AHCA/NCAL National Update and Managed Care

Narda Ipakchi, Director, Managed Markets
Reimbursement & Legal Affairs

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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

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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

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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

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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

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Managed Care in Post Acute and Long Term Care

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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

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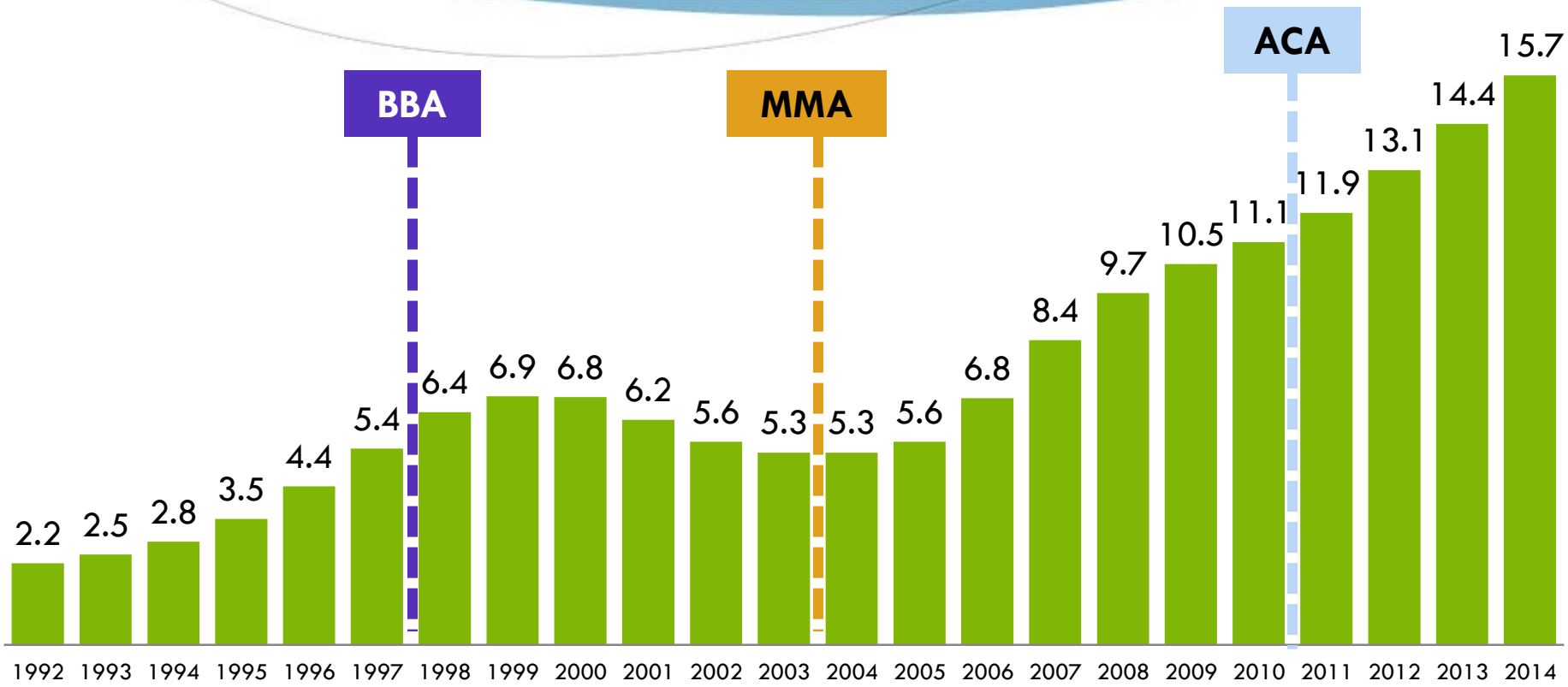
Medicare Advantage

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.
SOURCE: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2014, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 2001-2007. Report of the Medicare Board of Trustees, 2002.

