Institutional Special Needs Plans ("ISNPs"): Clinical and Financial Considerations

AUDIO CONFERENCE

Date/Time:
March 1, 2017, 10:30 – 11:30 a.m.

Presenter:
Marc Zimmet
President
Zimmet Healthcare Services Group, LLC, Morganville, NJ

Packet Contents:
• Handout
• Credit Instructions
• CEU Affidavit
• Evaluation/Credit Form
• Post-Test

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Institutional Special Needs Plans (ISNPs):
Clinical and Financial Considerations for Skilled Nursing Facilities
Agenda

- Introduction
- Understanding the Money Flow
- Clinical Considerations
- Financial Considerations
- IPA Contracting Arrangements
- Medicare ECCP (ISNP competition?)
- Additional Resources
Disclaimer

• This webinar is designed to provide an overview of the Institutional Special Needs Plan program and market trends in different states.
• Some of the concepts presented within are simplified, estimated or generalized for discussion purposes; participants may contact presenter for amplification or clarification.
• Presenter is a Member in Alpha Healthcare IPA, LLC, an entity that manages ISNP programs on behalf of Medicare Advantage plans.
Introduction

- **Improving Quality and Efficiency** (*utilization & cost reduction*) are common themes in the Healthcare Reform / Alternate Payment Model movement
  - Managed Care, ACOs, Bundles, Episodic, CCJR, etc.
- Medicare Advantage penetration is nearly one-third of all beneficiaries (and half of new beneficiaries)
  - Over 8% annual enrollment growth
- Medicaid systems transitioning to LTC managed care
- **LTC residents are Medicare’s last FFS cohort**
  - ISNPs target only this population
Special Needs Plans

- SNPs are optional Medicare Adv. programs designed to improve quality & reduce costs for specific populations
  - Institutional SNP (ISNP) applies to long-term care / SNFs
- Authorized By Medicare Modernization Act (MMA) of 2003 (would not be impacted by ACA repeal)
- ISNPs enroll only Medicare (A & B) eligible LTC residents (regardless of primary payer, no impact on CMI)
- Goal is to improve outcomes and reduce costs (esp. hospital admissions) through improved coordination of care management and enhanced clinical protocols
  - Use of Nurse Practitioners and emerging care management resources (e.g. TeleHealth, Technology)
Enrollment limited to beneficiaries with specialized care needs
Wide array of plans, varying degrees of success
Most recent data and policy suggests ongoing commitment to dual-eligible and institutional SNP models
Benefits of ISNP Participation

1. Enhance clinical capabilities
2. Move up the managed care “value” chain
3. Prepare for new FFS and managed payment models (bundle, episodic, capitation)
4. Leverage market position and clinical excellence to counter downward rate pressure
5. Introduce tools relating to “risk tolerance” and assumption of risk
6. Share in program savings
## 2016 ISNP Enrollment

