AHCA/NCAL National Update and Managed Care

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Reimbursement & Legal Affairs
Agenda

✓ DC and AHCA/NCAL National Update

✓ Managed Care in Post Acute and Long Term Care
  ▪ Medicare Advantage Overview
  ▪ Medicaid and State-Level Transformation Context
  ▪ Medicaid Managed Care Mechanics
  ▪ State Experience with Medicaid Managed Care
  ▪ Approach to Viable Managed Market Environment

✓ Q & A
DC Update
Board Direction for 2015

✓ Focus on
  ▪ Challenges and opportunities on the Hill
  ▪ Challenges and opportunities at CMS
  ▪ Challenges and opportunities with new payment models
2015 Policy Goals

- No Congressional cut other than Board-approved pay-fors
- No Congressional cut worse than other providers
- Advance payment reform proposal(s) in a demonstrable way
- Ensure a clean 2016 SNF PPS Rule
- Demonstrable evidence that we shaped Five Star revisions
- Deliver a Board-approved plan to CMS to obtain a 70% incentive pool in SNF Value-Based Purchasing rehospitalization program
2015 Quality Goals

- Launch Quality Initiative 2.0
- Demonstrable acceptance by CMS, states or MCOs of Quality Awards
- Demonstrable adoption by satisfaction vendors of AHCA’s CoreQ satisfaction questionnaires and measures
- Demonstrable adoption by AHCA members of therapy outcome measures or CARE tool for mobility & self-care
- Deliver a Board-approved solution to CMS on decreasing staff turnover in response to the President’s action on Five Star
Managed Care in Post Acute and Long Term Care
Executive Summary

✓ The industry is experiencing a sea change from fee-for-service to managed care

✓ Government is using plans to shift risk downstream and attempt to achieve savings

✓ States and CMS are forging ahead in the absence of savings and cost evidence and adequate oversight capacity

✓ Approaches to MLTSS programs vary significantly by state

✓ Stakeholder engagement and education of local policymakers are key to advocacy efforts
Medicare Advantage
Nearly 16 Million MA Beneficiaries in 2014

NOTE: Includes cost and demonstration plans, and enrollees in Special Needs Plans as well as other Medicare Advantage plans.
MA Payment Changes Have Little Impact on Expansion

- Payment change impact by quartiles
- Additional documentation pressures
- Arguments for administrative simplification

Ongoing Plan Expansion into Medicaid and Duals

2009
Affordable Care Act (ACA) with MA Plan Payment changes

2010
Concern about MA Plan payments – 114% of Medicare FFS

2012
ACA Medical Loss Ratio of 85% Requirement

2012
ACA Payment Changes Implemented Based on FFS spending levels in four quartiles.

2012
Implementation of ACA Payment Changes and Launch of Bonus Payment

2014-2016
Implementation of ACA Payment Changes and Launch of Bonus Payment

Provider Strategies
D-SNP Consolidation Does not Correlate with Decreased Enrollment

Source: AHCA analysis of CMS Data
Three Major MA Carriers Expanding Further into Medicaid

Medicare Advantage Enrollment by Major Carrier, 2014

- United: 20%
- BCBS: 17%
- Humana: 17%
- Kaiser: 8%
- Aetna: 7%
- Cigna: 3%
- Other: 28%

Source: KFF analysis of CMS Medicare enrollment files, 2014
New Jersey MA Landscape: 2014

MA Penetration Rate (2014)

- Number of Unique MA (non-SNP) Plans Offered: 30
- Number of Unique MA-SNP Plans Offered: 9
- Largest MA Carrier (by Enrollment): Aetna

Source: AHCA analysis of CMS Enrollment and Landscape Files
Minimal CMS Oversight Role in Plan-Provider Interactions

<table>
<thead>
<tr>
<th>Plan Challenge Area</th>
<th>Contract Negotiation Elements &amp; Preliminary AHCA Advocacy</th>
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<tr>
<td><strong>Downstream Intermediaries</strong></td>
<td>• Very little guidance</td>
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<td>• Virtually no oversight</td>
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<td>• Post-Acute Care Benefits Managers reach spreading</td>
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<td><strong>Claims Processing and Payment</strong></td>
<td>• Prompt Payment Incentives</td>
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<td>• Standardized business transactions</td>
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<td>• Electronic claims submission, claims payment, reason for denial</td>
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<td><strong>Administrative Simplification</strong></td>
<td>• Transparency of reported encounter data</td>
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<td>• Credentialing Processes</td>
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<td>• Survey oversight</td>
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<td><strong>Clinical Oversight</strong></td>
<td>• Prior authorization</td>
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<td>• Prohibition of arbitrary caps on LOS</td>
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<td>• Legal liability of provider in patient care</td>
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CMS Focus on Payment Accuracy

- Encounter Data Submitted to CMS by MA Plans to Support Claims
- New Health Insurance Prospective Payment System (HIPPS) requirements for SNF and HH will require submission of additional documentation
- Failure to provide documentation or inadequate documentation will result in recovery from MA Plans by CMS

Providers should...

