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Managed Care: *Preparing for Change*

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Today's Discussion

- Health care sector repositioning for health care reform
  - Health Systems
  - Physicians
  - Health Plans
  - New Entrants
- The Four Knows of Contracting
- New Delivery and Payment Models

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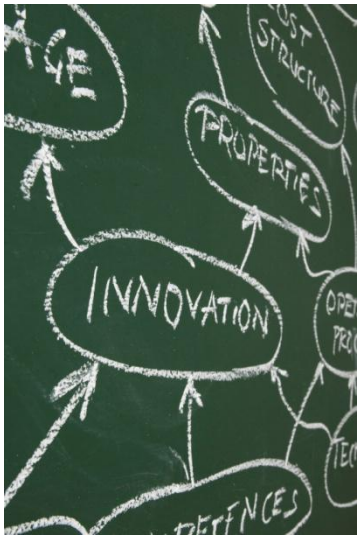
Health Provider Strategies

- Hospital/Physician Integration
- Collaborations w/ new partners – payers, vendors, post-acute providers etc.
- Ascension Health Venture Capital Firm
- Joint venture between University of Pittsburgh Medical Center's health plan and the Advisory Board to provide ACO technology and outsourcing services.
- Post-acute providers creating a seamless care continuum – Kindred, Genesis, LifeCare, Select, etc. Developing exclusive contracts to serve as PAC providers in selected markets.
- Implementation of Lean, Six Sigma and other cost efficiencies
- Advocate Health System in Chicago offers training for care integration and total cost of care management
- 980 Health Care Mergers in 2011 valued at $227B



Source: ACO service industry blooms - Healthcare business news and research | Modern Healthcare http://www.modernhealthcare.com/article/20111114/MAGAZINE/311149948#ixzz1k9bSVgZk ?trk=tynt

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Payer Strategies

- Many of the large insurance carriers have developed ACO divisions to serve as the administrative agent or a partner in ACOs as they develop.
- Insurance companies are merging and affiliating w/ both providers and other insurance carriers.
- Total Cost of Care Plans are being developed for younger health insurance beneficiaries across the country at a rate faster than ACOs
- Aetna and Genesis developed a national acute readmissions reduction program.
- UnitedHealth established OptumHealth as their provider division. It has $500B in sales or 6% of market expecting to grow to 9%. United operates physicians clinics in Florida, California, Arizona, Texas and Nevada and recently purchased Inspirus, a case management company operating in 39 states, a physician practice EHR and is developing a group practice management organization. They also have developed partnerships with physicians to provide ACOs.

Read more: Marriage of convenience - Healthcare business news and research | Modern Healthcare
http://www.modernhealthcare.com/article/20120102/MAGAZINE/301029918#ixzz1k9RpiGRX

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Performance Measurement in New Payment Models

Health Care reform and market changes are creating many new payment models, many of which require payments based on performance:

1. Accountable Care Act – ***Shared Savings***
2. Private Payers – ***Total Cost of Care*** contracts, Alternative Quality Payment contracts, etc.
3. Bundled Payments - ***Episodic Payments*** including payment incentives
4. ***Value Based Reimbursement***
5. ***Penalties/Payment Reductions*** based on performance
6. ***Managed Medicaid Long Term Care*** models
7. Others