<table>
<thead>
<tr>
<th>State</th>
<th>Enrollment</th>
<th>Percentage</th>
<th>State</th>
<th>Enrollment</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>New York</td>
<td>16,474</td>
<td>29.7%</td>
<td>Indiana</td>
<td>753</td>
<td>1.4%</td>
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<tr>
<td>Florida</td>
<td>3,840</td>
<td>6.9%</td>
<td>Oregon</td>
<td>748</td>
<td>1.3%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>3,383</td>
<td>6.1%</td>
<td>Delaware</td>
<td>520</td>
<td>0.9%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>2,912</td>
<td>5.3%</td>
<td>Nevada</td>
<td>514</td>
<td>0.9%</td>
</tr>
<tr>
<td>Maryland</td>
<td>2,870</td>
<td>5.2%</td>
<td>Missouri</td>
<td>314</td>
<td>0.6%</td>
</tr>
<tr>
<td>Colorado</td>
<td>2,772</td>
<td>5.0%</td>
<td>New Mexico</td>
<td>301</td>
<td>0.5%</td>
</tr>
<tr>
<td>Georgia</td>
<td>2,541</td>
<td>4.6%</td>
<td>Alabama</td>
<td>262</td>
<td>0.5%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>2,457</td>
<td>4.4%</td>
<td>Texas</td>
<td>229</td>
<td>0.4%</td>
</tr>
<tr>
<td>California</td>
<td>2,451</td>
<td>4.4%</td>
<td>Kansas</td>
<td>228</td>
<td>0.4%</td>
</tr>
<tr>
<td>Arizona</td>
<td>2,192</td>
<td>4.0%</td>
<td>Virginia</td>
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<tr>
<td>New Jersey</td>
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<td>3.4%</td>
<td>Oklahoma</td>
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<tr>
<td>Wisconsin</td>
<td>1,828</td>
<td>3.3%</td>
<td>Massachusetts</td>
<td>132</td>
<td>0.2%</td>
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<tr>
<td>Washington</td>
<td>1,652</td>
<td>3.0%</td>
<td>DC</td>
<td>80</td>
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<tr>
<td>Rhode Island</td>
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<td>2.9%</td>
<td>Kentucky</td>
<td>79</td>
<td>0.1%</td>
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<tr>
<td>Ohio</td>
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<td>2.0%</td>
<td>Michigan</td>
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<td>0.0%</td>
</tr>
<tr>
<td>Illinois</td>
<td>944</td>
<td>1.7%</td>
<td>Remaining 20</td>
<td>-</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Source: Kaiser Family Foundation
### Active NY SNPs (2015)

<table>
<thead>
<tr>
<th>Contract Name</th>
<th>Plan Geographic Name</th>
<th>Plan Enrollment</th>
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</thead>
<tbody>
<tr>
<td>UNITEDHEALTHCARE OF NEW YORK, INC.</td>
<td>New York Metropolitan area</td>
<td>9,052</td>
</tr>
<tr>
<td>UNITEDHEALTHCARE OF NEW YORK, INC.</td>
<td>Upstate New York</td>
<td>3,837</td>
</tr>
<tr>
<td>CATHOLIC SPECIAL NEEDS PLAN, LLC</td>
<td>NYC, Westchester, Putnam, Dutchess, Orange, Ononda</td>
<td>1,699</td>
</tr>
<tr>
<td>INDEPENDENT HEALTH ASSOCIATION, INC.</td>
<td>Western New York</td>
<td>1,365</td>
</tr>
<tr>
<td>CENTERLIGHT HEALTHCARE, INC.</td>
<td>NYC, LI, Westchester and Rockland Counties</td>
<td>1,082</td>
</tr>
<tr>
<td>ELDERPLAN, INC.</td>
<td>Bx, Ki, Monr, Na, NY, Qu, Ri, Suf, Wes</td>
<td>835</td>
</tr>
</tbody>
</table>
## Active NY SNPs (2015)

<table>
<thead>
<tr>
<th>Contract Name</th>
<th>Plan Geographic Name</th>
<th>Plan Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTHFIRST HEALTH PLAN, INC.</td>
<td>NYC and Nassau County</td>
<td>418</td>
</tr>
<tr>
<td>AGEWELL NEW YORK, LLC</td>
<td>NYC Metro Area, LI, Westchester</td>
<td>50</td>
</tr>
<tr>
<td>CENTERS PLAN FOR HEALTHY LIVING, LLC</td>
<td>NYC Metro, Rockland, Erie, Niagara</td>
<td>20</td>
</tr>
<tr>
<td>ELDERSERVE HEALTH, INC.</td>
<td>Counties: Brx, Ki, Na, NY, Qu, Ri, Wes</td>
<td>-</td>
</tr>
<tr>
<td>ALPHACARE OF NY, INC.</td>
<td>Bronx, Kings, New York and Queens Counties.</td>
<td>-</td>
</tr>
</tbody>
</table>

* Enrollment figures include contracts through IPA arrangement
The Most Common Questions

