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February 28, 2011

Agency for Healthcare Research and Quality
Immediate Office of the Director, Room 3028
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Rockville, MD 20850

Attention: Nancy Wilson, M.D., M.P.H.

Re: Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults

Thank you for the opportunity to respond to the above referenced Solicitation of Information regarding the development and use of an "Initial Core Set of Health Quality Measures for Medicaid-Eligible Adults," required by Section 2701 of the Affordable Care Act (ACA) for voluntary use by State programs, health insurance issuers and managed care entities. The American Health Care Association (AHCA) and the National Center for Assisted Living (NCAL) is the nation's leading long term care (LTC) organization representing more than 11,000 non-profit and proprietary facilities, which deliver the professional, compassionate, quality long term and post-acute care that more than 1.5 million of America's seniors and persons with disabilities rely on each day.

AHCA supports the use of adult, Medicaid-eligible measures for quality improvement and public reporting purposes. In fact, AHCA has developed Medicaid Policy Principles that calls for quality measures tailored to the Medicaid population and calls for States and plans to work with long term care providers in identifying a quality measurement system.¹ We agree that data collection for measure development and reporting should be structured to minimize the report burden on States and providers by aligning core measures with other existing quality reporting initiatives. However, the purpose(s) of collecting information for the Medicaid-eligible population is not clear. Conditions and outcomes for Medicaid-eligible adults who are receiving health care will already be included in many of the existing core set of measures. It is the underserved population, those individuals who do not have access to or do not seek routine healthcare, where data is needed.

For the Medicaid population residing in Assisted Living Facilities (ALFs) and other home and community based settings, we have concerns about the applicability of this initiative to the Medicaid waiver population. In some states, home and community based waiver providers such as ALFs would not be allowed to admit beneficiaries with conditions such as uncontrolled diabetes because of state licensing limitations. In virtually every case, each beneficiary's personal physician would need to complete this form given medical complexity of some of the measures.

¹Attachment: AHCA/NCAL Principles for Long Term Care Reform

Indeed, in many cases, only the physician would have the records necessary or the clinical expertise to respond to the measures. The level of nursing coverage also varies state-to-state depending on resident need, operational guidelines and state regulations making the possible involvement of a nurse questionable in some instances.

Unfortunately, the core set of measures offered for consideration are not used for Medicaid residents in nursing facilities and it is not apparent if these measure have been tested for use with institutionalized elderly and disabled. Any application of the proposed core set of measures in this setting will require additional data collection and reporting, will add to provider burden, and will conflict with similar nursing facility measures that are defined and constructed differently and which are required by regulation.

In a February 2, 2011 discussion with the Agency for Health Research and Quality (AHRQ) regarding the application of the core set of Medicaid-eligible measures to nursing facility patients, the use of measures derived from the Minimum Data Set (MDS) was questioned. An issue discussed related to the ACA, Title 3, Section 3104 (a) (1) (7) that states:

Data sets such as the outcomes and assessment information set for home health services and the minimum data set for skilled nursing services, which are used for purposes of classification systems used in establishing payment rates under this title shall not be quality and efficiency measures described in this subparagraph.

It is unclear whether the above statement refers to the MDS as a whole, or to the Resource Utilization Group (RUGs) used to determine payment. It is important to note that both MDS 2.0 and MDS 3.0 quality measures, approved under the National Quality Forum (NQF) consensus-development process, were recommended for quality improvement and public reporting purposes – not payment. It is also important to note that the MDS measurement system and the RUGs system are unlike in their development, purpose and construct and cannot be considered similar even though they use information from the same data collection tool. Based on this reasoning, AHCA recommends that AHRQ obtain clarification of the above statement and consider the use of MDS quality measures for Medicaid patients residing in nursing facilities since the measures are already publically available to States and plans.