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Potential Vulnerabilities

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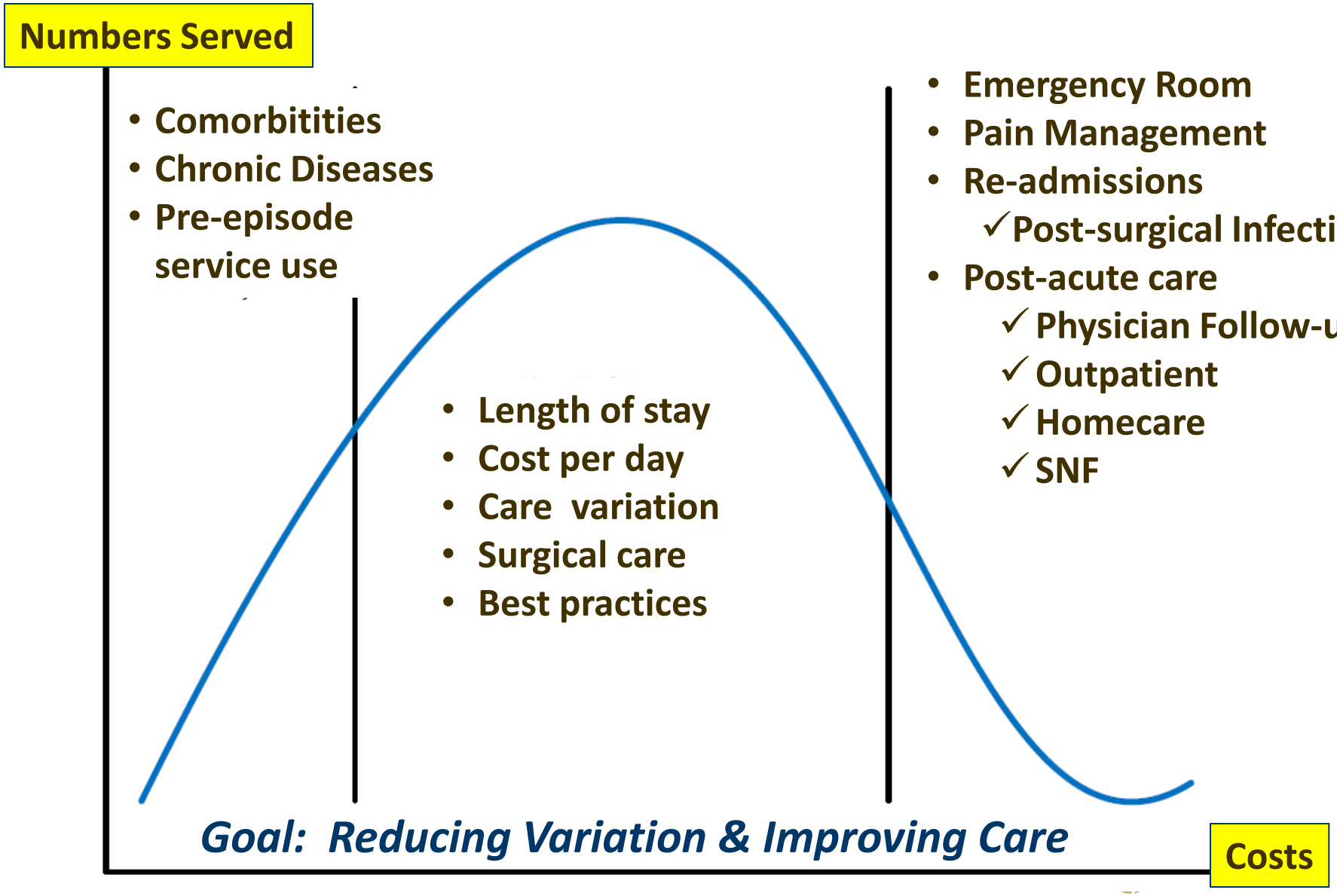

Keys to Success

These key success factors have not changed:

1. Volume
2. Marketshare
3. Strong, diverse referral network
4. Low cost, high quality provider
5. High customer satisfaction
6. Strong, positive reputation

New changes:

1. New performance metrics
2. Specialty services
3. Physician engagement and leadership
4. Incorporating health preservation and recovery into senior living
5. Relationship cultivation
6. Negotiation skills

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Contracting

In a Managed Care Environment

Contracting Stages

Early stage:

- Non-negotiable, uniform contract for post-acute
- Treated as commodity, limited distinctions between organizations
- Complete patient choice
- Price management

Mid-stage:

- Selected contracting terms – bonuses for performance metrics
- Some efforts to steer customers

Later stage:

- Partner with selected providers
- Increased focus on quality and continuum
- Increased care management
- Recognition of creating win/win

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The Four Knows of Contracting

1. Know the Rules

2. Know What the MCOs Need/Want?

3. Provider Know Thyself

4. Know your Contracting Strategy Options

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1. Know the Rules

- What does the state proposal to CMS for managed care for duals say?
- What does the State's Request for Proposal to the Managed Care Organizations say?
  - http://www.state.nj.us/humanservices/providers/grants/rfprfi/RFPfiles/Medicaid%20Managed%20Care%20Organization%20Application%2020122014.pdf
- What other information is available from the State agency administering the program about the program?

