Seven Lessons Learned for Future Success with Managed Care

LeadingAge New York
Saratoga Springs, NY
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A National Perspective

Overview

- National perspective on health plans, managed care, Medicare Advantage, Medicaid and the duals
- Managed care pressing into post-acute and long-term care and global impacts
- Seven lessons learned about succeeding with managed care
- Candid advice from the front line
Private Health Plan Enrollment Has Tripled in 10 Years

Nationally, 50 to 80 million lives are expected to be “on the move” due to reform.

Principal shifts nationally among major coverage categories:

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NOTE: Includes MAEs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans.


Flows do not include population growth.

Based on 300 million cell MPACT predictive coverage model which estimates flow of member lives at the county level.

In the scenario shown, 65 million individuals will change coverage.

Other scenarios show a range of 50 to 80 million individuals who will change coverage.
Medicare Advantage Varies But Is Expanding

NOTE: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans. SOURCE: MPR/Kaiser Family Foundation analysis of CMS State/County Market Penetration Files. 2014.

Medicare Advantage by County is More Telling

Source: CMS.gov; Prepared By: Josh Tapley, DataInk.com
Opinions Mixed about the Future of Medicare Advantage

Interestingly, the majority of MA growth in recent years has been beneficiaries switching out of the traditional Medicare program, rather than newly eligibles.

A recent study confirmed that beneficiaries in their mid- to late-60s made up the largest share of those who switched from traditional Medicare to Medicare Advantage.

Source: Health Affairs/KHN – January 2015
Medicaid Expansion Thinking

NOTES: Under discussion indicates executive activity supporting adoption of the Medicaid expansion. **WI has passed legislation adopting the expansion; it requires federal waiver approval. *AR, IA, IN, MI, PA, and NH have approved Section 1115 waivers. Coverage under the PA waiver went into effect 1/1/15, but it is transitioning coverage to a state plan amendment. Coverage under the IN waiver went into effect 2/2/15. HI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.


Dual Eligible Programs – A Haphazard Start

NOTES: *CO, CT, IA, MO, and NC proposed managed FTS models. NY, OK, and WA proposed both capitalized and managed FTS models; WA received approval for both demonstrations, but subsequently withdrew its capitalized model. NY withdraws its managed FTS proposal. All other states proposed capitalized models.

Dual Eligible Initiatives: The Unexpected Challenge

- Some plans and officials are concerned about the potential results of the duals demonstration and do not expect the cost savings originally expected.
- Of 1.7 million targeted duals in 11 states, only 343,330 have signed up as of April 1, 2015 (just over 20%).
- Opt-out provisions are the driving force and have created tremendous challenges in some states – California and Virginia have seen opt-out rates greater than 50%.
  - Some healthcare providers have told dual-eligible patients they will stop serving them if they enroll.
  - Plans have also reported trouble locating and contacting passively-enrolled beneficiaries who did not opt out and must receive an initial medical assessment to create a care plan.

Evolving Healthcare Economics

<table>
<thead>
<tr>
<th>Reality</th>
<th>Choice</th>
<th>Strategy</th>
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<tbody>
<tr>
<td>Health Services 2.5% Margin</td>
<td>Bigger</td>
<td>Integration</td>
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<tr>
<td>Goal</td>
<td>Dose</td>
<td>Reduce Cost Profile</td>
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<td>(Units and Price)</td>
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Consumer Purchasing Behavior

Value at What Cost
Health Systems moving into the Insurance Arena
20 percent of Health Systems will become Payers by 2018

- As of August 2013, 34 percent of the 100 hospitals and health systems surveyed indicated that owned health plans
  - 21 percent of hospital and health systems indicated that they plan to launch health plan

Source: HealthLeaders Media
Managed Care Presses Deeper into Post-Acute and Long-Term Care

What Does Managed Care Manage?

The Uncertain Cost of Tomorrow’s Health Care: A Set Price Today (aka RISK)

When payors hold the risk, they use three levers to manage it:

- **Medical Cost**
  - Benefits: • Coverages • Limits • Cost sharing • Incentives to shape consumption
  - Price: • Unit cost of a service • Negotiated rate • Payment terms
  - Volume: • Authorizations • Guidelines • Medical necessity • Severity of illness, intensity of service

WANT LESS | PAY LESS | USE LESS
Managed Care’s Broad Impact to PAC/LTC

- As managed care presses deeper into post-acute and long-term care, we can expect four fundamental changes:
  1. Shorter lengths of stay driven by increased oversight or involvement from MCO case managers and navigators
  2. Steady shifts away from traditional, fee-for-service per diem payment towards bundles, gainsharing and shared saving arrangements and inevitably capitation
  3. Further narrowing of provider networks, emphasizing quality performance and patient outcomes
  4. Decreasing volume of traditional Medicaid LTC population, given MCOs favoring home and community-based services

MCOs Exploring Post-Acute Networks…

The Narrow, Preferred Provider, or “Premier” Network

- The idea of networks is hardly new but has recently exploded for post acute services and SNFs in particular
- ACOs, regional health systems and MCOs have taken several approaches in constructing and creating networks – some better than others
- Forward-looking organizations are emphasizing partnerships with and among post-acute providers, rather than just a credentialed or vetted list of facilities
- Acute/post-acute integration, metrics, and care redesign are fundamental
The Rise of Third-Party Servicers…