MA Payment Changes Have Little Impact on Expansion

2009	2010	2012	2012	2014-2016
Concern about MA Plan payments – 114% of Medicare FFS	Affordable Care Act (ACA) with MA Plan Payment changes	ACA Medical Loss Ratio of 85% Requirement	ACA Payment Changes Implemented Based on FFS spending levels in four quartiles.	Implementation of ACA Payment Changes and Launch of Bonus Payment

Ongoing Plan Expansion in to Medicaid and Duals

Provider Strategies

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

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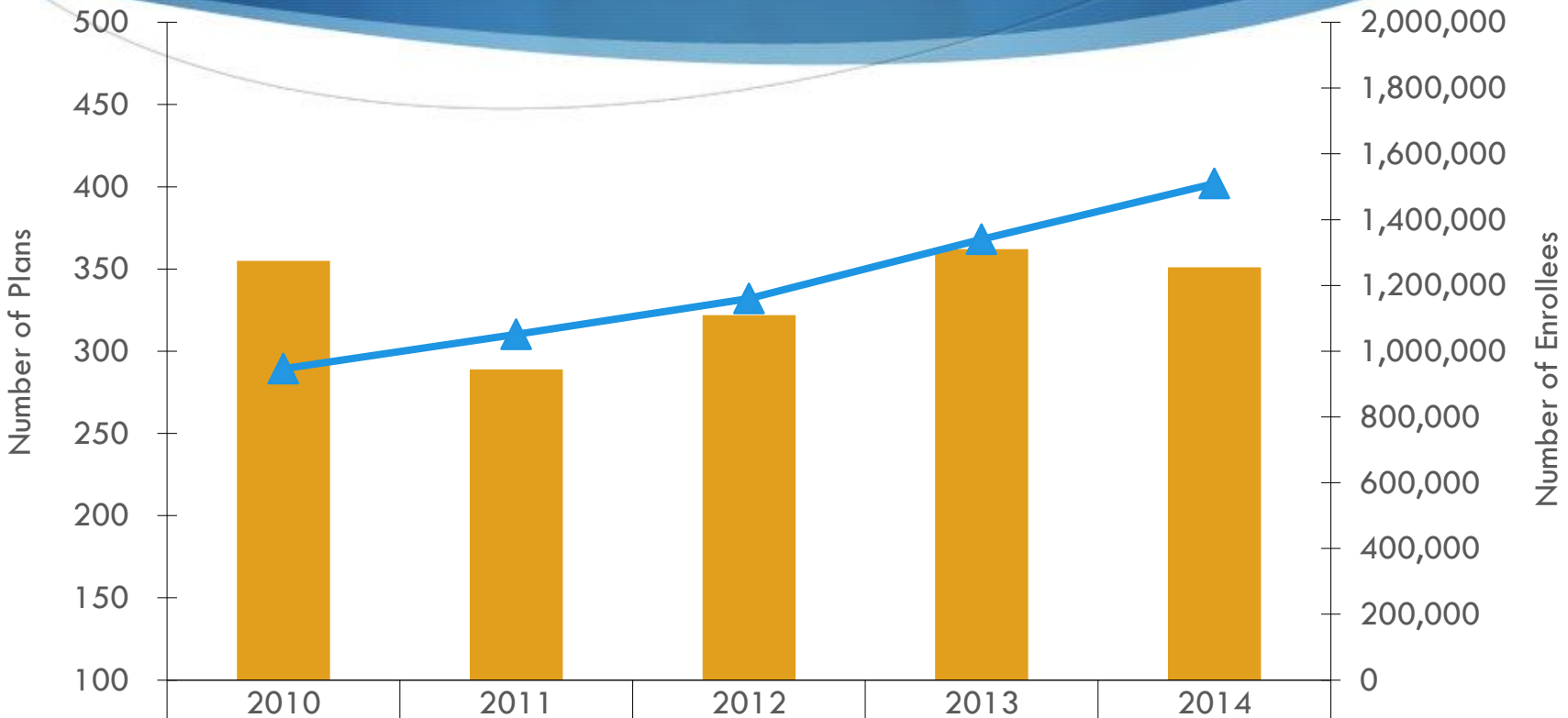
D-SNP Consolidation Does not Correlate with Decreased Enrollment