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1. Know the Rules: Program Basics

- When does the program start? Is it phased-in? If so, how/where?
- Who is the target population?
  - Medicaid only, full duals, certain geographies or diagnoses
- What are the target conditions (e.g., diabetes, COPD, CHF)?
- What are the requirements? How will the program work?
  - e.g., care coordination, medical home, risk assessments, etc.
- What are the state goals (e.g., reduce hospitalizations, reduce costs, etc.)?

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1. Know the Rules: Program Basics – NJ Section 1115 Demonstration

- Goals
  - Consolidate NJ Medicaid and CHIP under a single waiver authority
  - Promote increased utilization of HCBS for individuals in need of long-term care
  - Integrate primary, acute and long-term care as well as behavioral health for some populations
  - Promote efficient and value-added health care through health homes and ACOs
  - Provide flexibility in administration of the program to implement management efficiencies and purchasing strategies
  - Enhance access to community-based mental health and addiction services

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1. Know the Rules: Program Basics – NJ Section 1115 Demonstration

- Implement Date: October 1, 2012
  - 5-year demonstration until June 30, 2017
- Enrollment
  - Target Population: Individuals eligible for benefits under New Jersey's Medicaid Program
  - Targeted Percentage: 98%
  - Approximate Beneficiaries: 1.3 Million

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1. Know the Rules: Program Basics – NJ Section 1115 Demonstration

- Eligibility
  - Prior populations eligible for Medicaid and CHIP
  - Includes populations under the prior CHIP and childless adult demonstrations
  - Four previous 1915(c) waiver programs
  - Two previous 1915(b) waiver programs
  - Individuals eligible for both Medicare and Medicaid (duals) are covered under the demonstration for Medicaid services
  - Certain optional and expanded groups

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1. Know the Rules - Network & Contracting Requirements

- Distance/Access requirements: What are the state requirements around beneficiary access to providers by provider type ?
  - e.g. LTC providers cannot be more than 20 miles away in urban settings, 60 miles or less in rural
- By what date, must MCOs demonstrate they have a sufficient network of providers? (component of state readiness review of the plans)
- Must MCOs contract with all Medicaid providers for the initial contracting period?

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1. Know the Rules - Reimbursement

- Did the state set a rate floor or can MCOs negotiate any rate with providers?
- Must MCOs consider alternative payment models beyond FFS?
- Are MCOs required to share any of their payment incentives with providers?

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1. Know the Rules - Metrics

- What performance and/or quality metrics are the MCOs held accountable for by the state?
- Which ones are tied to incentive payments, if any?
- What metrics are the state tracking via claims or requiring to be reported by MCOs and/or providers as part of the program?

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1. Know the Rules: Metrics - Quality Measures

- ***Delivery System I*** – Managed Care Requirements

- ***Delivery System II*** – Additional Delivery System Requirements for HCBS and MLTSS

- ***Delivery System III*** – Behavioral Health

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2. Know the MCOs or Plans: What do they want?

They want what any accountable, financially at-risk organization wants, to:

- **Meet their contractual obligations**
  - Provider network adequacy
  - Compliance with state contractual requirements (e.g. claims paid within prescribed time, care coordination, appeals process)
  - Perform on designated quality metrics tied to P4P incentive payments
- **Access to right care at the right place at the right time for their members**
- **Standard contracts with providers**

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2. Know the MCOs or Plans

- **Spend less on beneficiaries' health care costs than they receive from the state = Make a Profit**
  - **This is achieved by:**
    - ◊ Ensuring members get right care at the right time
    - ◊ Care management/coordination/preventive care
    - ◊ Interdisciplinary care teams
    - ◊ Redesigning care
    - ◊ Substituting lower cost care when it can achieve good patient outcomes
    - ◊ Avoiding higher cost care (e.g., hospitalizations)

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2. Know the MCOs or Plans

- What does their standard contract say?
- Do they pay on time?
- Will they help educate your office staff?
- What do other providers think of them?
- Is there a merger in the works?
- Are they financially stable?
- Can they use your name in their advertisements?

