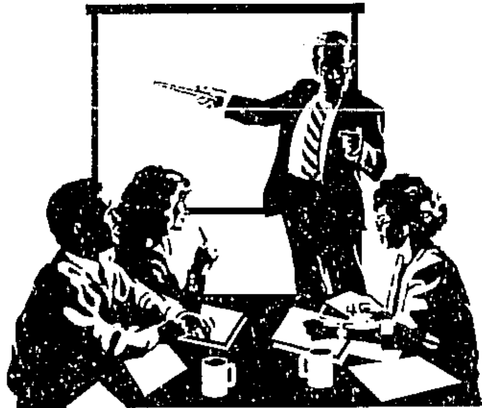
MANAGED LONG TERM CARE



WHAT IS IT?

HOW CAN WE IMPROVE THE OPTION?

JUNE AND JULY 1999

THE NURSING HOME COMMUNITY
COALITION OF NEW YORK STATE (NHCC)

WHY *MANAGED* LONG TERM CARE?

- The elderly make up only 13% of Medicaid recipients, yet payments for medical services to older recipients account for 33% of all Medicaid costs, largely due to long term care needs

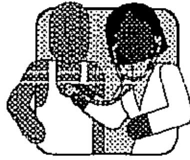
- Elderly are also greatest users of acute care (hospital) services largely funded through Medicare

- Elderly who are dually eligible for both Medicaid and Medicare services often have the highest utilization of Medicare services

- States must find a way to fund these services

- Proponents of Managed Long Term Care state that integrating Medicaid and Medicare payments will lead to better clinical outcomes, less administrative duplication and less cost shifting between providers and between Medicaid and Medicare; states will save money.

WHAT IS MANAGED LONG TERM CARE?



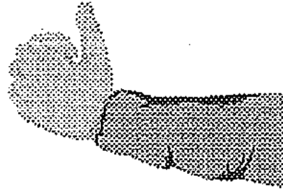
- One entity is responsible for providing and coordinating all acute and long term care

- Medicaid and Medicare reimbursements will eventually be integrated into one "capitated" payment to the plan

- The plan is at "risk" because the plan receives an amount of money that is "capped." If it spends more than the cap, it loses money; if it spends less than the cap, it makes money

- The plan can use the capped rate in many different ways

POTENTIAL BENEFITS OF MANAGED LONG TERM CARE



- A properly designed and implemented managed long term care plan can create a system which integrates and coordinates all services and payments which can overcome much of the disconnectedness and cost-shifting

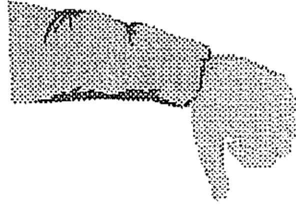
- Managed long term care can provide the flexibility to use resources to provide a broader array of services

- Managed long term care can lower costs by allowing providers to use reimbursement in creative and innovative ways which may save money in the long run

- Managed long term care can better emphasize preventive and community based care

- Managed long term care can create two points of accountability: the care plan and the state. With one plan responsible for providing and coordinating all care, patient care may be much more easily assessed and tracked

POTENTIAL PROBLEMS



CAPITATED PAYMENTS

- Capitation could become just a way to cut Medicaid costs if states set low payments to providers. If reimbursement rates to providers are not adequate, they will not be able to give needed services or will not want to enroll certain expensive enrollees

- A capitation may give plans incentives not to spend money on care

- Qualified providers may be unwilling to participate if rates are inadequate

- Access to specialists outside a plan may be limited to reduce costs

CONSUMER CHOICE

- There are limits on choices of providers

- Disruption in on-going care

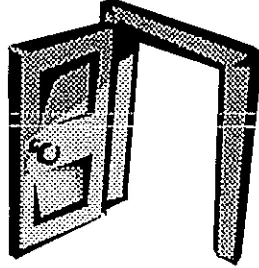
- Loss of consumer control

- Limits on nursing homes

- Managed care is difficult to understand
- How free will enrollees be to disenroll?