The spirit of ACA is to extend health care, including Medicaid, to newly eligible adults not previously insured. Throughout the ACA, “adults” refers to this newly eligible population under age 65. Eligible individuals over age 65 are typically covered under Medicare and Medicaid for long term care services. Considering this, clarification is needed on the age of the Medicaid-eligible population for whom the core set of measures will apply. In addition, clarification is needed on whether only the nursing facility patients under 65 years will be included in the core set of proposed measures if the MDS 3.0 driven quality measures are not used. It is important to note that the MDS 3.0 quality measures for long stay (Medicaid patients) includes all patient with a stay over 100 days regardless of age.

There is a need to clarify the age of the Medicaid population impacted by the core set of measures since many measures differ with regards to the age range impacted by the measure. There are also other issues with the proposed measures that need consideration before they are used for nursing facility patient. For example:

- Many of the proposed NCQA measures apply to people up to age 75 years and adults are defined as ages 18-75. There are some NCQA measures, like Imaging Studies for Low Back Pain that apply to patients up to 50 years old or Flu Shots Adult that apply to

individuals ages 50-64 years. The majority of long stay nursing home patients are over 75 years old.

- Many measures like NCQA, Annual Monitoring for Patients on Persistent Medications exclude patients from the measure who had an inpatient stay (acute or non acute) in the measurement year. This measure would exclude nursing facility patients.
- Some measures are designed to meet electronic specifications that are not common to nursing facilities.
- The AHRQ measures focus on conditions like congestive heart failure, chronic obstructive pulmonary disease, angina, asthma, etc., but do not account for individuals with multiple chronic conditions (MCCs). The MCC patient population is common to nursing facilities and with current initiatives to provide care to individuals in their home or community, more and more MCC individuals will be receiving care in the community as well. Given this, it is unclear how condition-specific measurement will facilitate an evidence-based and transparent process for determining population health and care quality when the measurement captures a single condition and does not account for other conditions that impact or contribute to the condition being measured.
- It is not clear if the frequency of assessments and data collection time frames are standardized across the proposed set of core measures. For example, will annual monitoring be the same time period for all measures? Certain conditions are influenced by season and seasonal variation has been noted in measures use in nursing facilities and in other settings.

In addition to clarifying the age range of individuals to be included in this initiative and in each measure and before determining if any of the proposed core set of measures can be used with a broader population scope, the accuracy, reliability and validity of each measure may need to first be verified.

AHCA recommends that the MDS 3.0 quality measures be considered for use in this initiative.² Using the MDS measures will include the nursing facility population in this initiative, will use measures already designed for this population, and will use measures already in the public domain and thus eliminates the issue of provider burden. There are several MDS 3.0 long stay measures for nursing facility patients that need consideration for inclusion because they are similar to several of the proposed core set of measures. These include: the provision of influenza and pneumococcal vaccines, residents with symptoms of major depression, physical restraint use, residents with urinary tract infections, and resident experiencing one or more falls with major injury.

Currently, MDS 3.0 data are being captured and measures are being evaluated based on definition changes (long-stay versus short-stay), the accuracy and validity of new and untested measures are being verified as well as the data accuracy associated with measures using the new discharge assessment. As a result, CMS has reported that the final set of MDS 3.0 quality measures will not be available for use until the spring of 2012. The MDS 3.0 long-stay measures receiving time-limited endorsement, meaning testing and verification are needed before public release, include residents experiencing one or more falls with major injury and residents with major depression.

²http://www.qualityforum.org/Projects/nr/Nursing_Home_Performance_Measures/Nursing_Home_Performance_Measures.aspx

AHCA has identified long term care application concerns about the core set of measures offered for comment. Since the MDS 3.0 measures, a reasonable alternative for institutionalized elderly and disabled will not be available for one year we recommend that nursing homes be excluded from the first set of measures. This time will be needed to determine if and what MDS 3.0 measures can be used and will offer more time to determine if any of the proposed measures can be reasonably adopted, tested and validated for our population and without adding to data collection and reporting burdens.

AHCA recommends that initially, only one to two key measures per measure category (Prevention & Health Promotion, Management of Acute Conditions, Management of Chronic Conditions, Family Experience of Care, and Availability) be selected for a State to collect and use in its monitoring of quality of care. More thought needs to be given to measuring care and outcomes for those adults who do not elect or have access to health care on a regular basis.