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2. Know What Plans Need/Want - Contract Terms

- Plans, typically, must meet current Medicaid requirements for access to providers
- Review contract terms carefully
  - All terms are negotiable, but need strong argument for higher reimbursement / change to terms
  - Don't check MedicareAdvantage box unless you know rates
    - ◊ Negotiate separately or as part of an alternative payment arrangement
  - "Lessor there of" clause – watch for this
  - Pay attention to definitions
    - ◊ related to qualifying for certain levels of payment

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2. Know What Plans Need/Want - Contract Terms

- If MCOs want a year of performance before establishing benchmarks and performance payments, make sure the following terms allow for this type of modification within the 3-year contract.
  - Who to negotiate the metrics and payments
  - What is the timing of those discussions?
  - Performance or incentive payments should be made on a sliding scale vs. all or none, with greater payout for achieving more benchmarks
  - Year 1 provider metrics could be process measures like the plans have

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2. Know What Plans Need/Want - Contract Terms

- **Medical necessity:** who determines it? Where are the criteria posted?
- What is the contract **term**? Is there an automatic renewal provision or annual rate negotiations?
- What are the **termination** provisions?
- What is the process for determining patient **eligibility for services**? (E.g., web, telephone)

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2. Know the MCOs or Plans - Contract Terms

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- Does the plan require **other information** beyond that submitted on a clean CMS1500 or UB92?
- Who is responsible for **coordination of benefits** – the plan or the providers?
- What are the **dispute resolution** provisions/ process?
- **What services can be billed to plan enrollees** (e.g. non-covered services, co-pays, deductibles)?

2. Know the MCOs or Plans

- Are there any pending litigations with other providers?
- Ask other providers about the MCOs level of service and satisfaction

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3. Provider Know Thyself

- What populations do you serve?
  - Chronic Conditions
  - Acuity
  - Geographies
- What services do you provide today?
- What other services are you willing to provide or populations would you serve, if reimbursed?

"Tell them your story"

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3. Provider Know Thyself

- What is your quality?
  - Performance
  - Dashboards
- What is your model of care?
  - Person-centered, social model, medical model
  - Best practices
  - Specialties
  - Staffing model

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4. Know Your Options - Contracting Strategies

- **Be vocal and proactive**
- **Read the MCO/State contract so you know your rights and the MCOs obligations**
- **Bring your own statistics about your organization and be prepared to discuss your value proposition**

Where do you have leverage?

•**Network:** Are you the only provider in a given geography? Do they need you to meet network adequacy?

•**Quality:** Do you have the highest quality or value in comparison to others?

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4. Know Your Options - Contracting Strategies

- **Don't be defensive.**
  - Talk about desire to "partner"
  - The MCOs want to make a profit but remind them they need you to be solvent too.
  - Plans will contract with the easiest organizations and those that can deliver the greatest volume first.
- **Be Part of the Solution**
  - Who are the MCOs problem cases? Situations? (e.g., clinically complex patients, care coordination, etc.)
  - Consider approaching the plans' foundations for grants to pilot certain services or care delivery redesigns

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4. Know Your Options - Contracting Strategies

- **Alternative Reimbursement Models** ***(to enhance your Medicaid reimbursement)***
  1. **Pay for Performance** (sliding scale vs. all or nothing)
  2. **Bundled payments**
  3. **PMPM arrangement**
  4. **Shared savings**

- **Propose alternative rates or additional services for which you can be reimbursed**

Escalate: If your contracting contact cannot approve alternate arrangements or language, talk to their Director or in certain circumstances talk to plan CEO/COO for your state.

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4. Know Your Options - Contracting Strategies

- **Rural vs. Urban**
  - Know the geographic limits / access standards of the plan
  - Leverage the situation

- **Being Part of the Solution**
  - Who are the MCOs problem cases? Situations?
  - Consider approaching the plans' foundations for grants to pilot certain services or care delivery redesigns

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4. Know Your Options - Contracting Strategies

- **What are the consequences if you don't sign a contract?**
  - What are your key referral sources and physicians doing? Are they contracting?
  - Are you required to contract with MCOs by the state?
  - Would you have to accept a lower FFS rate?
  - Would you lose referrals?

