Key Service Model Attributes and Care Processes

The Trusted Voice for Aging

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LeadingAge®

Center for Managed Care Solutions & Innovations

Tool Summary

- Identify Impacts of Managed Care on LeadingAge Providers by Service Type
- Outline Key Service Model Attributes for SNFs
  - Customer preference
  - Hospital referral sources
  - Health plans
- Identify Key Provider Care Processes
  - Care transitions between hospital and home
  - Care transitions between provider and other service providers/home
  - Medication reconciliation
  - Care authorization

IMPACTS OF MANAGED CARE ON AGING SERVICES PROVIDERS BY SERVICE TYPE

Skilled Nursing Facilities

- Skilled Nursing Facilities (SNFs) will need to help MCOs (Managed Care Organizations) achieve goal of providing high-quality care at lower cost
- MCOs will seek to negotiate the lowest rates for patient care with SNFs in their networks
- SNFs will need to reduce costs in order to remain a competitive alternative to other post-acute care providers
- Staff will be expected to work at the top of their licenses
- MCOs will case-manage SNF residents, and staff will need to adjust to various protocols to comply with the requirement of the MCO in which their residents are enrolled
- This may pose challenges where protocols vary among MCOs. Therefore, SNFs should attempt to define the best practice protocols for care and targeted conditions or diagnoses in order to increase the ability of their staff to comply with them and produce better outcomes.

Skilled Nursing Facilities (continued)

- Patients will be discharged earlier from the hospital and may be sicker/need higher levels of care in the post-acute setting
- MCOs may ask SNFs to “treat in place” instead of transferring a resident to the hospital, for which a SNF may be paid a higher rate to provide more intensive services
- SNFs will need enhanced information system capabilities and cost accounting competencies
- SNFs will need to measure resident care and quality outcomes
- SNFs will want to build alliances/networks with other long-term services and supports providers (e.g., adult day services, assisted living) to expand referral sources
- As hospitalizations are reduced, more referrals may come from the community over time than from the hospital
- SNFs may want to form alliances/networks with other SNFs to be attractive partners to MCOs, or with physician/hospital organizations who are willing to assume financial risk for providing skilled care

Assisted Living Communities

- MCOs may want to contract with assisted living (AL) communities who can offer competitive prices and demonstrate quality
- AL communities will need to help MCOs achieve the goal of providing care at lower cost, and demonstrate when the AL may be a more cost-effective alternative to nursing home care
- MCOs will want to negotiate the lowest rate for patient care with ALs in their networks
- MCOs will case-manage residents, and AL staff may need to adjust to different protocols to comply with the requirement of the MCOs in which their residents are enrolled
- This may pose challenges where the protocols vary among MCOs. Therefore, ALs should attempt to define the best practice protocols for care and targeted conditions in order to increase the ability of their staff to comply and produce better outcomes

Assisted Living Communities (continued)

- ALs will need enhanced information system capabilities and cost accounting competencies
- ALs will need to measure resident care and quality outcomes
- ALs may see the demand for their services increase from the Medicaid and dual-eligible populations, if they represent a lower-cost option than nursing homes, as the emphasis in many of the state dual integration programs is on increasing care provided in home and community-based settings
- ALs may want to form alliances with other long-term care providers to deliver/expand services to residents
- Some Medicare Advantage plans may offer supplemental benefits that could include some limited home and community-based services (e.g., adult day services, home care), which would require ALs to negotiate a contract and rates for those services

Life Plan Communities

- MCOs will assume responsibility for case-managing their enrollees, determining whether and to what extent services will be authorized
- Transfer decisions to another level of care (higher or lower) will be made by the MCO beyond the control of the Life Plan Communities (LPC)
- Coordination of health care for nursing home residents will be directed by physicians affiliated with the resident's MCO
- Residents will be discharged earlier from the hospital and may be sicker or need higher levels of care to meet their health care needs

Life Plan Communities (continued)

- If a resident's MCO does not contract with the LPC, they may be discharged to another contracted skilled nursing facility
- Life plan communities should familiarize themselves with Return to Home provisions that would permit some residents to receive services from their LPC skilled nursing facility *(see issue brief in LeadingAge Center for Managed Care Solutions & Innovations)*
- Potential LPC market may decrease. Potential residents/customers may question the need for a LPC and multi-level of care if their enrollment in a MCO will reduce their future health care costs and provide the entire scope of care they need.
- Consider extending services to non-residents to help build and protect referral sources. This may increase the LPC's value to the MCO by providing access to larger senior market in the community.