Prepare for increased documentation requirements

Review contract requirements for downstream implications
Medicare Advantage Toolkit and Other Resources

- Landscape MA Enrollment Data; Medical Loss Ratio Impacts
- Developing MA toolkit for members containing information and guidance around contracting with MAOs
- Divided into four focused modules
  - Primer on Medicare Advantage
  - Plan and Provider Rate Discussion
  - MAO Marketing Rules and Practices
  - Other Key Contractual Components
- Available at AHCA/NCAL website, now
Medicaid and State-Level Transformation Context
Total Medicaid Spending Growth, FY 1996 – FY 2015


Welfare Reform, Managed Care

Part D


Source: Kaiser Family Foundation, 2014
Medicaid Is Undergoing Substantial Transformation

Ongoing Federal and State budgetary concerns
Aging population and role of Medicaid in paying for LTSS
State desire for more flexibility in program design and administration
Push for coordinated care and improved outcomes
Federal funding and opportunities to test/implement new payment and delivery models
Potential alignment/integration of Medicaid benefits and services with the health insurance marketplaces

All have significant implications for nursing facilities, with the potential for unintended consequences as well as opportunities for enhancing care for beneficiaries.
Medicaid Managed Care Mechanics and Landscape
What Is Medicaid Managed Care?

- State contracts with a managed care organization (MCO) and provides a monthly payment per member (PMPM)
  - Covered services/populations vary by state
  - Typically, deliver services to children, families, and pregnant women
  - Increasingly, states are transforming the payment and delivery of LTSS by shifting to MLTSS models

- Members receive services through an established network of contracted providers

- MCOs assume and manage some or all of the financial risk for their members
  - Therefore, MCOs have a financial incentive to keep enrollee costs low
  - Often results in reductions in payments to providers
There Are Three Basic MMLTC Models

<table>
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<tr>
<th>Medicaid Services for Which Managed Care Contractor is at Risk</th>
<th>MODEL 1: Medicaid LTC Only</th>
<th>MODEL 2: Medicaid-Only</th>
<th>MODEL 3: Medicaid-Medicare Integration</th>
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<tbody>
<tr>
<td>Home and Community Based Services (HCBS)</td>
<td>Medicaid LTC Only</td>
<td>HCBS</td>
<td>HCBS</td>
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<td>Nursing Home Care</td>
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<td>Medicaid-Covered Primary Care Services</td>
<td>Medicaid-Covered Primary Care Services</td>
<td>Medicaid-Covered Acute Care Services</td>
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<td>Medicaid-Covered Pharmacy</td>
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<td>Medicaid-Covered Pharmacy</td>
<td>Medicare Acute Care</td>
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<td>Medicaid-Covered Pharmacy</td>
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<td>Medicaid-Covered Pharmacy</td>
<td>Medicare Prescription Drug Benefit</td>
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In most states, dual eligibles may also be enrolled in Medicare managed care and receive Medicaid LTC services in either FFS Medicaid, or in MMLTC Models 1 or 2. In NJ, dual eligibles must disenroll from Medicare managed care to be eligible for MLTSS.

Source: AARP Public Policy Institute Issue Brief, Medicaid Managed Long-Term Care, 2005.
Medicaid MCO Structure

Ownership: May be owned by providers or other entities

Payment: Plan paid on a PMPM capitated basis, with plan responsible for providing or arranging all covered services; providers payment rates set by state or by plan

Beneficiary Choice: Patients select or are assigned to a plan and, with limited exception, receive care from MCO provider network.

Care Management: Care management is at the plan level. Care managers, who are generally employed by the plan or a plan’s vendor, will manage care only for enrollees.