	2010	2011	2012	2013	2014
Plans	355	289	322	362	351
Enrollees	947,004	1,050,864	1,160,000	1,340,000	1,510,000

Source: AHCA analysis of CMS Data

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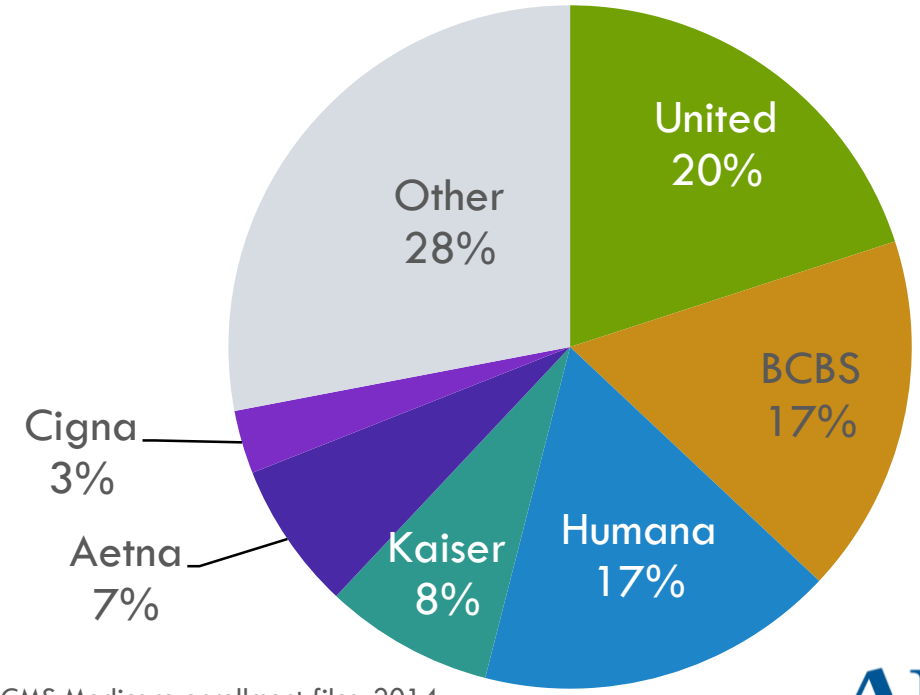
Three Major MA Carriers Expanding Further into Medicaid

Medicare Advantage Enrollment by Major Carrier, 2014



Source: KFF analysis of CMS Medicare enrollment files, 2014

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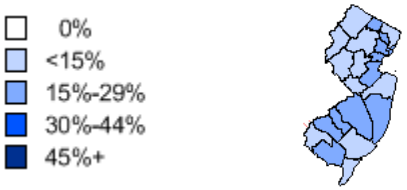
New Jersey MA Landscape: 2014

MA Penetration Rate (2014)



Change in MA Penetration (2013-2014)

- 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

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Minimal CMS Oversight Role in Plan-Provider Interactions

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

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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

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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

