

Medicaid Managed Care Programs in LTC

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Why do we need Managed Care?

- Medicaid was: A program to pay for the health care needs of the elderly and disabled who could not pay for it themselves.
- Medicaid is now:
 1. Health care program for healthy children
 2. A program that pays for health care **related** assistance
 3. A state program whose growth is sometimes a result from a desire to increase federal funds.
 4. The growth in Medicaid in the last 20 years is NOT a growth in provider reimbursement...but a growth in covered programs and growth in participants.

Medicaid LTC Managed Care?

- Managed Care- In H260 the legislature described Managed Care- as a program that will:
 1. Improve care, and
 2. cut costs,
- MCO's speak of increasing **choice**. An increase in choice not likely and states have not demonstrated savings from LTC Medicaid managed care.
- Quality improvement is possible through greater coordination. **Cause and effect?** Quality care often leads to lower cost. However, lower costs does not mean higher quality.

Access to Care is Critical

- A managed care system should provide access to all services which are currently available –
- However, the system should be able to respond when **patients choose** a setting that is:
 1. more costly than necessary, or
 2. not prepared to provide quality care to high acuity patients
- The managed care system must be able to **measure** a providers effectiveness – both in term of cost and quality outcomes.

Health Care Reform

- The Massive health care reform law was designed to help cut costs to both Medicaid and Medicare. Created Accountable Care Organizations (ACOs)
- An ACO is a little bit like a **unicorn**...We have all heard about them...and their seemingly magical powers, but no one has ever seen one.
- A lot of unanswered questions as to the effectiveness of MCO's specifically and health care reform in general.
- It is clear however that CMS is moving forward with innovation and care management in an effort to seek to improve care and lower costs.
- **This ship is not turning around.**

Lessons from Arizona

- Arizona implemented its Medicaid Managed Care program in 1982. It did not expand to LTC until 1989
- Price is negotiated in AZ, but managed care saves most of their money by directing patients to lower cost settings.
- Cost reports are now used again in AZ. Helps with price negotiations and facilitates provider assessment
- Managed Care working in AZ?
 - More than 100,000 Arizonans are expected to lose health coverage this year.
 - 30,000 low-income parents are expected to lose coverage by next July.

Lessons from New Mexico

- New Mexico implemented its LTC Medicaid Managed Care in 2008 and determined that:

“Growth of spending is **unsustainable**. Assuming no changes costs in 2012 will be 60% higher than in 2007... Overhead of about 10.5 percent or an estimated \$68 to \$71 million of estimated savings from managed care were **insufficient** to offset new overhead costs.”

New Mexico Human Services Department : Program Evaluation: Medicaid Coordination of Long-Term Services Program, February, 14 2011. Report to The Legislative Finance Committee



Lessons from Florida

Florida determined that :

- Retroactive payments must be made for services provided while Medicaid pending.
- Should create an independent appeal process for denial of claims and/or coverage.
- Rate setting process for floor should be retained, but should provide flexibility to allow higher rates for patients requiring more complex medical care (bariatric, mental health, vent. etc.)
- Ensure that Medicare crossover claims are processed properly to support requirements for Medicare bad debt.

Idaho Implementation?

- LTC managed care will probably never be implemented in **rural areas** of the state where there are not multiple facilities.
- If implemented, a LTC managed care system could actually be very different in **various parts** of the state
- Greatest cost savings to Medicaid would likely be in increasing coordination to **prevent admissions to higher levels of care**.
- Without coordination, cost savings simply **offset** each other. Only one sure fact...there will be **new managed care overhead costs**. How will that be paid for?



How states pay for Managed Care

- State's typically establish an actuarially sound capitation rate for each managed care contractor, based on previous case-mix history, cost factors, and inflation.
- Capitation rates include a profit factor and an administrative factor (10-15%)
- Future capitation rates can also adjusted for current year gains and losses. Incentives are usually built into the system for program contractors, and even sometimes for providers.

Importance of Coordination

- Currently, Medicare Advantage plans discharge “Part A” patients earlier. This only increases Medicaid costs as the patient returns to Medicaid earlier and thus increases Medicaid expenses.
- A Medicare recipient can choose a **rehab hospital** instead of a SNF which is much less expensive. This patient choice can greatly increase costs.
- Willing to manage **care** and manage the **choice**?

Coordination... continued

- Perhaps the most significant way to manage **Medicare** expenses for duals is to carefully manage how to deliver the appropriate care in a timely fashion before expensive hospitalizations are required.
- Seniors with severe disabilities living **at home** had significantly **higher** Medicare expenditures than seniors in facilities. **Trimming Medicaid** expenses can lead to **increased Medicare** expenses.

Coordination... continued

- To obtain the Medicare SNF benefit a patient must be admitted to the hospital for three days. Clearly, it would greatly benefit these fragile patients if they could receive appropriate rehabilitation in a SNF rather than having to move to a hospital for three days. The three-day hospital stay requirement is an artificial barrier to high quality, seamless and cost effective care for this population.
- By eliminating the three-day stay requirement, care for the individual would be enhanced and costs would be lower. We should seek to reduce hospitalizations, not require them.

Coordination... continued

- 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.
- Medicaid has not paid the Medicare crossover payments for almost 10 years. This has put the provider in jeopardy at no fault of their own on several occasions including when there was a new:
 - Medicaid payment contractor: Molina
 - Medicare intermediary

Simplification... then Education

- More than 60% of long term care patients are on Medicaid. Bureaucratic Medicaid eligibility process is expensive.
- The ADRC should work in tandem with a managed care plan to help duals avoid Medicaid if at all possible. The duals should be incentivized to look to LTC insurance, home equity and family before turning to Medicaid.
- Medicaid and Medicare must be simplified! Then, we can educate seniors and their families. It takes an attorney and a social worker to explain the current programs & benefits.



Reduce both Medicaid and Medicare expenses in LTC

- Of course MCO has an incentive to reduce costs.
- Should provide proper assistance, and incentives for providers who **prevent decline and hospitalizations**.
- Provide incentives to LTC providers who more **quickly discharge** to lower level of care.
(opposite incentives exist today)

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 and cert requirements if MCO 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:
 - 1. Lead to unintended consequences and increase other program costs.
 - 2. Increase MCO profits but not decrease Medicaid costs.
 - 3. decrease access and choice to consumers.
- Program contractors can have financial problems if they accept capitated rates from Medicaid that are lower than final actual costs. The state must have a plan to pay for care if a contractor enters bankruptcy.
- Many providers experience long payment delays by the plans after managed care implementation (not another Molina transition?)



Other risks with MCOs

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Any Willing Provider?

- Some states allowed plans to limit the providers in their network based on certain criteria and to exclude any provider from their network after the initial 12-month period.
- Conversely, nursing homes were required to participate in all qualified Plans selected by the agency for their region. This clearly provides contracting leverage for the MCOs.
- Do not restrict consumer choice



A FEW Positive Points..

- There is more room for innovation. Managed care is typically more receptive to specialty programs than traditional cost based reimbursement. If a facility can keep a patient out of the hospital, the plan will pay more than the current special rate process. This is often true for patients with behaviors, ventilator dependent, or bariatric, etc.
- Medicaid managed care may help facilities gear up for the CMS pay for performance models