Managed Care – What it Means for Providers?

- Changes in business processes
- Changes in strategy
- Changes in referral and growth (new consumers)
- Changes in cash flows
- Changes in profitability and margins
- Changes in systems and data needs
- Changes in reimbursement models
What is MLTCP?

- The Medicaid Managed Long Term Care Plan (MLTCP) is
  - Designed as an alternative to institutional care
  - Serves frail, long-term care eligible population
  - Covers Medicaid home care and long-term care services

MLTCP Covered Services Include:

| Care Management | Social and Environmental Supports |
| Home Care       | Nursing Home Care               |
| Optometry       | Medical Social Services         |
| Dental Services | Personal Care                   |
| Rehabilitation Therapies | Podiatry                     |
| Audiology       | Non-Emergency Transportation    |
| Respiratory Therapy | Home Delivered Meals          |
| Nutrition       | DME                            |
|                 | Social Day Care                 |
|                 | Prostheses                      |
|                 | Adult Day Care                  |
|                 | **Assisted Living Program** (pending) |

MLTCP Eligibility Requirements

- At least 18-years old
- Eligible for Medicaid
- Live in the service area of the plan
- Eligible for nursing home level of care (based on a skilled nursing assessment)
- In need of community-based, long-term care (CB-LTC) for at least 4 months
- Able to remain safely at home with assistance (for activities like bathing, dressing, walking or preparing food)
- CB-LTC services defined as the following:
  - Personal Care Services
  - Certified Home Health Agency Services
  - Adult Day Care Services
  - Private Duty Nursing Services
How Can you Prepare?

- Financial Readiness
- Operational Readiness
- Managed Care Strategy

Financial Readiness
Understand Your Costs

- Review cost structure
  - Where can you be more efficient without reducing quality?
  - Where can you invest to improve outcomes and quality?
  - Who can you partner with to solve problems and achieve savings (e.g., shared services across providers?)
- Do you have a managed care billing process?
  - What is your average managed care billed to collected time frame?
  - Know your claims and accounts receivable processes

Cost Accounting

- Be prepared to negotiate for services you perform on a more granular level
  - For instance, could you propose a variable fee based on an individual’s needs?
- Can you develop an activity based costing model?
- Be prepared to “price out” services
- MCOs will pay differently by each of their product lines
Billing

- Claim submission timeframes
  - Varies by contract or Line of Business
  - Varies by payer
- Claims submission processes
  - Software/EMR
  - Electronic
  - Paper
- Claims follow up
  - Staffing implications
  - Claims often need to be “worked”

Common Causes of Claim Denials

- Claim missing required information
- Claim billed with invalid information, e.g.:
  - Incorrect Member ID#
  - Incorrect Provider NPI or TIN#
  - Invalid Rev Codes/Diagnosis Codes
- Member not eligible for date of service billed
- Wrong revenue code
- No prior authorization not obtained
- Untimely filing
- Duplicate claim
Operational Readiness

Operational Readiness Assessment

- Admissions & Eligibility
- Case Management
- Record Management Plan/Information Systems
- Quality Assurance
- Marketing
Admissions

- Every patient/member prior to receiving service must receive a form of an authorization
  - Some Plans allow for “deemed” authorized or “retrospective” authorizations
- Collection of complete referral information is key
  - Insurance coverage
  - Clinical admission criteria
- Primary and secondary insurance coverage must be verified by admissions staff, billing staff

Authorization

- All services take place within the context of an authorization process
  - Plans may have slightly different requirements
  - Certain services will require pre-authorization, while others services may involve new criteria around minimum and maximums
- Services must be essential, as opposed to merely beneficial
- Medical necessity principles related to cost-containment and outcomes will be applied to non-medical services
Authorization

• Managed care concepts such as “the most appropriate and cost-efficient care in the appropriate setting” are being applied to a greater degree

• Plans ask questions, follow up on how ALPs are managing care and may deny ongoing care or suggest another service or a different level of care

• Plan members have extensive Grievance and Appeals rights (internal process) as well as Fair Hearing rights (external process)

Ongoing Authorizations

• All services are subject to continued renewal requests
  • Even for a custodial/long-term population that is permanently placed in a nursing home

• Timeliness for requesting authorizations varies by plans

• Supporting evidence may be required to justify ongoing service utilization
## Documentation
### Supporting the Necessity for Services

- Medical Necessity – Standards established in health care
- Need evidence person is not regressing or gaining skills
- Need evidence service has value
- Do you have an EMR? If yes, **DOCUMENT EVERYTHING**

## Know Your Data

- Systems and data
  - Electronic health records
  - Internal reporting capacity
  - Ability to share data with managed care companies

- Assess your data for accuracy

- Monitor your data on an ongoing basis
Quality & Outcomes

- Know your quality ratings
- What quality metrics can you develop internally?
- Know your programs and services that set you apart
  - What can you demonstrate?
  - What new products can you launch?
  - What don’t you do well?

Brand Differentiation

- Continue to offer the highest quality care
  - Excellent customer service
  - Capitalize on reputations
  - Outcomes and performance

- Pursue operational excellence:
  - Pursue efficiencies in operations
  - Right-size programs
  - Pursue niche programs
Optimization

- Optimize facility/program assets to create higher-performing operations
  - Ambiance/environment important to consumers and their families
  - Focus on concepts such as scalability and lean operating models

Formal or Informal Mergers & Affiliations

- Joint ventures/facility alliances which develop strategies to retain mission and identity while reducing costs
- Formal mergers with designation of one facility as sole member
- Continued development of other formal alliances to capitalize on economies of scale, group contracting, purchasing, IPA development etc.
Managed Care Strategy

Develop Your Managed Care Strategy

1. What's your value proposition?
2. Review your current Managed Care contracts
3. Identify who you want to partner with
4. How many contracts do you want to sign?
5. Are you equipped to take risk?
### Contracting Strategies

- Evaluate your current managed care plan participation
  - What is your value proposition? What do you excel at?
  - Why are you a good partner for a managed care plan?
  - Review your current contracts; do you have any VBP "Level"-like contracts already in place?
- Evaluate the DSRIP PPS networks you've joined
  - Identify your peers that are participating in the same PPS
  - Do your services/expertise overlap?
  - Engage your PPS to identify their VBP strategy
  - Will you engage in direct MCO contracts or work through your PPS?