• How does contracting work?
• Do all my long-term care patients have to enroll?
• How does enrollment work?
• Do we still bill Medicare for enrolled patients?
• Do only Medicaid primary patients qualify?
• Does ISNP enrollment impact Medicaid CMI?
• How does my Medicare short-term re-hospitalization rate impact my performance?
• How does ISNP enrollment impact my therapy billing and relationship to my contract therapy company?
• Can I have more than one ISNP plan in my facility?
• What if we can’t effectively manage clinically?
The Money Flow

- **CMS** pays the plan **PMPM Premium** for each enrolled beneficiary
  - For purposes of this webinar, we will use $2,000 per member per month premium *as an example*
  - Plan has overhead, ACA sets minimum spending % (“Medical Loss Ratio” or “MLR”)
  - Enrolled residents are no longer “Fee-for-Service”

- **PMPM Premium** is based on the base rate per County adjusted by **Hierarchical Condition Code ("HCC") scoring** per patient

- Goal is to optimize HCC scoring for highest PMPM
  - Recent CMS accusations of “over coding” by Plans

- 2017 base is reduced (causing Plan exit in some Counties)
  - May be mitigated in part by improved HCC accuracy

- SNF may contract directly with the Plan or through an IPA
  - If IPA used, payment may still flow directly to SNF
Clinical Considerations

• How well do I manage clinical changes of my long-term care population?
• How does my hospitalization rate and Medicare billing (for LTC population) compare to my peer group of providers (internal and third party)?
• Am I prepared to “Care in Place”
  – Am I prepared to do so at “all hours”
  – Is my nursing staff up to the challenge?
Clinical Considerations

- What additional resources will I need to reduce hospitalizations of my LTC population?
- Am I prepared to integrate third party clinical judgement into my care model?
- How do I reconcile family demands and expectations?
- What will my physicians think of this program?
Financial Considerations

• How much Medicare revenue am I generating from my FFS long-term care population?

• How it works:
  – All Medicare payments, administration costs, NP, etc. must be paid by the Plan from PMPM Premium

• Evaluate LTC – hospital admits (“Admits/1,000”)
  – Part A revenue derived from LTC population
  – What is my average Part A rate for LTC population?

• Part B therapy (billing, therapy company use, cap issues) & other ancillaries (are they related parties?)

• Medicaid rate: Higher rate makes SNP more attractive because Medicaid days will increase as Part A decreases
Contemporary ISNP Payment Model

- Fixed PMPM to SNF for Medicare Part A “replacement” revenue
- Fixed PMPM to SNF for Medicare Part B “replacement” revenue (mostly therapy)
- Small allowances for additional Part B items (e.g. Blood Glucose testing)
- Small PMPM for certain quality issues (e.g. immunizations, Survey, etc.)
- “Shared Savings” component:
  - Calculated as a percentage of remaining Premium after all costs are deducted, including Plan administration
  - May include only “Upside” or both Upside and “Downside” risk
  - Typically reconciled and paid 2 – 4 times per year
The ISNP Equation

**Poor Candidates**
- Many LTC hospitalizations
- High % of Part A $ from LTC population
- High Part B ancillaries (esp. in-house therapy)
- Low MA rate

**Marginal**

**Excellent Candidates**
- Few LTC hospitalizations
- Low % of Part A $ from LTC
- Low ancillaries/outourced therapy
- Higher MA rate
SNP EXAMPLE Calculation
(all #s per month)

• CMS pays plan: $2,000 PMPM
• Plan pays SNF: $380 PMPM (Part A guaranty)
• Plan pays SNF: $50 PMPM (Part B guaranty)
• Plan pays SNF: $20 PMPM (Other incentives)
• Plan pays other: $850 average PMPM
• Plan admin: $100 PMPM
• Remaining: $600 PMPM
• SNF share (30%): $180 PMPM
• PMPM SNF revenue: $630 PMPM
• Enrollees per month x 100
• TOTAL SNF rev/mo: $63,000

— Compare this to current FFS
SNP EXAMPLE Comparative Calculation

• Comparing historical Financial net revenue pre/post-SNP (for SNP population):