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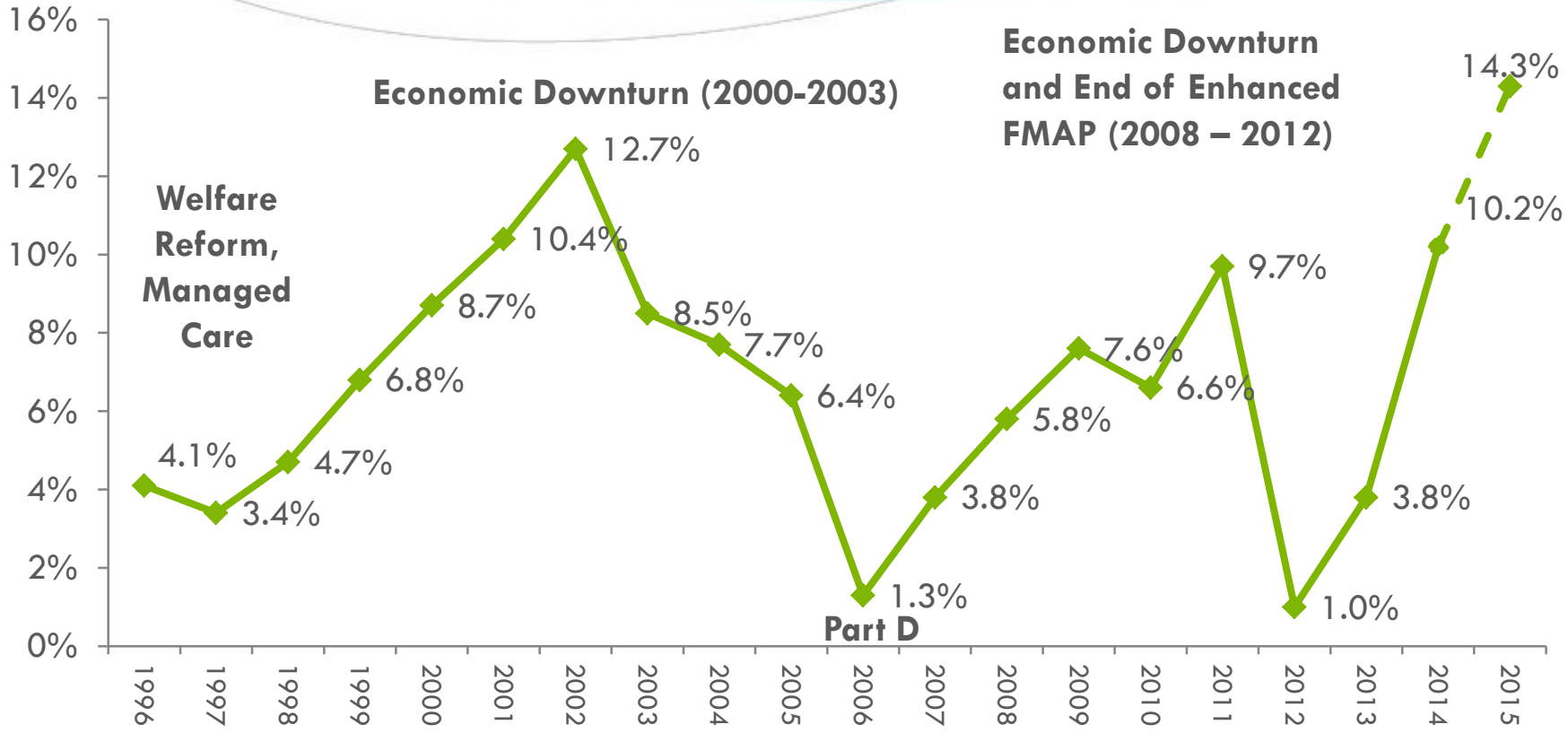
Medicaid and State-Level Transformation Context

Total Medicaid Spending Growth, FY 1996 – FY 2015



Source: Kaiser Family Foundation, 2014

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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

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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

	MODEL 1: Medicaid LTC Only	MODEL 2: Medicaid-Only	MODEL 3: Medicaid-Medicare Integration
Medicaid Services for Which Managed Care Contractor is at Risk	Home and Community Based Services (HCBS) Nursing Home Care	HCBS Nursing Home Care Medicaid-Covered Primary Care Services Medicaid-Covered Acute Care Services Medicaid-Covered Pharmacy	HCBS Nursing Home Care Medicaid-Covered Primary Care Services Medicaid-Covered Acute Care Services Medicaid-Covered Pharmacy
Medicare Services for Which Managed Care Contractor is at Risk	None	None	Medicare Acute Care Medicare Prescription Drug Benefit

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.