AHCA/NCAL welcomes the opportunity to work with AHRQ on future discussions related to the purpose of this initiative and on the development and refinement of measures for Medicaid-eligible adults. We thank you for the opportunity to offer these comments.

Sincerely,



Sandra L. Fitzler
Senior Director of Clinical Services

AHCA/NCAL Principles for Long Term Care Reform

Executive Summary

Preamble

Continued Medicaid cost growth and increasing numbers of long term care users are driving states and the federal government to fundamentally reform the Medicaid program. Because long term care costs drive much of Medicaid growth, long term care reform – primarily within Medicaid reform efforts -- has become a top policy priority for the federal government and most states.

In order for AHCA/NCAL to best represent member interests, a cross-cutting member work group developed a set of broad long term care reform policy principles – or essential programmatic elements -- to guide or serve as a framework for AHCA/NCAL long term care policy development and reaction to federal and state proposals. The long term care reform principles build upon current AHCA long term care and Medicaid policies and will guide future AHCA/NCAL activity. Additionally, the principles also support one or more of AHCA's long term care and/or Medicaid Policy goals previously developed by AHCA's Finance Subcommittee.

The member work group determined that managed care warrants its own set of principles. These principles and background information begin on page 8.

The Principles

Three key principles frame a long term care program(s) that will: (a) support consumer preferences and needs; (b) foster policy efforts aimed at creating a more sustainable array of long term care financing options; and (c) provide a viable operating environment for long term care providers. Each principle includes several key elements.

Principle I. Publicly and privately financed long term care and related supports and services must meet consumers' and families' needs and be responsive to their preferences.

- *Recognize that consumers are key stakeholders in long term care policy decision making and government must include them in development, oversight and monitoring.*
- *Provide that every eligible individual who needs long term care services receives them in a timely manner in an appropriate setting, taking into account individual preferences and clinical needs.*
- *Acknowledge the key role that family care givers play and provide family care giver supports.*

Principle II. Long term care policies should promote and integrate a comprehensive array of public and private long term care financing options.

- *Encourage individuals to plan for long term care and provide viable private long term care financing options.*
- *Ensure that individuals have the tools they need to manage their long term care services as beneficiaries assume more personal responsibility for services – publicly and privately financed.*
- *Recognize the impact of reimbursement changes on long term care providers.*
- *Ensure that efficient coordination of benefits reduce administrative burdens on beneficiaries and providers.*
- *Encourage individuals, providers and government payers to engage in a policy debate on balancing public and private financing of long term care.*
- *Encourage the design of tax policies that coordinate with long term care financing strategy alternatives.*

Principle III. Through sufficient federal and state governmental infrastructure, policies should ensure that long term care service delivery systems provide an adequate array of services and administered by knowledgeable and quality driven providers across the long term care spectrum.

- *Include a strategic plan for building needed infrastructure and ensure a sufficient supply of long term care providers that engage in a variety of services to meet the needs of the population.*
- *Ensure that beneficiaries may move seamlessly among services across the long term care spectrum.*
- *Foster and support quality and efficiency in Medicaid services, as well as provide operational flexibility.*
- *Managed care plans should recognize that long term care providers deliver services that are distinct from acute care providers.*
- *Funding is adequate and timely in order to provide stability and predictability to meet the needs of long term care recipients at the appropriate time, in the appropriate place, and at the appropriate cost.*
- *Encourage development and use of a standardized post-acute assessment and benefit package to facilitate determination of patient need and placement.*

Complete AHCA/NCAL Principles for Long Term Care Reform

Introduction

Patients and their families are increasingly interested in sources of care and sites of services that are non-facility based, including home- and community-based settings (HCBS). Local communities, states, and the federal government are responsive, particularly since they believe that HCBS will be less costly and therefore save money. Because of consumer preferences and related federal and state policy changes, the proportion of long term care services delivered in facility-based settings is smaller than in the past. Medicaid reform has become the major vehicle for these and other long term care reform efforts at both the state and federal levels.