Licensure Requirements: Required to obtain a state license and, in some states, are required to establish adequate reserves.
Use of Medicaid MCOs- 2008

Use of Medicaid MCOs- 2013

Source: Manatt Health Solutions Analysis of Medicaid Managed Care Prevalence Across States. 2013
Enrollment Largely Concentrated in Public Fortune 500 Companies

Regional MCO 56.0%

- WellPoint 7.6%
- United 7.1%
- Centene 6.8%
- Molina 6.0%
- WellCare 4.4%
- HealthNet 3.9%
- Other Multi-State 8.2%
- Other 3.9%

Six MCOs account for ~36% Medicaid MCO enrollment nationwide

Source: KFF Medicaid Managed Care Market Tracker
10% annual enrollment growth since 2003

Compound annual growth rates range from 2% (Humana) to 18% (Centene)

Combination of market expansion/RFP activity and acquisitions
In NJ, Horizon Accounts for Approximately Half of MMC Enrollment

Source: HMA New Jersey Medicaid Program Overview. November 2014
Alignment Across Markets Will Change the Managed Care Marketplace

The state may apply similar standards across programs in key areas, including:

- Quality Standards
- Provider Networks
- Cost Sharing
Medicaid Managed Care Evidence and Future Considerations
Evidence Is Needed to Understand the Effects of Managed Care

Mixed Evidence to Date

Costs/Savings
- No effect on overall Medicaid spending
- States with more generous Medicaid reimbursement prior to MLTSS implementation realized greater cost savings,
- Administrative costs of contracting with MCOs

Quality/Outcomes
- Most available data emphasizes process measures rather than outcome measures
- Quality measures vary across states/plans

Beneficiary Choice and Access
- Difficulty recruiting physicians willing to accept lower rates
- According to one survey, over 2/3 MMC states reported beneficiary access to specialists as a challenge

Sources: Sparer M. Medicaid Managed Care: Costs, Access, and Quality of Care. Robert Wood Johnson Foundation. September 2012
Medicaid MCO contracts often include incentives for shifting LTSS expenditures away from institutional care. However, evidence suggests that this does not necessarily produce cost savings and/or lead to improved outcomes.

“More and Better Research is Needed to Draw Robust Conclusions about How the Setting of Care Influences the Outcomes and Costs of LTC for Older Adults”
Overall Spending in the Community is Roughly the Same as Nursing Center Care for Dual Older Adults

Spending is Roughly the Same in Total (e.g., Medicare and Medicaid)

Sources: Kane, R., Wysocki, A., Parashuram S., Shippee, T., Lum, T. Effective of Long-term Care Use on Medicare and Medicaid Expenditures for Dual Eligible and Non-dual Eligible Elderly Beneficiaries. Medicare & Medicaid Research Review 2013: Volume 3, Number 3.
Higher Acute Care Costs in the Community

- Some studies point to higher rates of avoidable hospitalization and emergency room use among HCBS participants

- Historically, states have focused only on Medicaid outlays

- Increased Medicare spending for expanding HCBS programs was not considered or not a primary concern for states

- Low Medicaid reimbursement correlates with high Medicare spending

Caregiver Capacity Could Exacerbate Medical Care Challenges

Caregiver Support Ratio, United States

Volume will Come with Time: Elderly and LTC Spending, 2000-2040

LTC spending projected to double as % of GDP as baby boomers age

Source: Grabowski, D., MD, PhD., Harvard School of Medicine
State Experience with Medicaid Managed Care
# Approaches to MLTSS Programs and Policies Vary across States

## Comparison of Key Characteristics of State MLTSS Programs

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<tr>
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<th>MN</th>
<th>KS</th>
<th>TN</th>
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<tr>
<td><strong>Level of Stakeholder Engagement</strong></td>
<td>Ample opportunity for provider and beneficiary input throughout the process; input was well-received and incorporated into program design</td>
<td>Program implemented through 1115 with stakeholder collaboration; MLTSS program not addressed in state legislation</td>
<td>Limited opportunity for meaningful stakeholder input before and during implementation process; some protections incorporated through legislative process</td>
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<tr>
<td><strong>Pace and Scope of Implementation</strong></td>
<td>Program started small in scale as a pilot and gradually expanded over time</td>
<td>Once enacted, program was immediately implemented statewide</td>
<td>Program implemented in one region and then phased in to remaining regions over the course of one year</td>
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<td><strong>Plan Offerings</strong></td>
<td>Under State law, only non-profits are permitted to provide health insurance of any kind</td>
<td>For-profit corporations</td>
<td>Mix of non-profit and for-profit organizations</td>
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<td><strong>Population Served</strong></td>
<td>Elderly population only; pilot with disabled population proved to be unsuccessful</td>
<td>Elderly and disabled populations</td>
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<td><strong>Plan Accountability</strong></td>
<td>Plans are required to return excess reserves back to the state</td>
<td>Limited understanding transparency of plan accountability processes</td>
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AHCA interviews with executives from Care Providers of Minnesota, Kansas Health Care Association, and Tennessee Health Care Association
Rising healthcare costs and budget pressures are primary drivers of shift to MMC, leading to approaches that are not always designed to promote care quality and health outcomes:

- Typical “first response” from States/MCOs have been rate cuts/freezes
- Providers are not incentivized to participate in initiatives that decrease utilization without payment models that minimize their financial losses

New initiatives add additional administrative complexity, increasing costs for providers.