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Contracting Tactics

- **Understand current performance metrics** compared to community, particularly the costs to payer
- **Determine if terms of contract are acceptable**
  - If not, negotiate per referral
- **Sign contract**
  - Reduce operating costs
  - Increase the admissions screening processes
  - Attempt to negotiate add-on for special circumstances
  - Look for volume increases from other non-Medicare/Medicaid Managed Care clients (private pay beneficiaries and Medicare FFS)
  - Seek bonus payments for assisting payer in meeting their performance targets, i.e., readmissions, ER use, vaccinations, screening tests, etc.
- Using relationships with physicians and/or health systems **apply pressure for favorable contract terms**
- Using relationships w/ customers to **influence choice of payer**

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Current Performance Measurement – Health Plans

1. Medicare Advantage – 50 metrics – 5 Stars – Up to 5% bonus based on:
   - Customer service on responsiveness
   - Prevention services and vaccinations
   - Health outcomes
   - Complaints, appeals and voluntary disenrollment
   - Call center patient satisfaction
   - Managing chronic care
2. Private Health Plans – Negotiated Separately
3. Managed Medicaid – similar to Medicare Advantage – State insurance regulations may define payment options

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Managed Care Contracting Tips

For the Negotiation and Contract

Bring to Negotiation

- Your Value Proposition
  - Describe your organization and its non-profit value
  - Demonstrate Your Quality
    - ◊ Dashboards with performance metrics
- Your Questions
  - Ask what they are trying to achieve and how your organization might be able to help.

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Additional Managed Care Contracting Tips - "Page One" Issues

- **Caption**
  - Correct entity names-make sure both parties names are legally correct.
  - Effective date
- **Recitals**
  - High-level description of the purpose of the agreement
  - Courts may look to the recitals for context and the parties' in the event disputed terms are ambiguous
  - Incorporation into the agreement

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Managed Care Contracting Tips - Definitions

- **Plans, Payors and/or Clients**. Ensure these terms are not defined overly broad to avoid inadvertently agreeing to discounted rates for services furnished to broader scope of individuals than you intended.

- **Covered Services**. Your principal obligation under the agreement is to furnish "Covered Services" to the Plan's members. Ensure this term is carefully defined in light of the full scope of services you intend to provide and for which you expect to be paid. Where possible, consider listing and defining each service by developing a separate schedule.

- **Medical Necessity**. Ensure that the definition of "medical necessity" does not give the Plan the sole authority to determine what is medically necessary. Instead, the definition should rely upon the clinical judgment of the Provider and/or community standards.

- **Standard of Care**. Avoid provisions that impose a duty on you to furnish the "highest" or "best" quality of care. These types of provisions can enable Plans to prevail more easily in a breach of contract action, and they might give an easier path in medical malpractice claims.

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Managed Care Contracting Tips – Your Obligations

- **Delivery of Services**. Ensure that you not only know the scope of covered services under the contract but also any terms and conditions regarding the delivery of those services (e.g., prior authorization requirements, qualifications of the caregiver, etc.)
- **Records Requirements**.
  - Does the contract impose records maintenance and/or retention obligations that differ from your standard practices?
  - Consider negotiating a general provision stating that Provider must retain patient records for the period prescribed by applicable state and federal law.

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Managed Care Contracting Tips – Your Obligations *(continued)*

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- **Policies and Procedures**.
  - Watch for provisions that are incorporated by reference such as the Plan's policies, guidelines or other standards. Obtain copies of any such documents before executing the contract.
  - Ensure that the contract does not permit the Plan to change those standards and enforce them under the contract without advance notice to you.
  - Ensure that you are aware whether the contract or the standards govern in the event of a conflict between the two.
- **Audits.**
  - Carefully review the Plan's rights to conduct audits and who pays for the audit.
  - Does the contract allow the Plan to use statistical methods to project alleged over-payments?
  - What is the look-back period for audits?

Managed Care Contracting Tips – Your Obligations *(continued)*

- **Utilization Management**
  - Understand who at the Plan performs utilization management (e.g., qualified clinicians).
  - Understand how member eligibility is verified.
  - Understand how much time the Plan has to respond to prior authorization requests.
  - Know your appeal rights in the event you disagree with a Plan decision.

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Managed Care Contracting Tips –Claims Payment

- **Time Period and Process for Submitting Claims**. Compare to your standard practices and consider negotiating "special circumstances" provisions to permit you additional time in certain situations.
- **Who is Responsible for Paying** You and What is the Timeframe?
- **Nonpayment.** In addition to the right to terminate, the Provider would desire the right to suspend services and impose penalty fees in the event of non-payment by the Payor (or other entity responsible for payment).
- **Retroactive Denial of Claims**. Consider negotiating provisions that prohibit the Plan from retroactively denying claims that were positively adjudicated absent fault or fraud of the Provider. Consider also negotiating cut-offs for any look-back time periods.