To date, many long term care reform proposals focus on delaying or preventing facility-based placement while encouraging use of personal long term care planning and expanding HCBS availability. The culminating outcome likely will be decreasing use of nursing homes and intermediate care facilities for persons with mental retardation (ICFs/MR).

This is not to suggest that the need for facility-based services will disappear. Rather, facility-based services are likely to play a relatively smaller role at least in the next ten to fifteen years. In the longer term, it is less clear how long term care will be delivered. Short term pressures and out-year ambiguity suggest that AHCA -- the largest formal long-term care provider group in the country -- adopt a forward-looking, leadership-based approach to shape long term care policies and ensure that there is a sustainable array of long term care services -- and related privately and publicly financing options -- for all Americans.

In late January, AHCA and NCAL members began the process of developing a set of guiding Medicaid reform principles. Principles were developed and assessed against the following dimensions:

- *Will the principles foster policy efforts aimed at creating a more sustainable long term care financing model?*
- *Do the principles support consumer preferences and needs?*
- *Will the principles foster a viable operating environment for long term care service providers?*

The principles were drafted to encapsulate existing AHCA/NCAL policy and provide a more succinct tool for sharing AHCA/NCAL positions as well as to frame proactive policy initiatives. The principles build on past policies by condensing concepts that are highly interrelated, promoting policies that are viable in the current political and

budgetary environment, and providing a proactive positive framework for representing AHCA/NCAL interests. The principles also directly relate to AHCA long term care and Medicaid policy goals developed by the AHCA Finance Subcommittee.

The Principles

Three key principles frame a long term care program(s) that will: (a) support consumer preferences and needs; (b) foster policy efforts aimed at creating a more sustainable array of long term care financing options; and (c) provide a viable operating environment for long term care providers. Each principle includes several key elements and also supports one or more of AHCA's long term care and/or Medicaid Policy goals previously developed by AHCA's Finance Subcommittee.

Principle I. Publicly and privately financed long term care supports and services must meet consumers' and families' needs and be responsive to their preferences. Unlike acute and primary health care services, long term care services are not discrete events (i.e., a sore throat, broken leg, etc.) that require specific medical interventions. Instead, receipt of long term care services becomes a lifestyle for both the person receiving services and his or her family. Long term care services are integrated into virtually every aspect of an individual's life and make the experience of long term care highly personal. To that end, long term care policies must:

- *Recognize that consumers are key stakeholders in long term care policy decision making and government must include them in development, oversight and monitoring.* State Medicaid agencies are required to provide public notice and time for comment when changes to the Medicaid program are proposed. They also are required to respond to stakeholder concerns. The federal government should require documentation that these requirements have been met.
- *Provide that every eligible individual who needs long term care services receives them in a timely manner in an appropriate setting, taking into account individual preferences and clinical needs.* Policies must recognize the individual – to the extent possible -- as the key decision-maker regarding their supports and care. For privately financed options, policies also must ensure that these options – particularly insurance products – recognize the importance of consumer preference.
- *Acknowledge the key role that family care givers play and provide family care giver supports.* Family care givers are a critical – but often unrecognized – segment of the long term care spectrum. State and federal programs must provide incentives and assistance for family care giving such as income tax deductions, availability of respite and day programming, and family counseling services.

Principle II. Long term care policies must promote and integrate a comprehensive array of public and private long term care financing options. As the proportion of our population age 65 or older increases and the number of younger

persons with disabilities increases, the federal government and states must take steps to increase use of private long term care options. Increasing the use of private options will improve the sustainability of a publicly financed long term care program, currently Medicaid. And, reimbursement policies must recognize the potentially interrelated impacts of payment policy changes to ensure a stable long term care provider marketplace. A stable array of long term care providers will be better positioned to meet consumers' needs and preferences. To increase use of the array of long term care financing options, policies must:

