

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO <i>Liggett</i>	DATE <i>2-28-14</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>000302</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Mr. Heck</i>	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____
	<input type="checkbox"/> FOIA DATE DUE _____
	<input checked="" type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			



Lutheran Homes
of South Carolina

promoting the well-being of older adults

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FEB 28 2014

Department of Health & Human Services
OFFICE OF THE DIRECTOR

February 27, 2014

Anthony Keck, Director
SC Department of Health and Human Services
1801 Main Street
Columbia, SC 29201

Dear Tony,

Thank you for the opportunity to meet last week with me and Richard Fields from Presbyterian Communities. Both of our organizations have great interest in participating in the Medicaid skilled nursing home program and have been stymied from participation by the current practices of the Medicaid Permit Day program.

As we discussed last week, we believe that the permit day program will be made obsolete when Prime is fully implemented. This position was outlined in the document which I left with you (attached). Additionally, our organizations are working hard to accommodate the changes in the health care system as we develop new partnerships with hospitals, physicians, home health agencies and non-skilled home services organizations. But, reforming the healthcare system requires not only reform of service delivery but reform of those regulatory barriers to exploration and testing of new models of care. The permit day program is a regulatory hindrance to innovation in post-acute care as well as a possible violation of a Medicare beneficiary's freedom of choice to select any willing provider for rehabilitation services.

I encourage continuation of the department's current policy which allows managed care organizations to contract with any willing skilled nursing facility and look forward to continue working with the department to design and test new models of long term services and supports.

Sincerely,

Thomas E. Brown, Jr, DrPH
President and CEO

SC Medicaid LTSS System

1. Background

Prior to 1984, South Carolina's Medicaid long term care system provided skilled nursing facility services and home health agency services. With the institution of the Community Long Term Care program (CLTC), Medicaid eligible beneficiaries who qualified for skilled nursing facility admission and desired to age in place and receive the long term services and supports in their own home had another alternative. In order to assist with implementation of this new program, the General Assembly provided state match funding and implemented a moratorium on CON's for new skilled nursing facilities. In the mid-1980's this moratorium was replaced with the current Medicaid Nursing Home Permit program, which was designed to control Medicaid skilled nursing facility expenditures while increased funding was provided for the CLTC program services and "slots".

For over 25 years, this state policy has been successful in controlling the number of Medicaid eligible nursing home residents. Changes (increases and decreases) in this number have occurred in accordance with the number of days authorized in the annual state budget. For example, in 1997 the average daily census of Medicaid skilled nursing facility residents was 11,160. Five years later in 2002, the number had increased to 12,154 and in 2012 the average daily census was 10,416.

Over this same time period, the state's Medicaid policy goal was to increase access to home and community-based services for those individuals requiring long term care services. As a result, Community Long Term Care's average census has grown from 6,269 in 1997, to 11,011 in 2002 and to 12,106 in 2012.

In addition to the increased availability of home and community-based services, dually-eligible South Carolinians residing in Orangeburg, Richland and Lexington Counties have access to long term care services through the state's two Program of All-Inclusive Care for the Elderly (PACE) programs.

Implementation of Healthy Connections Prime, the SC DuE project, in 2014-2015 will significantly impact provision of Medicaid LTSS. Following an initial period of voluntary enrollment, elderly dually eligible South Carolinians will be enroll in a managed care organization (MCO) which will be responsible for all aspects of medical and health care, including LTSS. With successful implementation there will be a growing number of MCO members who are in the MCO's LTSS system and smaller numbers in the regular Medicaid fee-for-service system.

2. Impact of Current State Medicaid LTSS Policy

The current LTSS policy has significantly increased access to home and community-based services and maintained a relatively constant supply of Medicaid permitted skilled nursing facility beds. Implementation of the permit day program effectively grandfathered in existing facilities and, over the past 25+ years, has limited new skilled nursing facilities' ability to participate in the program. Additional criteria for participation, such as quality of care, patient preference and value purchasing, and a contracting process that does not allow open enrollment for any willing provider have not been incorporated into the contracting process. Consequently, the Medicaid program and its skilled nursing facility eligible beneficiaries are not receiving the highest value and quality of care for the Medicaid expenditures.

Another unintended consequence of the permit day program is that skilled nursing facility residents who reside in a non-participating facility must relocate to another facility when they outlive their resources and become Medicaid eligible for skilled nursing services. Another transition, which is very detrimental to the residents' health and safety and adversely affects life expectancy, occurs when Medicaid eligible beneficiaries needing skilled nursing post hospitalization are discharged to facilities located far away from their home simply because that facility had permit days. This practice does not maintain the family support system and diminishes the likelihood of a successful transition to the community.

Lastly, this process is even more complicated when the individual is dually eligible for Medicare and Medicaid and exercised his choice of skilled nursing facility services for a Medicare Part A rehabilitation stay in a non-participating facility. If further institutional care is needed following the rehabilitation period, a transfer to a participating facility is required.

South Carolina's Medicaid nursing home permit program is unique among the nation's Medicaid programs. While it has been effectively used to manage program expenditures in the past, it is not compatible with today's changes in the health care financing and delivery systems and hinders the state's policy goal of increasing the availability of quality LTSS.

3. SC Department of Health and Human Services (SC DHHS) policy re: skilled nursing facility participation in Healthy Connections Prime

SC DHHS staff is considering policy options regarding MCO's enrollment of skilled nursing facilities. Members of Leading Age South Carolina support the following policy options:

- a) contract with any willing provider,
- b) all plans offer contracts to all SNF's regardless of the SNF's current Medicaid participation status, and
- c) continuation of existing DHHS policy that enables MCO's to contract with any willing SNF provider.

4. What about the "woodwork" effect?

The current permit day program has successfully orchestrated nursing facility expenditures for a number of years, including a recent year in which the permit program was used to reduce

nursing facility expenditures. There is a fear that implementation of any change in the permit day program would expose the SC DHHS Medicaid program to potential loss of control of the nursing home line expenditures.

There are a number of factors that do not support the existence of a potential nursing home backlog:

- First, no one wants to enter as skilled nursing facility unless they are convinced that this service is needed to meet their care needs.
- Second, SC DHHS/CLTC staff will continue to have responsibility for determining medical necessity for skilled nursing facility services under all Medicaid programs – regular Medicaid (fee for service), MCO - Medicaid Only, and MCO – Healthy Connections Prime. There is no indication that this process will change in the future.
- There are years of experience in pre-admission screening and care plan development in the CLTC data base. With these data and a slight modification of the level of care criteria, the CLTC screeners could develop recommended placement options, i.e. CLTC or SNF, to the applicant and their family.
- Fourth, the CLTC nursing home waiting list has been at all-time low numbers in recent years. This low number has been primarily the result of greatly increased availability of CLTC slots.
- Lastly, MCO's will be incentivized to utilize community-based long term care options to maintain their members in community-settings. However, it is possible that MCO's may influence their institutionalized member to move inappropriately to a non-institutional setting that jeopardizes their care and safety. Occurrences of this event should be evaluated by the Medicaid agency.

5. Compression of Morbidity

A recent National Institute of Aging funded study has reported evidence for significant compression of morbidity in the elderly population. This study evaluated 20 years' of data and found that disability has been compressed into the period just prior to death. Disability-free life expectancy rose, and disability life expectancy declined. Additionally, disease-free survival increased and survival with a major disease increased as well. The impact of these findings on future expenditures for skilled nursing services would be a) a shorter length of stay for individuals who utilize long term care supports and service and b) a potential decrease in the percentage of older persons who are admitted to a skilled nursing facility.



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