Senior Housing

- Delivery of services (home care/case management) in housing will be increasingly important in meeting the residents' needs. On-site services may be an expectation of the MCO.
- Health systems and physician groups may be willing to locate services on a campus as a way to control readmissions
- Housing residents will be discharged from the hospital earlier and sent home needing a higher level of care from service providers (home health care)
- The MCO will determine the amount of home and community-based services to be provided, which may be less than under fee-for-service insurance

Senior Housing (continued)

- Residents in MCOs may be required to use only contracted providers, (e.g., home health) requiring the housing provider to open its doors to multiple providers serving multiple health plans
- Residents may seek guidance from the housing manager on whether to join a MCO
- Residents may seek the housing manager's help in advocating with the MCO on their behalf (e.g., re a claim issue)
- Housing providers may want to form alliances with other long-term care providers to deliver/expand services (e.g., home care) to residents
- Some Medicare Advantage plans may offer supplemental benefits that could include some limited home and community-based services (e.g., adult day services, home care), which if provided by the senior housing would require them to negotiate a contract and rates for those services.

Adult Day Services

- Medicaid MCOs may contract with Adult Day Services (ADS) requiring the ADS provider to offer competitive negotiated prices and demonstrated quality
- MCOs may look to ADS centers to function as delivery sites for health care services either through contractual arrangements or with other providers
- Care coordination will be increasingly important, as MCOs look to ADS programs to coordinate medical and social needs of participants
- Medicaid reimbursement may be provided through a Managed Medicaid MCO. ADS programs will need to be part of contracting networks or have separate relationships with several MCOs to ensure an adequate volume of participants. ADS may also be provided as supplemental benefits under Medicare Advantage plans.
- ADS programs will need to find ways to develop a larger private pay market to provide financial stability. This could include marketing ADS to employer groups as a service for employee caregivers and retirees.

Home Care – Medicaid Managed Care

- MCOs are typically paid a per-member-per-month (PMPM) fee for providing a defined set of services that may cause them to limit the amount of home care services provided
- However, many state dual integration and managed Medicaid Long-Term Care (LTC) programs seek to incent MCOs to provide more services to consumers in the community rather than in an institutional setting. As such, demand for home and community-based services is expected to grow.
- MCOs will determine the tipping point at which nursing home care becomes more cost-effective than home care services for an individual

Home Care – Medicare

- Beginning in 2019, Medicare Advantage (MA) plans may offer enrollees supplemental benefits such as in-home support and home-based palliative care, which if provided by the home care provider would require them to negotiate a contract and rates for those services
  - These options will expand further in 2020, as they will no longer need to be primarily health-related, potentially creating new opportunities for home care providers to provide services paid for by an MA plan
- MA plans are also able to target some of their benefits to specific chronic conditions such as: diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), patient with past stroke, hypertension, and coronary artery disease
- Other clinical conditions may be covered, provided the conditions can be objectively identified and the benefits are related to the condition

SERVICE MODEL ATTRIBUTES

Major Service Model Provider Attributes as Viewed by Different Stakeholders – Transitional Care Unit (TCU)/Short-Stay Rehabilitation

Service Attributes	Consumer	Hospital Referral	Health Plan/MCO
1. Trained staff to care for medical needs	++	++	++
2. RN on duty 24/7		+	+
3. Admissions on 24/7 basis		+	+
4. Access to outcome data to demonstrate delivery of quality services	+	+	+
5. Implementation of best practices		++	++
6. Access to therapy at least 6 days a week	++	++	++
7. Close coordination with physician	++	+	+
8. Personalized care planning with patient and family	++		+
9. Private room	++	+	
10.Separate entrance to TCU/distinct activities	+		