- *Encourage individuals to plan for long term care and provide viable private long term care financing options.* The federal government should promote the development of innovative programs, such as incentives for families to purchase long term care insurance, save money for long term care or otherwise plan for private long term care needs. State and federal government also should fund programs to raise awareness of long term care planning needs and help individuals and families make the best long term care financing decisions.
- *Ensure that individuals have the tools they need to manage their long term care service as beneficiaries assume more personal responsibility for services – publicly and privately financed.* Long term care reform proposals include a wide range of elements that give beneficiaries more control over services and service dollars. Examples include HCBS Individualized Budgeting models, Money Follows the Individual and Cash and Counseling programs. In addition to increased control and responsibility, government also should provide adequate supports to beneficiaries on how to direct their own services and wisely allocate service dollars. Government should have safeguards and oversights in place to ensure that these services are appropriate and effective in achieving the care planning goals of the beneficiary.
- *Recognize the impact of reimbursement changes on long term care providers.* Long term care providers receive payments from private sources, Medicaid, and Medicare for post acute care stays. Policy changes that decrease or otherwise affect revenue streams should be evaluated in the broader context of the array of financing sources, e.g., the impact of changes to Medicare payments when providers experience shortfalls under Medicaid.
- *Ensure that efficient coordination of benefits reduce administrative burdens on beneficiaries and providers.* Beneficiaries should be able to move seamlessly among services across the long term care spectrum without limitation due to burdensome administrative requirements that are commonly placed on providers and beneficiaries. Attention to streamlining coordination of benefits will result in better care as needs change.
- *Encourage individuals, providers and government payers to engage in a policy debate on balancing public and private financing of long term care.* The increasing long term care population and accompanying growing costs results in a

need for all stakeholders to be engaged in discussions on how best to finance this expanding population's care. This discussion should examine and weigh both public and private financing options.

- *Encourage the design of tax policies that coordinate with long term care financing strategy alternatives.* Identification of financing strategy alternatives is valuable only to the extent that such alternatives are implemented. Incentives, such as tax policies, will aid implementation efforts.

Principle III. Through sufficient federal and state governmental infrastructure, policies must ensure that long term care service delivery systems provide an adequate array of services and service providers across the long term care spectrum. Long term care reforms are being proposed and implemented at a rapid pace. Changes in service delivery systems, such as significant increases in HCBS use, must be accompanied by adequate increases in state administrative infrastructure including quality assurance and improvement, payment systems, data collection, and consumer and family information and referral services. To ensure market driven long term care system change at an appropriate pace, policies must:

- *Include a strategic plan for building needed infrastructure and ensuring an adequate array of long term care providers.* For publicly financed programs, government should require a reasonable plan for phasing-in changes that require substantial build ups in provider capacity and state infrastructure development. Government also should require that milestones or markers be met before additional changes or expansion. Government should encourage the notion that beneficiaries who need long term care services receive them at the needed intensity level (including facility-based services) as well as an adequate array of care management supports that do not place undue hardship on the individual or family caregivers.
- *Ensure that beneficiaries may move seamlessly among services across the long term care spectrum.* Long term care systems and providers are highly insular. For many beneficiaries, the result is typically a fragmented service system that is confusing and produces questionable outcomes. Government must ensure that long term care providers have the capacity to develop service arrays, partnerships, and business arrangements that foster a seamless service experience.
- *Foster and support quality and efficiency in long term care services, as well as provide operational flexibility.* Long term care providers face significant operational costs including purchasing or upgrading health information technology systems, capital improvements to existing facilities, and financing innovative services that could support specialty populations. Government regulation should not impede long term care service innovations among long term care providers that follow consumer preferences in a cost effective manner.