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Managed Care Contracting Tips – Term/Termination

- **Contract Duration.** Ensure that it is clear. Future rate uncertainties might suggest a longer term.

- **"Without Cause" Termination**. Carefully review the terms of the proposed contract. Consider negotiating a mutual right to terminate without cause with reasonable advance notice periods and clear requirements for submission of prior claims post-termination.

- **For Cause Termination**. Consider including a cure period for any alleged "for cause" termination reason. For cause termination can have collateral impact for providers in certain situations, and therefore providers should ensure that the standards are clear.

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THE HOT POINTS

- Certification/Credentialing
- Case Management Coordination
- Audits/Overpayments
- Manuals and unilateral amendments
- Dispute resolution
- Encounter Data

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Hot Point: Certification/Credentialing

- **Licensure**-Why isn't licensure/Medicare/ Medicaid enough
- **Checklist-**ask for requirements
- **Time limit to make determination**-can take up to 6 months for approval once submitted
- **Provisional credentialing**-ask for "provisional" status so claims can be processed for payment while process for full credentials approval is pending.

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Certification/Credentialing: What is generally required?

- **Licensure -**State and Medicare/Medicaid provider information
- **Accreditation-** JC, CARF, CHAP, CCAC etc.
- **Survey History-** State and Federal
- **Language competencies**
- **Verification of credentialing-** staff both Internal and Outsourced
- **Insurance certificates**
- **Attestations-** Malpractice and other negative events
- **Site Visits** – generally for nonaccredited facilities

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Hot Point:
MANUALS AND UNILATERAL AMENDMENT

- **Manuals:** Read the manuals for utilization criteria, authorization guidelines, quality measures, etc.
- The manual is the contract
- **Unilateral Amendments:** Look for negative notice provisions that require you to notify the MCO to opt out of future amendments to the agreement.
- **Incorporation of other contracts**, such as the state contract and other product lines

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Hot Point: Dispute Resolution

- Each MCO is different
- **Purpose:** To avoid going to court
- **Beware of contracts** that permit the MCO contract manager to make the final determination
- Make sure you **retain the right to go to court,** if the process fails you.

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Hot Point: Encounter Data/Reports

- Know **what is required**
- **Request your data-** You have the right to request your data and peer or other comparisons
- **Reimbursement-** How are they are going to use your data for the pricing mechanisms to be discussed
- **Reports**- Request the reports/ know your contractual rights to copies

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Quality Care Initiatives

- **Evolving concept -**will be the "guise" for cost control.
- **Buzz words** – "Benchmarks" and "Outcomes"
- **Don't allow vagueness** – Know exactly what metrics are being measured
- **Be wary** of this being the basis for "medical necessity"
- **Benefit creep** – MCO pushing down State requirements

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Penalties

- Mostly a creature of the State Contract and law
- Pass through by the MCO
- Indemnification of MCO for penalties they receive.
- Can include attorney's fees and investigative costs of the government agency

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Electronic Health Records

- **Cost item:** MCO may require your EHR be compatible with their system
- **Disparate systems:** Is there a mandate in the program for use of EHR and interoperability?
- **Security concerns:** Whole new level of HIPAA concerns
- **Stealth Audits:** Review of electronic records for compliance

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How do you Contract for what you want

- **Addendums:** MCO Contracts will have required provisions that must comply with State requirements. However, in order to add or modify contract provisions, prepare an addendum that reflects your desired changes to be incorporated as part of the Agreement.
- **Read the Manuals:** They are part of what you have agreed to via the Agreement
- **Know the State Contract** so you are knowledgeable of what is required or not required
- **Develop a relationship-** with your contract provider representative as they can provide assistance and make the relationship a win-win for all.