- Post-acute management solutions, provided by a third-party, contracted to a Medicare Advantage plan
  - Typically involves patient assessment, navigation and care management before acute discharge, through post-acute stay
  - Assessment process drives care plan development, derived from deep data across a range of health conditions
  - Commonly results in improved post-acute LOS (25-40% shorter) and better outcomes (readmits down 15-20%)

Seven Lessons Learned
Change Your Paradigm

Think Different

Seven Lessons for PAC/LTC and Managed Care

- Managed care penetration into PAC/LTC represents a fundamental shift in thinking – about operations, clinical practice, financial management, and RISK.

- The multiple contract, multiple payer, and multiple expectation future is rapidly becoming reality.
#1: The “Us vs. Them” Mentality

- Adversarial relationships have become “the norm” between payors and providers
- Educating one another, finding solutions, and improving will take both sides working together
- And if you want to grow business, you’re going to have to work together
- This isn’t a battle. The payor isn’t the enemy

Let it go.

#2: Understand Your Outcomes & Your Value

- No surprise – data drives everything, and your outcomes are the foundation of your value for all payers:
  - Length of stay
  - Functional outcomes/improvement
  - Patient satisfaction
  - Admissions and readmission rates
  - Infection and fall rates
  - Five-star ratings
  - Survey and inspection results
  - EHR adoption and use

- But data outside a comparative setting is meaningless – so how do you compare to benchmarks and other providers?
Hallmarks of the Partner of Choice

- Low/near zero hospital readmissions
- High patient satisfaction (>90%)
- Innovative care delivery approaches, either via technology or advanced skillset
- Robust continuous quality improvement with documented results (i.e., what is your model?)
- Cost of care is lowest in comparison to peers with comparable or better quality
- Demonstrated person-centered approaches to care and management of transitions
- Meaningful use of EHR and level of interoperability

Creating Your Value Proposition in Context

In Three Broad Parts:

1. Understanding the environment, challenges, and issues – “the value gap” – what does THIS payer need?
   - At-risk payment environments/penalties
   - Quality challenges / cost management

2. Demonstration/evidence of solution – your solution for THAT payer
   - Measurable outcomes – quality, process, cost
   - Service/continuum offerings – settings and skills, niche/distinctions
   - Future planning/intentions – how preparing for the next gap and future

3. Working Together - matching solutions to problems
   - Transactional and strategic suggestions – programmatic specifics, pilots of demonstration efforts
   - Network participation – being a premier provider or engaging as such
   - Taking risk via partial or full arrangements, bundles, quality bonuses
#3: Remember What’s Important: The Beneficiary

- Managed care plans must also meet certain quality expectations with whom they contract (i.e., CMS, states, etc.) – Medicare Advantage plans have their own five-star rating system
- Beneficiary satisfaction is an important measure for plans
  - Dissatisfied beneficiaries will score them poorly, or worse, dis-enroll towards another plan or return to FFS
- Focusing on beneficiary satisfaction and experience of care in post-acute should be always be top of mind while interacting with MCOs

Three Things to Consider about Beneficiary Experience

1. **Programmatic Offerings**

2. **Physical Aesthetics**
   - Age of plant, all private rooms, dedicated units, in-suite amenities, concierge services, valet parking, a la carte dining

3. **Customer Service**
   - Hospitality oriented culture that is consistent across the organization, service recovery, after-the-sale

*Experience and environment of care plays an important role in characterizing your value to a plan and beneficiaries – but it’s only one dimension of your broader value*
#4: Learn How to Negotiate

- Negotiation – like selling – is a skill that requires training and time to develop via repeated practice
- Unfortunately, it is often NOT a core skill for most post-acute and long-term care organizations
- Specific professional development around negotiation will be essential, especially when it comes to innovative payment arrangement or breaking outside the mold
- Get busy learning, or get busy dying

Some Suggestions about Negotiation

- Do your homework before you start
- Don’t be afraid to ask for what you want
- Aim high and expect the best result
- Don’t be in a hurry
- Talk less and listen more
- Focus on the other guy’s issue and show how your organization meets their need
- Don’t take the first thing offered
- Don’t give away anything without getting something in return
Homework and HEDIS Both Start with H

- HEDIS (Healthcare Effectiveness and Data Information Set) is used by nearly all health plans to measure performance on important dimensions of care and service.
  - Measures are specifically defined, making it possible to compare the performance of health plans on an "apples-to-apples" basis
  - Plans also use HEDIS results to see where they need to focus their improvement efforts
- Reviewing HEDIS data as part of your homework can offer insight into where plans struggle and where you might bring value.