Key
+ Desirable
++ Preferred

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Major Service Provider Attributes – Long-Term Care

Service Attributes	Consumer	Hospital Referral	Health Plan/MCO
1. Trained staff to care for all needs	++	++	++
2. Transfers back from Emergency Room/Department on 24/7 basis		+	+
3. Access to outcome data to demonstrate quality services	+	+	++
4. Implementation of best practices	+	+	++
5. Close coordination with on-site physician	++	+	+
6. Person-centered care planning with resident/family	++	++	+
7. Private rooms	If have the ability to pay privately		

Key
+ Desirable
++ Preferred

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BEST PRACTICES

Care Model Within a Transitional Care Unit (TCU) or Long-Term Care Unit

- Strong initial assessment and medication reconciliation
- Onsite capabilities to assess/treat conditions, including:
  - Onsite diagnostic/portable x-rays (look at vendor costs)
  - IVs, other
- Proactive management of acute episodes through use of best practices
  - INTERACT system
    - Skills enhancement/training on care pathways
    - SBAR communication tools
    - Stop/Watch
- Physician/nurse practitioner team visit within first 3 days (desired) of new admission to TCU or at least within first week
- Physician/nurse practitioner team coordination/communications
- Advance directives/POLST(Physician's Orders for Life Sustaining Treatment) implementation
- Engagement of patient/resident and family in person-centered care plan

INTERACT for Skilled Nursing Facilities / Others

- Evidence-based clinical system that resulted in 20% reduction in hospital readmissions from skilled nursing facilities
- Updated to SNF INTERACT 4.0 to include additional clinical, data tracking tools and electronic connections to facility's clinical electronic health record
- Communication tools:
    - Skills enhancement/training on care pathways
    - SBAR communication tools
    - Stop/Watch
- Advance planning tools
- Extended INTERACT Assisted Living and Home Health

INTERACT for Nursing Homes / Others (continued)

- Care paths expanded to 10 clinical and diagnostic categories to assess/treat conditions:
  - CHF
  - UTI
  - Acute Mental Status
  - Fever
  - Dehydration
  - Symptoms of Lower Respiratory Illness
  - Shortness of Breath
  - Change in Behavior
  - GI symptoms
  - Falls
- Website: http://www.pathway-interact.com/; coordinates all training and certifications

Care Transitions Process

- Definition of Care Transitions: “The set of actions necessary to ensure coordination and continuity of health care as patients transfer between different health care settings or levels of care.” (Coleman and Berenson. Ann Intern.med. 2004 140: 533-536)
- Four Critical Components of Safe Transfer*:
  - Medication reconciliation
  - Patient education (coaching)
    - Resolve confusion over medications
    - Identifying indicators of worsening conditions (red flags) and knowing who to call

*based on research and PowerPoint presented at American Geriatric Society Convention 11/4/2009; “Safe Care Transitions – Bridging the Silos of Care”

Care Transitions Process

- Four Critical Components of Safe Transfer (continued)*
  - Communication between sending and receiving providers
    - Discharge summary /care transitions plan
    - Patient
    - Propriety software
    - Email and/or phone
  - Timely physician follow-up

*based on research and PPT presented at American Geriatric Society Convention 11/4/2009; “Safe Care Transitions – Bridging the Silos of Care”

Example 1: Care Transition - Transition from Hospital to TCU

- Clearly communicate the type of patient TCU can handle/acuity
  - Hospital understands type and acuity of patient community can care for
  - TCU staff trained for medical complexity (IVs; specific pathways for diagnosis specialty)
- Transfer of patient information/safe transfer
  - Meet with hospital to discuss content of transfer packet and standardize across all hospitals in area
  - Set up electronic transfer of information versus paper, if feasible to reduce errors
- Medication reconciliation: Understand how this process is done in provider setting