  Part A revenue from LTC population (1):  $100,000
  Less: Ancillary costs during stay (2):  $10,000
  Less: Additional Medicaid revenue (3):  $40,000
  Net Medicare revenue of LTC pop:  $50,000
  SNP revenue from participation  $63,000
  Net Impact of SNP participation PM  $13,000

1. 100 residents, 6.77 average Part A census (200 days/month) at $500/day
2. Average $50/day in ancillary costs (therapy, pharmacy, lab, etc.)
3. Medicaid rate of $200 per day x 200 days
   Assumes a reduction in LTC hospitalizations required to achieve results from prior slide
Shared Savings Implications

- “Upside / Downside” defined
  - “Skin in the game”
  - Evaluate Risk Tolerance
  - Who will manage risk in your facility?

- Change in mindset: Every dollar billed to Medicare for an enrolled patient negatively impacts the SNF’s financial performance
  - What does this include? EVERYTHING!

- Reinsurance considerations
So Many Variables...

- Amount of PMPM “Guaranty”
- Miscellaneous Incentive and Other Payments (e.g. Vaccinations, Blood Glucose, Surveys, etc.)
- “Diversion Days”
- % of Shared Savings; Upside / Downside
- Timeline of Shared Savings and Payment Schedule
- Options for Nurse Practitioner and Primary Care Physician Payments
  - Important if you want NP to see non-ISNP enrollees
SNF Contracting Options

1. Direct SNF contract with MA Plan / SNP

2. SNF group starting its own MA / SNP Plan

3. Form / join an IPA (Independent Provider Association) contracting with MA Plan / SNP
IPA Contracting Option

- **Independent Provider Organization**
- Secure better deal based on scale
- “Intermediary” between SNF and Plan
- SNF advocate
- Additional benefits often “tested” under IPA auspices
  - TeleHealth
  - Care Management Technology
  - Care Transitions Programs
  - New payment models (e.g. Episodic)
MA/SNP Marketing

• **Medicare Advantage Plans must:**
  - Use marketing materials that have been
    - Submitted to CMS and Reviewed according to guidelines
  - Comply with the “Do not call registry”
  - Provide information in a professional manner
  - Use state-licensed, certified, or registered individuals to market plans
    - If state requires it

• **Medicare Advantage Plans may not:**
  - Make any unsolicited contact with a potential beneficiary
  - Solicit Medicare beneficiaries door-to-door (unless invited)
  - Send unsolicited email
  - Enroll people by phone (Unless the person calls them)
  - Offer cash payment as an inducement to enroll
  - Misrepresent or use high pressure sales tactics
Medicare Enhanced Care & Coordination Providers (ECCP) Program

• Per CMS: 45% of 2005 H admits of LTC patients were avoidable, equaling 314K episodes and $2.6B in Medicare spending; up to 80% may now be avoidable

• ECCP is a CMMI initiative to help improve the quality of LTC beneficiaries (FFS duals only) by reducing potentially avoidable hospitalizations

• Implement evidence-based interventions that both improve care and lower costs

• Now in Phase II which includes payment reform

• De facto ISNP competition/alternative
Medicare Enhanced Care & Coordination Providers (ECCP) Program

• 3/24/16: CMS announced cooperative agreements with 6 organizations to expand the initiative to include approximately 250 SNFs starting Fall 2016

• Participating Sites:
  – Alabama Quality Assurance Foundation (Alabama)
  – HealthInsight of Nevada (Nevada)
  – Indiana University (Indiana)
  – The Curators of the University of Missouri (Missouri)
  – Greater New York Hospital Foundation (New York)
  – University of Pittsburgh Medical Center (Pennsylvania)
ECCP Demonstration in NY

- GNYHF Reducing Avoidable Hospitalizations (NY-RAH)
- 29 SNFs in the New York City metro area
- RNs deployed in the partnering SNF to train (but not provide direct care) to SNF staff on INTERACT tools and identify root cause for avoidable hospitalizations
- CMS (Medicare) pays up to $218/day (on top of Medicaid rate) for a limited benefit period to avoid hospitalization due to these conditions:
  - Pneumonia, Dehydration, Congestive Heart Failure, UTI, Skin Ulcers, Cellulitis, COPD
- Expectation of enhanced clinical care management and technology
  - https://innovation.cms.gov/initiatives/rahnfr/
For More ISNP Information