- *Managed care plans should recognize that long term care providers deliver services that are distinct from acute care providers.* A key long term care reform component is managed care – particularly for Medicaid-financed long term care. Experiences in states like Arizona show both positive outcomes and concerns for long term care providers. As managed care for Medicaid beneficiaries who are elderly, blind and have disabilities is expanded, federal and state officials should avail themselves of the long term care professionals’ policy, operational, and clinical expertise as these arrangements unfold.
- *Funding is adequate and timely in order to provide stability and predictability to meet the needs of long term care recipients at the appropriate time, in the appropriate place, and at the appropriate cost.* Government should recognize that demand for long term care services and financial pressure on providers -- as well as increased risk bearing at the plan, provider and consumer levels -- make additional investment in provider capacity, service quality and efficiency a necessity. Government payment rates at all levels of the long term care spectrum should be sufficient to provide quality services and cover the cost of operating, as well as needed capital improvements.
- *Encourage development and use of a standardized post-acute assessment and benefit package to facilitate determination of patient need and placement.* As opportunities to receive services are expanded, the need for uniformity in assessment becomes increasingly important.

Framework for Moving Forward

Since the inception of the Medicaid program, responsibility for long term care financing and delivery gradually has migrated away from the beneficiary and the family to the public sector. Increasing reliance on Medicaid for long term care services raises serious questions about programmatic sustainability. Additionally, demography, care delivery challenges (such as worker shortages), marketplace demands, financing, legal and regulatory, and industry trends, create an unprecedented need for the long term care professionals to help shape its future.

In partnership with consumer groups, long term care providers, including HCBS providers and facility-based, will lead the effort toward development of an integrated, flexible long term care array that responsibly informs and educates Americans about their long term care responsibilities and options, but also delivers Medicaid-financed services in a cost-effective, customized manner. In order to achieve these goals, AHCA/NCAL will partner with other long term care organizations based on its long term care policy principles to address the challenges and opportunities associated with building a sustainable long term care system.

AHCA/NCAL Managed Care Principles

At the AHCA/NCAL long term care reform work group meeting held on January 26, 2006, participants decided that managed care warrants its own set of principles. Staff were assigned the responsibility of drafting such principles for discussion at the March meeting.

Work group participants asked that additional attention be paid to managed care because of growth in :

- 1. *Managed care for Medicaid-only Beneficiaries Who Are Aged, Blind or have Disabilities.*** The effects on long term care systems will be: a) increasing pressure to use less costly services including earlier hospital discharges into sub-acute facilities or temporary placement in nursing homes; b) limited use of nursing home services until all less costly options have been explored; c) increased competition among nursing homes based on managed care organizations' (MCO) focus on best price; d) additional bureaucratic layer, which results in the redirection of a significant portion of available dollars from the bedside into administration; e) increased potential for duplication (among and between MCO's) in both quality assurance and regulatory intervention, which is both costly and cumbersome; and f) increased flexibility and opportunity for innovation.
- 2. *Managed Medicare and Medicaid Integration Programs.*** The Medicare Modernization Act of 2003 Special Needs Plan (SNP) authority could lead to increased state interest in managed care arrangements that integrate or better coordinate the Medicare and Medicaid programs. Commercial interest has been considerably greater than expected; to date, 296 SNP products are available.¹ Additionally, the 2007 Medicare Advantage plan application includes an expanded SNP section for Medicare and Medicaid integration options. And, Dr. McClellan has made integration one of his top policy priorities. A significant number of states are exploring managed care arrangements that would capitate both Medicare and Medicaid payments to managed care plans. In turn, providers would be reimbursed with rates based on the Medicare and Medicaid capitation payments to plans. While integrated care may be helpful from a continuity of care perspective, Medicare and Medicaid Integration programs will negatively impact provider reimbursement as it will be considerably lower than traditional Medicare
- 3. *Managed Care Delivery of Preventive Care (i.e., disease management (DM), care coordination, and wellness initiatives).*** DM, care coordination and disability management programs hold the promise of reducing disability acuity and the impact of chronic illnesses. In turn, such outcomes also result in lower costs and reduce financial strain on the health care system. Many Section 1115 Medicaid waivers include wellness incentive programs for beneficiaries. States

¹ Presentation by Jennifer Podulka, MEDPAC staff person using CMS data, at the MEDPAC meeting. January 11, 2006

also are heavily leveraging Medicaid managed care plans and/or integrated Medicare/Medicaid managed care plans to deliver such services.

