Health Care Reform/Managed Care Readiness Toolkit

Introduction

Health care reform has spurred significant changes to the health care market across the country. In response, LeadingAge, in collaboration with CliftonLarsonAllen LLP, is pleased to provide its members with “The Essentials for Aging Service Providers in the Reforming Health Care Environment.” This toolkit provides skilled nursing facilities, supportive service providers, CCRCs, independent and assisted living, and aging service providers, in general, with the resources to:

- Understand key health care reform trends.
- Explore the concept of managed care and how it has crept into the long-term care world.
- Recognize how managed long-term care and dual integration programs work in other states and consider how managed care will change provider behaviors.
- Discover what managed care hopes to achieve and why it is both inevitable and unavoidable.
- Prepare for change.

Health Care Reform

National health care reform was passed in 2010, and rapid efforts to shift health care delivery from a system driven by volume to a system driven by value are underway. As of July 2012, there are over 100 Medicare-certified Accountable Care Organizations (ACOs) in 38 states. ACOs are responsible for managing the total cost of care for a designated population. Numerous commercial and Medicaid ACOs have evolved across the country as well. Massachusetts, Minnesota and California are all states with a notable presence of ACOs. Other examples of payment and care delivery reform include bundled or episodic payments, value-based payment and Medical Homes.

Preventable readmissions and chronic disease management remain important issues for the post acute space. In August 2012, CMS issued the first round of readmission penalties to hospitals. Hospitals with lowest quartile performance received penalties of up to 1 percent of their Medicare inpatient program reimbursement.

Perhaps even more noteworthy, commercial payers are rolling out total cost of care contracts (TCOCs), while states around the country seek to implement programs for the dual eligible population under the Center for Medicare and Medicaid Innovation Center’s Financial Alignment Initiative. The Financial Alignment Initiative established an opportunity for states, for the first time, to pursue dual integration programs and benefit from by sharing in any savings achieved by these programs.
In the past, if a state established a dual integration program to provide more seamless, better quality care for dual eligibles, often the state Medicaid program ended up paying more as dual eligible beneficiaries, while Medicare raked in the resulting savings. This is because in better coordinating care for duals and improving outcomes (e.g., reduced hospitalizations), typically, a dual utilizes more preventive care or Medicaid covered services.

Now, 26 states have applied to be able to implement dual integration programs under one of two models – Capitated Integration or Managed Fee-For Service. Most states have proposed paying managed care organizations, or integrated care organizations to coordinate and provide the care under their proposed dual integration programs. Whether it is ACOs, MCOs or TCOC arrangements, it will be crucial for long term and post acute care (LTPAC) providers to develop competencies in contracting that were not essential in prior fiscal years.

Nationwide, a clear shift away from volume-based reimbursement to value-based reimbursement is underway. Healthcare providers, employers, and insurers are faced with a cultural shift that will require upfront investments and decrease near-term reimbursements to ensure long-term success. Patient-centered care will be the lynchpin for success in this shift from volume to value.

Managed Care in the Health Care Reform Era

Managed care previously failed to reduce cost and coordinate care delivery, but it’s back! It’s back because state Medicaid budgets are strained, the Innovation Center presented states the opportunity to share in any resulting savings, and CMS has embraced that the way forward is to deliver the Triple Aim – Better Care, Better Health and Reduced Costs. What is different about how it is being deployed now is that providers and plans cannot benefit financially by just reducing costs or achieving savings, they have to also achieve certain patient outcomes. We believe managed care, especially for long term care, is here to stay. See the next steps below for a more detailed overview of managed care, what is different this time around and what to expect.

Taking the next steps in preparing for managed care:

- Determining your readiness for health care reform/managed care
- Managed care terms
- Impacts of health care reform/managed care on aging service providers
- Developing your value proposition
- What metrics you should be tracking
- How to prepare for discussions about contracting with managed care organizations
- What managed care contracts look like (coming soon)
- Legal contracting due diligence
Preparing for Managed Care and Defining Your Value Proposition

Every organization, regardless of what role it has in health care delivery, will need to decide how to strategically position themselves for managed care and the evolution of care and payment delivery under health reform. Identify what your organization can do to:

• Identify efficiencies and remove waste.
• Embrace evidence-based medicine.
• Measure outcomes.
• Manage different reimbursement methods in the near- and mid-term.
• Select strategic partners.
• Determine IT needs.
• Create a culture of change that honors patient choice.

In conclusion...

There are four strategic priorities for aging services providers:

1. In each market in which you operate, position your organization to be #1 or #2 for your key referral sources and collaborative partners.

2. Develop / coordinate / collaborate to create a full continuum of capabilities in each market.

3. Continue to invest in technology and update physical plants to meet contemporary requirements.

4. Improve your operating performance and build your balance sheet.

*Overall focus:* assemble basic performance data – tighten pre- and post-acute network – focus on developing relationships with providers that will ultimately control or influence the flow of funds.