RECOMMENDATIONS

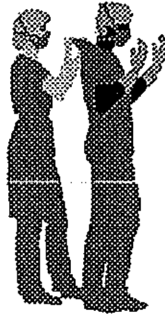
- Quality concerns must be paramount over cost containment
- Consumers must be involved in the development of regulations and approval of plans
- The plans are ***demonstration*** projects. The state must adequately evaluate them
- Mechanisms must be developed for continuous and meaningful public participation
- The state must hold the demonstration projects accountable for their actions
- The categories of eligible participants must be broad and inclusive
- Consumer protections, and educational and ombuds services must be in place



Access, Eligibility, Enrollment and Disenrollment

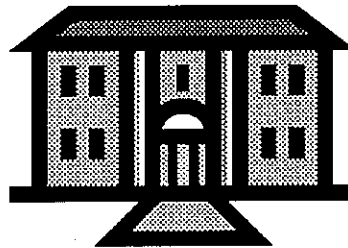
- Set rates at adequate levels
- Allow plans to operate only when both Medicaid and Medicare are fully capitated
- Mandate that plans enroll or keep enrolled persons who have legitimate disagreements over proposed changes in a care plan
- Limit ability of plans to deny enrollment or involuntarily disenroll someone based upon "health and safety" concerns

Appropriate Care and Provider Capacity



- Plans must demonstrate ability to provide or arrange for all services

- Plans must offer a wide and varied selection of nursing homes



- Plans must offer options to use out-of-plan specialty providers or nursing homes

- Allow new enrollees to continue with existing providers for a specific time period

- All care managers must be professional with training in geriatrics and/or experience working with such populations

Consumer Rights

- Require plans to allow enrollees the right to remain living as independently as possible in the community

- Assure a thorough and vigorous education program by state and plans for enrollees, families, proxies and designated representatives

- Use large print, plain English, other languages, Braille or audiotape, etc.

- Allow enrollees to retroactively disenroll based upon misunderstandings

- Mandate active participation in care planning

- Create and fully fund an ombuds program

- Require all grievance and appeals processes to be swift and simple

- A Medicaid fair hearing or Medicare appeal must be possible at any time

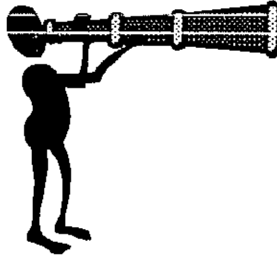
- Allow complaints to be submitted orally or in writing

- Require all plans offer a 24 hour toll free telephone access

Marketing

- Prohibit gifts and incentives
- Require that a plan's marketing program be approved by DOH
- Contract with an independent enrollment broker to assist consumers
- Publish annually a guide on plans
- Publish a list of basic questions to be asked

General Regulation, Oversight and Enforcement



- Consumers must be involved in the development of regulations

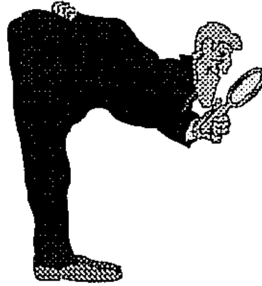
- Establish mechanisms for regular public participation and feedback to DOH

- Conduct quarterly, anonymous surveys of participants and providers to asses issues of quality of care, quality of life and access to and availability of care

- Aggressively monitor plans, cite them for deficiencies if warranted, and use sanctions and fines to enforce compliance

- Conduct annual, unannounced inspections of each plan, including interviews with enrollees, their families, and individual clinicians, during evenings, nights and weekends.

Data Collection and Evaluation

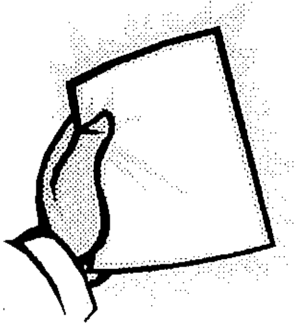


- Require all plans to collect and submit data on plan marketing, enrollment, denial of enrollment, voluntary and involuntary disenrollment, access to care, quality of life, patient and provider profiles, utilization of services and discharge disposition, complaints, appeals, and grievances and their resolutions, health outcomes, requests for information, and how the plan spent the capitated payments

- DOH should review and approve data collection systems

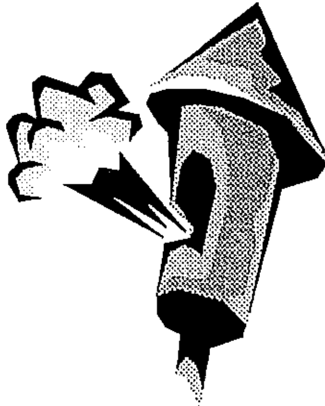
<u>Legislation</u>

- Require written reports by the Health Commissioner



- Provide funding to DOH to contract for an independent evaluation

- Enact strong whistle-blower protections



NEED FOR AN INDEPENDENT OMBUDSMAN PROGRAM

- Resolve complaints, grievances and appeals

- Assist individuals in navigating plans and assessing services

- Help enrollees understand their rights

- Collect, analyze and report on data submitted by plans

- Develop and promote public policy recommendations