs by \$100 per patient per month. ArchCare believes this case management experience makes it well positioned to step into the FIDA program as an MCO.

Like others closely watching the move to managed care, senior ArchCare staff also expect to see managed care networks narrowing to include only downstream providers that provide high-quality, cost-effective care. Those that cannot will be squeezed out.

The environment will be challenging, but ArchCare believes it can thrive. It will try to do so by getting ahead of the drive to managed care. For ArchCare President and CEO Scott La Rue, becoming a fully integrated health plan--and not just a service provider--is critical to the system's future. "That's the direction things are going to go," he says. "It is the final frontier in long-term care" (La Rue, 2013).

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A Passionate Voice for Compassionate Care

Washington, DC Office

1875 Eye Street NW, Ste. 1000
Washington, DC 20006
202.296.3993 *phone*
202.296.3997 *fax*

St. Louis Office

4455 Woodson Road
St. Louis, Missouri 63134
314.427.2500 *phone*
314.427.0029 *fax*

www.chausa.org