### Contracting Strategies

- Specify payment terms
- Develop acceptable payment options
  - e.g., what degree of risk may you be comfortable with?
- Develop payment for quality outcomes
- Research how quality measures are used today with MCOs
  - These will likely be applied towards you!
Payment Terms

- **Fee for Service**
  - Conventional reimbursement for every service provided

- **Capitation**
  - Lump sum payment for each enrolled member, per period of time, whether or not that person seeks care or uses services

- **Performance Bonuses**
  - Conditional income, paid out only if certain operational, quality or financial measures are met

Payment Terms

- **Gain Sharing**
  - Assumes some financial responsibility for the profit and none for the potential loss in serving members

- **Partial Risk**
  - Assumes some financial responsibility for the profit and the potential loss in serving members

- **Full Risk**
  - Assumes full financial responsibility for the profit and the potential loss in serving members
Contract Basics

- Contract Structure
- Sections
- Things To Look For
- What You Can And Can’t Change

Contract Structure

- Cover Sheet
- Terms & Conditions
- Signature Pages
- Standard Clauses
- Appendices or Amendments
- Lobbying or Other NYS Specific Documents
- Credentialing Forms
What To Look For When Contracting

- **Participating Parties**
  - Your name and address
  - Plan’s name and address
  - Plan’s licensure

- **Definitions**
  - Standard terms defined; e.g.:
    - Clean Claim
    - Participating Provider
    - Medical Necessity

- **Responsibilities of the Provider**
  - Licensure
  - Credentialing
  - Insurance
  - Care Management Participation
  - Quality & Performance Improvement Participation
## What To Look For When Contracting

### Responsibilities of the Plan
- Licensure
- Insurance
- Payment
- Quality and Utilization Review
- Compensation & Billing
- Payment Terms
- Coordination of Benefits
- Claim submission timeframes
- Denial timeframes
- Appeals & Grievances
- Hold Harmless

### Reporting
- What information must you report to the plan
- How frequently
- Can you do it? Will it require additional or new resource?

### Confidentiality
- Records
- Term and Termination
- Contract term
- Early exit clauses
  - Plan Initiated Termination
  - Provider Initiated Termination
  - Mutual Termination

### Arbitration & Dispute Resolution
- Indemnification
- Miscellaneous
- Audits
- Amendments
- Assignability
- Non-solicitation
- New product lines
What To Look For When Contracting

- Appendices
  - Service Area
  - Lines of Business
  - Covered Services
  - Compensation
    - Exclusions
    - Add-ons
    - Bonuses

Provider Contracting

- All agreements must be negotiated in good faith
- All Agreements will have the “New York State Standard Clauses for Managed Care Provider/IPA Contracts”
- FIDA contracts will include Medicare standard clauses
- Due process rights must be included for providers that allow the provider to appeal any determination identified by the MCO
### Reviewing The Provider Manual

- Review all identified manuals
  - e.g. provider manual, member handbook, quality improvement programs
- Provider Manual typically contains detailed information on:
  - Contact Information
  - Product Lines
  - Member Benefits & Responsibilities
  - Provider Rights & Responsibilities
  - Credentialing
  - Pre-Authorization - Utilization Management – Process
  - Appeals Process for Denied Services (on Pre-Auth or post provision)
    - Utilization Management
  - Billing and Claims Process
  - Post-Claims Process
  - Quality Management & Data Reporting

### What Can And Can’t You Change

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<tr>
<td><strong>Timeframes</strong></td>
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<td><strong>Terms and Conditions</strong></td>
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<td><strong>Rates</strong></td>
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<td><strong>Just About Everything Else!</strong></td>
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- **DOH Standard Clauses**
- **CMS/Medicare Standard Clauses**
- **Certification Forms**
- **Credentialing Requirements**

*If the plan claims that your requested change is a "material change" it may require DOH approval*
Are You Being Delegated Credentialing?

- Plans must credential the ALP and their providers
- Credentialing of ALP staff may be delegated to the ALP
- MCOs must verify that the ALP credentialing process complies with Federal and State requirements

Contracting Strategies

- Contracting Approaches
  - Individual
  - Group
  - IPA

- Approach to Plans
  - What’s your value proposition? What do you excel at?
  - Why are you a good partner for a managed care plan?

- Evaluate the DSRIP PPS networks you’ve joined
  - Identify your peers that are participating in the same PPS
  - Do your services/expertise overlap?
  - Engage your PPS to identify their VBP strategy
  - Will you engage in direct MCO contracts or work through your PPS?
Contracting Strategies

- Specify payment terms
  - Identify all elements of rates that should be expressly articulated
  - Take nothing for granted
- Develop acceptable payment options
  - What, if any, alternative reimbursement models work?
- Develop payment for quality outcomes
- Research how quality measures are used today with MCOs

Managed Care Plan Relations

- Plans maintain "Provider Relations" departments
- Providers need to identify a point person to manage their Plan relationships
- Participation with a Plan’s provider network is increasingly competitive
Key Take Aways

1. Understand your financial weaknesses and areas of opportunity
2. Identify operational needs to accommodate a managed care operating model
3. Build a managed care strategy

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