**ZHSG ISNP White Paper**

**CMS Guide to Special Needs Plans**

**Kaiser Family Foundation Medicare Advantage 2016 Spotlight**

**Optum ISNP White Paper**
https://www.optum.com/content/dam/optum/Landing%20Page/CarePlus-white-paper.pdf

**HealthFirst SNP Presentation**
http://assets.healthfirst.org/api/pdf?id=pdf_4529c9e7d2&key=b3b1e756abbbf9f4c4fb70e40802c16864e61e305
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• CEU Affidavit
• Evaluation/Credit Form
• Post-Test

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Please note: Credit certificates will be issued approximately one month after the program.

Credit Details: The FLTC is a certified sponsor of professional continuing education with the National Association of Boards of Examiners of Long Term Care Administrators (NAB). NAB has approved this program for 1 hour of continuing education credit. State licensure boards, however, have final authority on the acceptance of individual courses.

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Please fax to FLTC: 518.867.8386 or email edu@leadingagency.org

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**Credit:** 1 hour of Licensed Nursing Home Administrator (NAB) credit and/or CPA credit

Organization: ____________________________________________________________________________

Name of Registrant: ________________________________________________________________________

This form attests that _____________________________________________________________,  
(Full name of attendee seeking credit)

______________________________________________________________________________________, was in attendance for the full 1 hour of the  
(Title) audio conference, Institutional Special Needs Plans ("ISNPs"): Clinical and Financial Considerations.

Witness: (Print) _______________________________________________________________________

(Staff in attendance, other than the attendee)

(Signature) ___________________________________________________________________________ Date: __________________
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Date/Time: March 1, 2017, 10:30 – 11:30 a.m.
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2. Please check the box that best describes your rating:
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      - Good
      - Fair
      - Poor
   b. Presenter’s knowledge of material/topic
      - Yes
      - No
   c. Usefulness of the knowledge/skill required
      - Yes
      - No
   d. Appropriateness of topic content
      - Yes
      - No
3. Was participating in this seminar a wise business decision?  
   - Yes
   - No
   If not, why?
   _______________________________________________________________________________________________
   _______________________________________________________________________________________________
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   - Yes
   - No
5. What new developments in the field do you believe will have an important future impact?
   _______________________________________________________________________________________________
   _______________________________________________________________________________________________

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Name & Title of Person Seeking Credit: _____________________________________________________________
Organization: __________________________________________________________________________________
Address: __________________________________________________________________________________________
City: __________________________ State: ______ Zip: ______________
Telephone: ( ) __________________________ E-Mail: ________________________________________________

[ ] NAB CREDIT: NYS NH Administrator License No.: _______________________________________________

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[ ] CPA CREDIT

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Date/Time: March 1, 2017, 10:30 - 11:30 a.m.
Credit: 1 hour of Licensed Nursing Home Administrator (NAB) and/or CPA credit

Name of Registrant: _______________________________________________________________

Name of Person Seeking Credit: __________________________________________________

PLEASE CIRCLE THE CORRECT ANSWER:

1. ISNPs enroll only Medicare eligible LTC residents.
   a. True
   b. False

2. Medicare advantage plans must use marketing materials that have been submitted to CMS and reviewed according to guidelines.
   a. True
   b. False

3. Telehealth is an additional benefit often “tested” under IPA auspices.
   a. True
   b. False

4. The benefits of ISNP participation are:
   a. Enhance clinical capabilities
   b. Leverage market position
   c. Share in program saving
   d. All of the above

5. Poor ISNP candidates include:
   a. Few LTC hospitalization
   b. Huge percentage of Part A dollars from LTC population
   c. Higher MA rate
   d. Low outsourced therapies