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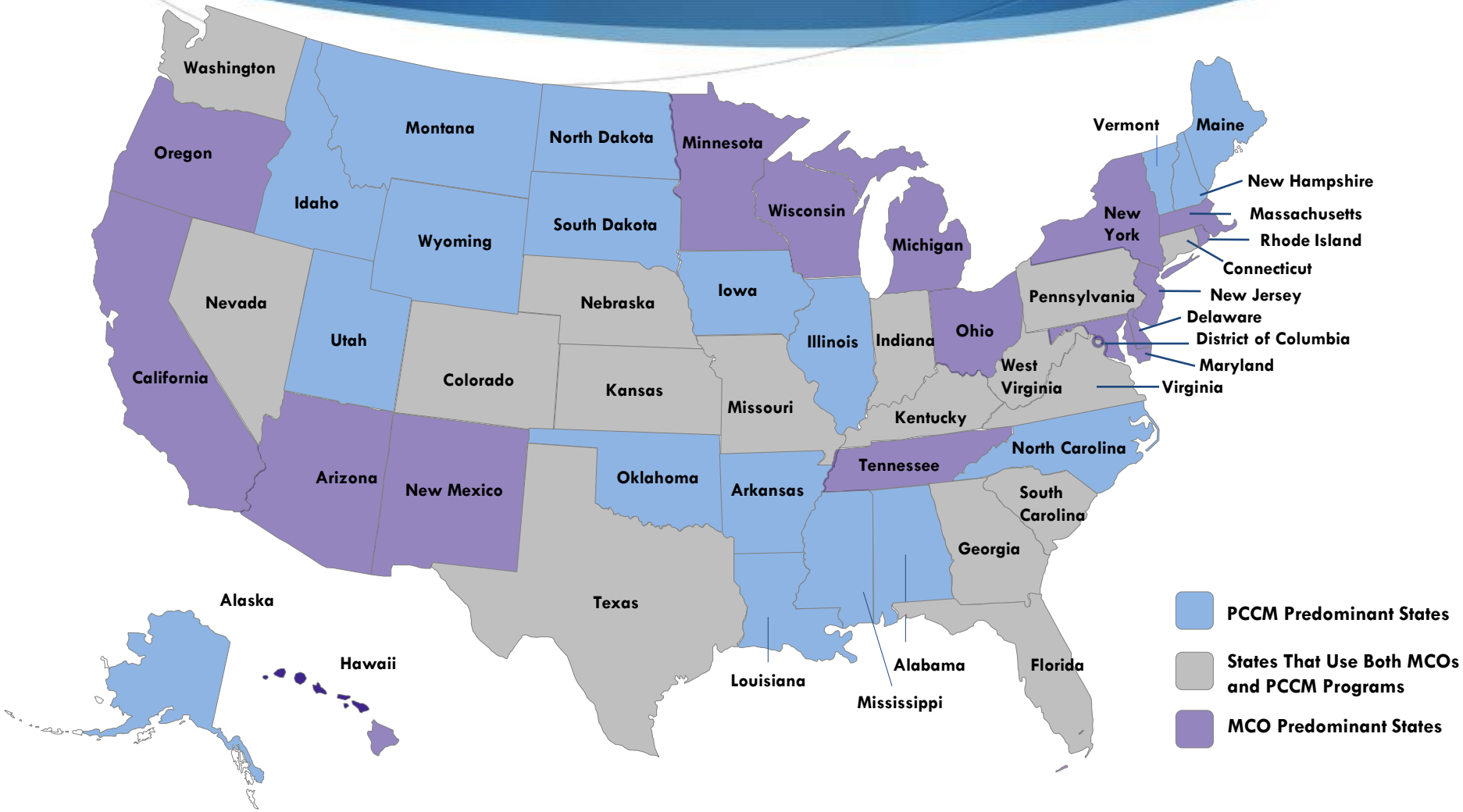