Learn more: [http://www.ncqa.org/HEDISQualityMeasurement.aspx](http://www.ncqa.org/HEDISQualityMeasurement.aspx)

Considering the Contract

- Be smart about contracts
- Understand the specific program requirements or expectations – can you meet them?
- Scrutinize level of care definitions and clinical performance expectations
- Beware of single rate arrangements; shifts in acuity can be detrimental
- Will the process or requirements require changes in your standard operating approach?
- Understand opportunities for alternative payment, gain-sharing and shared savings opportunities
#5: Provider, Change Thyself

- Accept that your established operational and clinical service delivery model will likely require revision
- Shifting from The Three Pillars of Payment to a multiple payer environment means managing multiple expectations
- Preparing yourself for change:
  - Perform organizational self-assessment around managed care readiness
  - Identify opportunities for improvement
  - Create an implementation plan
  - Secure the necessary training, support, and education

Focus Areas for Change & Improvement
Developing processes and practices to encompass four key areas:

<table>
<thead>
<tr>
<th>Admissions</th>
<th>Clinical Operations</th>
<th>Discharge Planning</th>
<th>Billing</th>
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<tbody>
<tr>
<td>• Efficient cycle time for accept and approval</td>
<td>• Protocols for concurrent reviews (i.e., nutrition, therapy, nursing)</td>
<td>• Educate/inform prior to admission</td>
<td>• Documentation key to avoid payment and reimbursement issues</td>
</tr>
<tr>
<td>• Consistent protocols for preauthorizations and authorization</td>
<td>• Goal setting, monitoring and interaction with MCO case mgt.</td>
<td>• Pts meeting defined functional goals are acceptable for next level, if safe home</td>
<td>• Aggressively manage claims recovery and appeals</td>
</tr>
<tr>
<td>• Understanding the carve-outs or exclusions</td>
<td>• Addressing expectations around leveling</td>
<td>• Family and patient education key for transition</td>
<td>• Keep MCO billing separate from govt.</td>
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<tr>
<td>• Plan-of-care determinations before admit</td>
<td>• Therapy evaluations</td>
<td>• Strategic relationships with HHA, AL, DME</td>
<td>• Know your contracts</td>
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Managed Care Tools for Success
Standardizing tools and P&P drives efficiency and consistency

- Managed Care Contracting Process & Reference Book
- Pre-Admission Initial Assessment
- Pre-Authorization Process and Checklist
- Benefit Verification Form
- Managed Care Task and Responsibility
- Case Management Initial Assessment Form
- Case Management Policy
- Daily/Weekly Meeting Guidelines and Forms
- Clinical Review Document for Manage Care Patients
- MNS Process
- Billing Documentation Guidelines

#6: Communicate, Communicate, Communicate

- Managed care relationships are like a marriage, so err on the side of over-communication at every opportunity
  - Work to integrate case managers or care coordinators as an integral part of your organization or team
  - When mistakes happen, be upfront about them (on either side)
  - Never pass up an opportunity to share your outcomes (especially if they're good)
  - Beyond on-the-ground MCO staff, maintain a dialog with the contracting officer
#7: Service the Relationship

- Relationships with managed care organizations are just like the relationships you hold with referral sources – they’re worth their weight in gold.
- Don’t expect to form a relationship with the contracting officer 10 minutes before you negotiate.
- You need to establish relationships early on and service them regularly.

Rule #1 about Relationships

It’s not who you know. It’s who knows you.

This is – pretty much – the whole acute and post-acute healthcare world. And it’s important to note: People don’t refer to institutions, they refer to other people.

(People that they know. People that they like.)

All things being equal, people want to do business with their friends.

We buy from people we like.

To be successful with managed care organizations, you don’t need more strategies or quick-fix techniques. You need to become friends.
Candid Advice from the Front Line

Some Provider Thoughts as a Recap

When negotiating with managed care organizations:
- Come prepared with data, including length of stay for all payers and re-hospitalization rates.
- Show them why they can't afford to not work with you.
- If your data is accurate and supports why you are a necessary partner, you will have more leverage to negotiate higher rates -- even if it's down the road a little ways.
- Prove your performance every chance to get. Be actively accountable. Maybe the MCO isn't seeing the whole picture.

Even when the data supports a higher rate:
- They may not be interested. What are you willing to do over the next year to invest in results that they cannot ignore?
- Think about: MD/extender coverage, case management improvement, new services that the MCO needs in particular
- Don't depend on them to provide these kinds of enhancements, and don't apply to them one contract: investments liked this should be good for every payer.
Some Provider Thoughts as a Recap

**Build & Maintain Relationships**
- Approach contracting with a collaborative approach. Build the right relationship with the person that you will sit and negotiate with.

**Know the Facts**
- Get to know what the other is working on for their Star rating or HEDIS measure and figure out what you can use as an easy give to help them out.
- Also try to find out who influences the contract – who decides who is in and out. Case management oftentimes has a huge say at the table.

**Self Analysis**
- The bottom line is know what kind of partner you really are. Know your own data and performance measures.

**Negotiate with Your Head (not Your Heart)**
- Focus on what is really important it could be different for each contract.

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**CHANGE IS GOOD.**

**Don't Wait!**
Stepping into Change
These are the good old days

As our industry changes, so must our business and culture

Questions?
Thank You!

Andy Edeburn, MA
29 North Wacker Drive, Suite 1010
Chicago, IL 60606
(763) 479-9519
aedeburn@thecamdengroup.com