Experts' Roundtable

In each issue of *ALC*, we will ask a panel of experts to comment on a pressing issue of the day. Watch for this roundtable, and let us know if you have any suggestions regarding experts you would like to hear from or questions you would like to see addressed.

How do you envision managed care being involved with ALFs and their residents in the near future? In particular, has the Medicare Modernization Act (MMA) opened the door to greater possibilities with the development of Special Needs Plans?

Tim Schwab,
MD, MHA
Chief Medical/Information Officer
SCAN Health Plan

Special Needs Plans (SNPs) have opened up the ability for managed care plans to serve people with multiple impairments; and these are the types of individuals most likely to be living in assisted living facilities. A new risk-adjusted payment methodology will allow CMS to pay plans more appropriately for patients who have more diseases and comorbidities. As a result, managed care organizations will begin to see assisted living facility residents as people they want to enroll and serve.

The ability for managed care plans to have a number of members in one facility or several facilities in one region opens up the door for partnerships between MCOs and ALFs. The medication management piece of the Medicare Modernization Act will be a lot easier to manage if 100 people in one facility have the same plan. This presents opportunities such as bringing a pharmacist in to work with SNP residents in one day. We'll see of lot of innovative activities starting to happen, thanks to this legislation and the SNP provision.

The MCOs will be able to bring services into ALFs that these facilities previously couldn't provide as part of their resident packages or weren't able to pay for otherwise, for example, bringing in a physician or nurse practitioner to provide specific care for individual residents. If the MCO has significant numbers of members at one facility, it could possibly implement house calls, pharmacy management services, and other special programs or services. There also will be more opportunities for health management programs and resident education.

MCOs will come to see ALFs increasingly as desirable customers and ALF residents as members that they can serve effectively. There are likely to be a growing number of partnerships between ALFs and MCOs. And it is feasible that ALFs will begin reaching out to MCOs. There are many ways that facilities can do this. They can contact the plan's provider relations department or sales and marketing department. The facility can present itself as a doorway to potential new enrollees. It will be useful for the facility management to present resident data, including information about insurance coverage, hospitals utilized, and so on.

Valerie Wilbur
Vice President
National Health Policy Group

The AL population includes a lot of high-risk residents with multiple chronic conditions who need multiple providers and different kinds of services. For example, Medicare beneficiaries with five or more chronic conditions see an average of 14 physicians per year, have about 40 office visits, and fill an average 50 different prescriptions annually. Without coordinated management, all of these elements can lead to negative medical outcomes. But in a traditional service environment, you don't have any coordination of care.

Managed care models like the SNP provide an opportunity to address the problems that are particularly difficult in high-risk populations—such as management of comorbidities, polypharmacy, and risks related to hospital and nursing facility admissions—such as iatrogenic-related illnesses and functional decline.

Historically, managed care providers such as standard Medicare+ Choice programs haven't had the legal authority or financial incentives to target enrollment to specific high-risk groups such as nursing home residents, chronically ill beneficiaries, and the dually eligible. The MMA authorized a new type of managed care plan—or SNPs—that enables plans to target a specific population. This ability to target specific populations creates incentives to develop the special programs and services needed to address their unique health care needs. It also provides a vehicle for administrative economies of scale related to integration of programs for the dually eligible. It also enables plans to generate the critical mass necessary to attract physicians and get them to change the way they practice medicine, resulting in improved outcomes for special needs beneficiaries. I think SNPs represent a real opportunity to move in these directions.

I also think it is important to look beyond the advantages of the SNP model in relation to targeting enrollment of special beneficiaries to what kind of future policy changes are needed to maximize the potential value of SNPs. SNPs provide an umbrella for many kinds of program innovations offered by current demonstration models. To implement these innovations in mainstream programs, however, some additional statutory

authority may be needed. For example, to the extent that they serve dual eligible residents, ALFs should consider the opportunities SNPs provide to better integrate Medicare and Medicaid benefits. I see the SNPs as an important first step toward Medicare/Medicaid integration in a mainstream model outside of demonstration authority. But additional statutory authority is needed to enable SNPs to integrate benefits and financing and administrative functions, creating a uniform structure like the existing dual demonstrations have been able to achieve under waiver authority. Other statutory or regulatory enhancements to SNP authority—such as frailty-adjusted payments—could result in a kind of super model that allows a managed care plan to implement multiple program innovations created by various demonstrations under one umbrella.

ALFs provide the housing side of the equation and some supportive services. Affiliation or partnerships with SNPs would enable them to take advantage of financing and delivery innovations available under SNPs and become a "full service" provider. SNPs would value such an affiliation because ALFs could assist plans in targeting the very population they are intending to serve.

Roy Erickson,
MD
Chief Medical Officer
Evercare

Health plans should recognize that assisted living represents an ideal site to provide medical care services to older and potentially frail enrollees. These individuals can access support services as needed; and this setting can provide economies of scale for both the provider and the payor. With the full implementation of risk adjustment in 2007, health plans will get more appropriate payments for ALF residents.

Evercare is a contracted provider for the Minnesota Services Health Options program. Some of our enrollees are supported in assisted living facilities. We have provided nurse practitioners at several of the assisted living faculty campuses. The nurse practitioner is able to provide care in the member's home. These assisted living facilities also have skilled nursing facilities onsite capable of providing subacute care. If one of our members becomes acutely ill (ie, pneumonia), we often can transfer the member directly to the subacute facility for treatment of the acute illness and avoid an acute care hospitalization. We also provide extensive care management services in ALFs in Arizona and Florida as part of our long term care Medicaid nursing home diversion programs.

The ALF setting also could provide the opportunity for "group visits" for residents. These are group educational sessions lead by a physician for individuals with chronic illnesses such as diabetes or heart disease. Self-management techniques and other educational materials are presented. Results suggest that these individuals require fewer emergency room visits and hospitalizations.

The question remains as to how the Special Needs Plans under the MMA can help the development of medical care programs in assisted living facilities. It seems that a limited number of ALF residents would meet financial criteria to qualify for SNPs for dual eligibles. As CMS more clearly defines additional criteria for Special Needs Plans, these may be the opportunity to allow providers and payors to focus on the ALF as an important link in the continuum of long term care.

Shawn Bloom
President and CEO
National PACE Association

As the feature article in this issue explains, PACE presents an important means of ensuring that ALF residents continue to have access to the services they need. PACE has the ability to augment the services that the AL provider can bring to bear and, so, from the state's standpoint, it provides the continuity of placement beyond what the state's assisted living reimbursement system will allow. From the consumer's standpoint, they are theoretically more desirable or more likely to want to live in a less institution-like setting and better able to age to place.

Taking a step back, I generally think that organizations that are receiving capitated payments—especially those providing capitation across the full continuum of Medicaid/Medicare services—are extremely wise to find non-institutional models of placement where those economies of scale can be achieved. I think that there are opportunities in the marketplace for providers to think of care settings in a much broader sense.

I think if we really want to develop a national policy and a national program, there should be a national standard—because, right now, there are variations across the states; and we found that—with some risk adjustment—there was quite a redistribution in terms of payment. I think there are a variety of benefits to devising a national standard. However, given our experiences working with the states, it is going to be hard to bring them together to reach a consensus—unless there is something of an authoritarian approach.

I suggest that—in the short term—ALF residents who qualify for nursing home care come in like special HMO beneficiaries who qualify for that care. ALFs would need to make their residents aware of their ability to do this so that they can have the same access to services. ALC