Even after implementation, care is not well integrated/coordinated.

States are expending varying levels of effort/collaboration to improve coordination.
Maintaining a Viable Managed Care Environment in NJ
NJ MLTSS MCO contract has a two-year Any Willing Provider and Any Willing Plan (AWP) provisions for providers: AL, Community Residential Services (CRS), NF, and Special Care Nursing Facilities (SCNF).

During the AWP period reimbursement rates for these providers will be the higher of: (a) the rate set by the state as of April, 2014 with the possibility of an increase each fiscal year for inflation, dependent upon available appropriation; and, (b) the negotiated rate between the contractor and the facility.
Several States Set Minimum Requirements for MLTSS NF Rate Setting

Based on Review of 5 Existing State Programs and 1 Pending (RFP)

- 4 states establish either the actual or minimum rate MCOs must pay, usually equal to the FFS rate
  - 2 states require payments “at or above” the minimum rate (KS, TX)
  - FL does not reimburse for payments above the established rate and prohibits such payments from impacting future pmpm rate calculations
  - NM does not stipulate a requirement, but MCOs default to FFS rate in practice

- 5 states adjust cap rates and require MCOs to arrange for patient liability collection

- 4 states require MCOs to make retroactive payments to reflect state initiated rate adjustments
Other State Rate Setting and Reimbursement Practices

**Iowa:** State blends institutional and HCBS populations into a single rate cell to incent institutional entry management. Blending percentage updated annually to reflect enrollment mix.

**Kansas:** MCO has opportunity to audit case mix data and recommend adjustments for purposes of determining facility-specific reimbursement rate.

**Tennessee:** Tiered per diem NF rates based on LOC needs.
- MCO can request to modify tier, but may only reduce reimbursement with approved LOC eligibility and NF billing reflecting adjustment.
- MCO must reprocess payment adjustment notifications from state without any action by the provider within 30 days of state notification.

**Texas:** MCO must pay state’s Medicare coinsurance obligation for qualified dual Medicare-covered stay.

**New Mexico:** MCO conducts LOC reassessments; NF is responsible for collecting Medicare crossover payments.
Key Advocacy Points

- State should set rates rather than plans to support continuity of care
- Provider assessment supplemental payments must be included in rates or directed payment within capitation
- Any willing provider requirements to ensure beneficiary choice/access to needed services
- Administrative simplification must be a top priority as the role of the MCO evolves after the initial two-year period
- RFP and competitive bidding process should be used to identify and select health plans eligible to provide MLTSS services
- Medical Loss Ratio (MLR) requirement should be increased from 80% to at least 85% to ensure funds are further allocated on beneficiaries and services
- Technical assistance for LTSS providers must be available as well as an ongoing forum for input and problem solving
- Transparency concerning amendments to 1115 waiver
Other Opportunities to Create Viable Managed Market Environments

**Volume**
- Rebalancing to HCBS where possible & diversified business lines
- PAC will remain critical for return to home and for 85-plus long-stay

**Administrative Overhead Controls**
- Information technology with interoperable capacity will be critical
- Capacity to interface with multiple payers and track coverage source
- Ability to report on an array of quality measures
A long term care facility must educate itself about managed care contracts and utilize strategies to maximize its effectiveness when negotiating with MCOs

Consider the use of outside financial, legal and other professionals if that expertise does not exist in-house

Facilities should try to enter into a specially negotiated contract rather than relying on the form contract provided by the MCO.

Clarity is important:
- Make sure the contractual language is clear.
- Define important terms.

Facilities should make sure they have the complete contract, including all documents the contract makes references to.

READ AND UNDERSTAND.
# AHCA Member Resources

## Webinars
- Medicaid Managed Long Term Care: Just the Basics
- Medicaid Managed Long Term Care: State and Plan Roles and Responsibilities Part 2
- Medicaid Managed Long Term Care: Contracting and Provider/Plan Relations Part 3

## Issue Briefs
- Antitrust Guidelines for Post-Acute Care Centers in a Medicaid MLTSS Environment
- Evidence Is Needed to Understand the Effects of Managed Care

## Toolkit
- Medicaid Managed Long Term Services and Supports Toolkit
- Updated Medicaid Managed Long Term Services and Supports Toolkit and Contracting Guide to be Released Q2 2015