Example 1: Care Transition - Transition from Hospital to TCU (continued)

- Timely visit of physician for new admission
  - Within 3 days of admission; minimum within a week
- Internal review of readmissions/transfers
  - Complete root-cause analysis of each readmission or transfer to hospital
- Regular ongoing hospital meetings
  - Review transfer/readmission data with hospital
  - Work with hospital to improve transitions between hospital and nursing home
  - Review ways to help hospital to reduce patient's length of stay in hospital

Example 2: TCU Transfer/Discharge Patient to Home

- Involve patient/family engagement in plan of care from day of admission
- Monitor average length of stay – patient's progress to be made each day
- Assess functional assessment and need for connections/support upon transfer
  - Time of transfer (Friday morning versus afternoon--limited home health)
  - Living arrangement/support services needed

Example 2: TCU Transfer/Discharge Patient to Home (continued)

- Develop person-centered transitions plan that is understandable to patient
  - Medication reconciliation
  - Referrals to home health and other community support services
  - Primary care physician follow up appointment made
  - Patient education – red flags
  - Connections to Area Agency on Aging for future support
- Telephone follow-up within 3 days to ensure patient is following plan

CONCLUSION

Other Key Care Processes Impacting Providers that are Unique to Managed Care Plans

- **Precertification:** "The process of communicating the need for health care to the health plan prior to receiving care." (1)
  - Some health plans require notification and certification prior to admission to the TCU or the start of covered services. An MCO may have penalties if a member receives care without precertification, and others may not pay benefits if it is not obtained.
- **Prior Authorization (PA):** "The process of obtaining prior approval by the health plan as to the appropriateness of a service or medication." (2)
  - Example: Facility staff need to call and obtain authorization for a certain or specific number of days of TCU coverage
    - MCO may only grant 7-day authorization, requiring the facility to obtain additional PA to continue care beyond the 7-day period

- (1) HealthFirst--common managed care terms and definitions
- (2) Glossary of Terms/Michigan ICO Proposal with CMS

Other Key Care Processes Impacting Providers that are Unique to Managed Care Plans

Care Coordination: "The process used by a person or team (MCO) to assist beneficiaries in gaining access to necessary Medicare, Medicaid and waiver services, as well as social, educational and other support services, regardless of the funding source for the services": (2)

- Provider needs to know whether MCO has assigned a care coordinator for member and how to coordinate with this person when developing or monitoring the member's care
- MCO may contract out this function to a third party (e.g., Area Agency on Aging)
- State Medicaid agency may require special conditions on Medicaid health plans for the delivery and scope of care coordination services (e.g., limit to high-risk patients; specific care plan format)

- **Clean Claim:** Process and timetable required by health plan for submitting claim to assure reimbursement of services
  - Provider most likely will need to set up electronic billing with each contracted health plan
  - Provider will need coordination between clinical staff who are obtaining prior authorizations for services and billing staff to ensure proper coding and levels of payment authorized
  - Health plans have specific time frames for submitting claim
  - Billing staff needs to alert leadership if payments are not being received in a timely manner in order to effectively troubleshoot problems with contracted health plan

* Glossary of Terms is available in the LeadingAge Center for Managed Care Solutions & Innovations at: www.leadingage.org/managedcaresolutions

(2) Glossary of Terms/Michigan ICO Proposal with CMS

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Summary of Key Service Attributes and Care Processes Toolkit

- Providers need to adapt care processes and service offerings to better meet the needs of consumers, hospitals and managed care organizations
- Care processes should be based on evidence-based best practices
- Service providers need to review their administrative and clinical processes to ensure that they are operationalizing the key processes necessary to successfully implement the terms of the health plan contract, thus ensuring continued referrals and timely reimbursement
- Collect and analyze key data to determine root cause of issue and develop plan to address any concerns

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- hyperlink to LeadingAge Glossary of Terms document in the Center:www.leadingage.org/managedcaresolutions ...(fill in with link to LeadingAge

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