Managed Care Principles

Managed care policies should recognize that long term and post acute care providers deliver services that are distinct from acute care providers. A key long term care reform component is managed care. Experiences in states like Arizona show both positive outcomes and concerns for long term care providers. As managed care for Medicaid-only beneficiaries who are elderly, blind and have disabilities or for dually eligible individuals is expanded, federal and state officials should avail themselves of the long term and post acute care professionals' policy, operational, and clinical expertise as these arrangements unfold. Five key managed care elements should be considered with the managed care principle:

- *Enhanced Flexibility in a More Competitive Operating Environment.* Long term care providers should have the freedom to take on a wide array of roles in the coordination and provision of individuals' long term and post acute care. Policies should allow providers to take on various roles, alone or in partnership, in the delivery of long term and post acute care services including risk contracting, administrative organizations roles, information and referral, care coordination of an individual's clinical needs, as well as care management and disease management.
- *Inclusion in Managed Care Program Development and Operational Decision Making.* Long term care providers should be meaningfully included and engaged in managed care program design. Specific points of engagement should include: (1) ongoing participation in capitation payment methodology and rate development and refinement; (2) agreement on, development and testing of a uniform assessment tool that identifies service needs and will ensure a reasonable and adequate payment by site of service; (3) plan contracting requirements – specifically, plan profit requirements (ensuring that plan profits and overhead costs are not excessive), development of provider rates and processes for reconciliation; (4) ensuring a level playing field, including decisions on “any willing provider” requirements; (5) prompt payment; and (6) coverage, prior authorization and utilization management processes.
- *Special Consideration As Capitation Rates, Risk Adjusters, and Subsequent Provider Rates Are Developed.* Long term and post acute care providers must have the resources to deliver services, meet capital costs associated with facility or unit maintenance, and meet both state and federal licensure and operating requirements. First, MCO contracts and state oversight must ensure that plan capitations payments – including any frailty adjuster -- associated with individuals using long term care be fully available for that purpose. Second, in Medicare and Medicaid integration arrangements, states must ensure that rates including or based on Medicare capitation payments to plans and providers also be actuarially sound (currently a Medicaid requirement for managed care capitation payment

rates). Third, the long term care provider marketplace faces significant capital costs to maintain aging facilities, upgrade existing facilities, and/or develop new service settings – such as small congregate settings or single occupancy capacity. Payment rates must include a margin that will support critical capital maintenance and development and ensure provider financial viability and sustainability.

- *All long term and post acute care settings should have quality measures tailored to the type of service setting and long term or post acute care populations. Acute care quality measures and measurement tools are inappropriate for long term care settings and, in some instances, long term care populations. States and plans must work with long term and post care providers to: identify a quality measurement system that is (a) targeted to long term care or post acute care service outcomes; and (b) based on current clinical or social supports best practices. Finally, all willing providers with the capacity to implement and collect data on the quality measures in a managed care coverage region should have the opportunity to participate in the provider network.*
- *Managed care plan coverage determination processes (i.e., medical necessity definitions and related procedural guidance) must reflect the difference between acute care service outcomes and long term care service outcomes. Because of the unique needs of the long term care population and the nature of long term and/or post acute care settings, coverage determinations on access to care should emphasize maintenance of functioning and specialized healthcare needs. Additionally, coverage determinations should reflect that long term care consumers' physical and psychosocial support needs are ongoing and must be tailored to individual preferences to the degree possible.*
- *Development and use of a standardized post-acute assessment and benefit package to facilitate determination of patient need and placement. As opportunities to receive services are expanded, the need for uniformity in assessment becomes increasingly important.*

Conclusion

The long term care system is under considerable pressure driven by payer and consumer preferences to shift from facility-based care to consumer-directed home- and community-based or more home-like services, along with tighter reimbursement, and difficult to manage Medicare and Medicaid operating requirements. Considerable attention must be given to the potential impact of managed care on the stability of the long term care provider marketplace to ensure erosion of capacity is not accelerated. The principles and key elements above should be used by policymakers, providers and others to help craft policies, including a long term care provider bill of rights to address issues arising from the expansion of managed care for long term care populations.