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New Organizational and Program Models

New Market Entrants

1. Walgreen's now has a number of ACOs starting in 2013. They also have developed partnerships with hospitals to provide post-acute pharmacy monitoring, medication delivery, etc. for discharging patients.
2. Remedy Partners, Inc., an NY based company, and NaviCare, Inc are acting as conveners for providers participating in the Model 2 & Model 3 Bundled Payment programs
3. Wal-Mart is expected to expand their primary care offerings.
4. The pharmacy field has developed a predictive modeling tool using current medication use and adherence to prescribing regime to predict future health care use. This is expected to lead to a larger role of pharmacy companies in the development of ACOs and other new incentive based payment models

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New Models

- New revenues & programs
  - Retail medicine
- Technology enhanced site of care alternatives
- Community ACOs
- Health, Wellness and Prevention
- Predictive modeling to change utilization
- Physician engagement at post-acute
- Peri-acute programs
- Partnership potentials for innovation
  - Wal-Mart
  - Walgreen's
  - Other

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Ascension Health – Transformational Development

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Transformation at the Core

1. ***Creating Opportunities*** - Ascension Venture Capital Fund
2. ***Leveraging Opportunities*** - tapping Into the Ascension Health Community
3. ***Developing Opportunities*** – partnering to create *Open Innovation* and targeting specific industries/vendors for engagement
4. ***Identifying Opportunities*** – established a system to collect and process innovative technologies, models of care and ways of applying old ideas in new ways

Nations First Virtual Care Center *

- Mercy, headquartered in Chesterfield, MO announced plans for a $90 million center that will be linked to hospitals, clinics and even patients homes.

- Mercy serves:
  - 3+ Million patients annually
  - 30 hospitals
  - 200+ outpatient facilities
  - Missouri, Arkansas, Kansas, Oklahoma

- VCC intended to be “home” to a number of telehealth initiatives and link existing programs:
  - Safewatch: ICU monitoring of 400 ICU beds in 10 hospitals over 4 state area
  - Telestroke Program: Neurologists on-call 24/7 via telemedicine from across the country

- Remote Disease Management: Patients connected via home based technologies to monitor weight, blood pressure, blood glucose, EKGs, and more.

*Source: Mercy press release dated October 13, 2011 accessed via the web at http://www.mercy.net/sites/default/files/files/download-media-release-pdf-4739.pdf

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Carondelet Village Community

- Started with legislative innovation grant. A three year pilot to integrate care and community.
- 14 partners – physicians, home care, health plans, health systems, home care, health researchers and community based providers.
- Serves clients on the campus and within five to seven mile radius. Requires a referral & enrollment.
- Annual report due to MN Legislature with evaluation and ability to replicate.
- Potential Metrics:
  - Rehospitalizations
  - Acute Care hospitalizations
  - Medications

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Communities Without Walls - Friends Life Care at Home (PA and DE)

Using the Continuing Care Retirement Community Without Walls model – Offers a choice of coverage or programs in the home**. Offers members a predetermined set of benefits** that accrues over a period of time. Unused benefits can be utilized in the future. Program is **flexible and works if a member relocates to another part of the country**. **Care coordinators are a key element** to coordinate member services including:

- Care Coordination
- In-home care & services
- Emergency Response Service
- Telehealth
- Nutritional Support
- Adult Day Care
- Periodic Home Safety Review
- Travel and Social Activities
- Wellness & Prevention Services
- Home inspections
- Annual physical Exams
- Meals – in-home and central location

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Center for Self-Management (Henry Ford Heath System)

- Co-located with Home Care offices, ambulatory therapies and diagnostic testing
- Managed by Home Care
- Designed for post-acute and chronic care management and those seeking a “higher” health status
- Designed to integrate technology, personal health records, patient teaching and counseling and professional consultation – virtual or in-person
- Includes wide range of health services and applications

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Time Banking – Extending Support & Services

“Time banking” is a pattern of reciprocal service exchange that uses units of time as currency. Essentially, the "time" one spends providing services earns "time" that one can spend to receive services.” (Source: Wikipedia)

- VNS of NY manages an extensive “TimeBanking” program on behalf of their Special Needs managed care program.
- Time banking began in US with Social HMOs and were discontinued as the Social HMOs dissolved or changed funding mechanisms but is resurfacing as a tool to help support family caregivers.

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Personal Health Technology System

- Integration of telehealth w/ preventative technology, self-management applications and communications with health care team
  - HealthSense
  - IPhone/IPad type applications
  - Social Networking
  - Visual communications
  - E-communications

- Business model that supports personal health technology – white coat support

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Questions / Discussion

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THANK YOU!

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For more information on health care reform, go to CliftonLarsonAllen's Health Care Reform Center at:

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