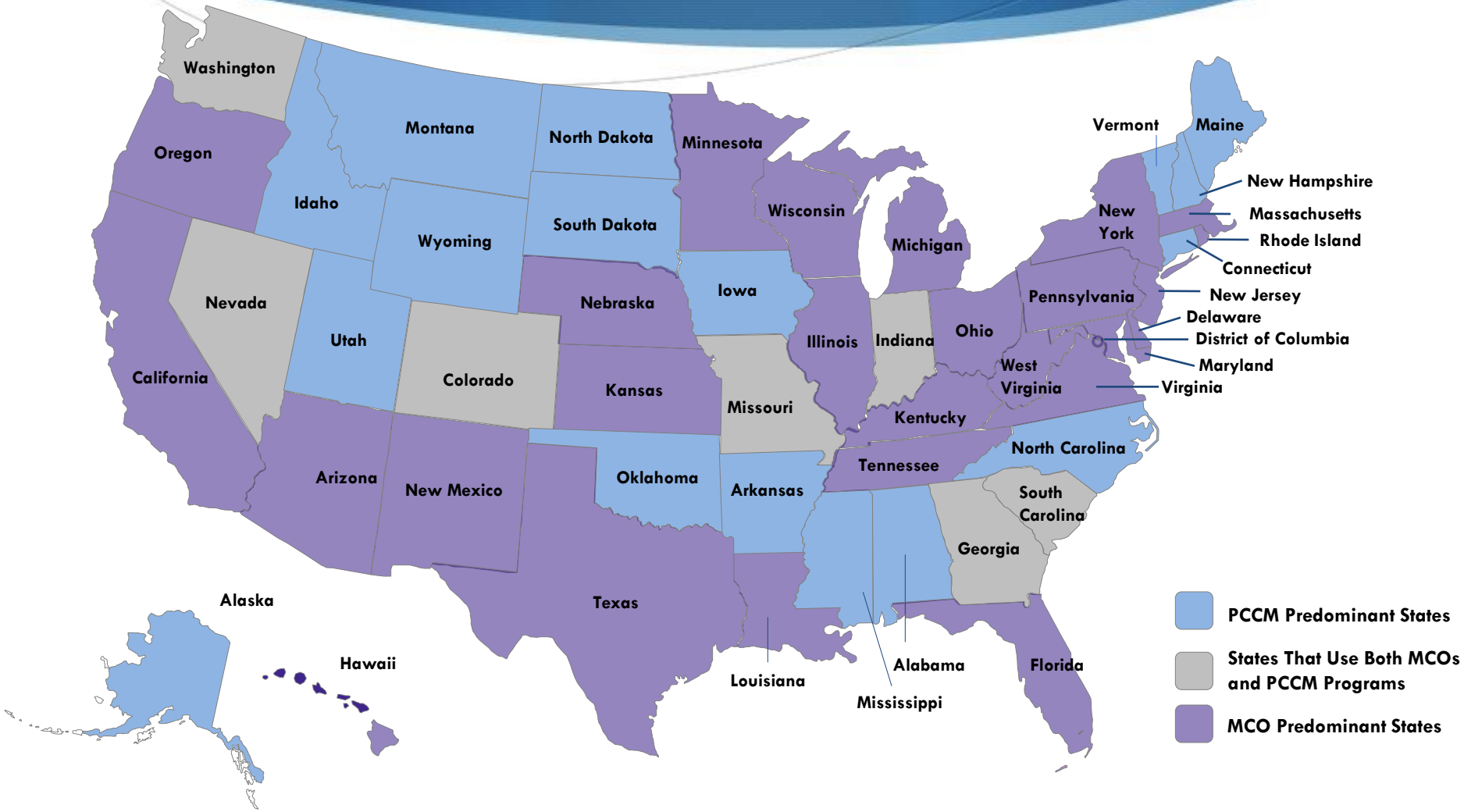
Use of Medicaid MCOs- 2008



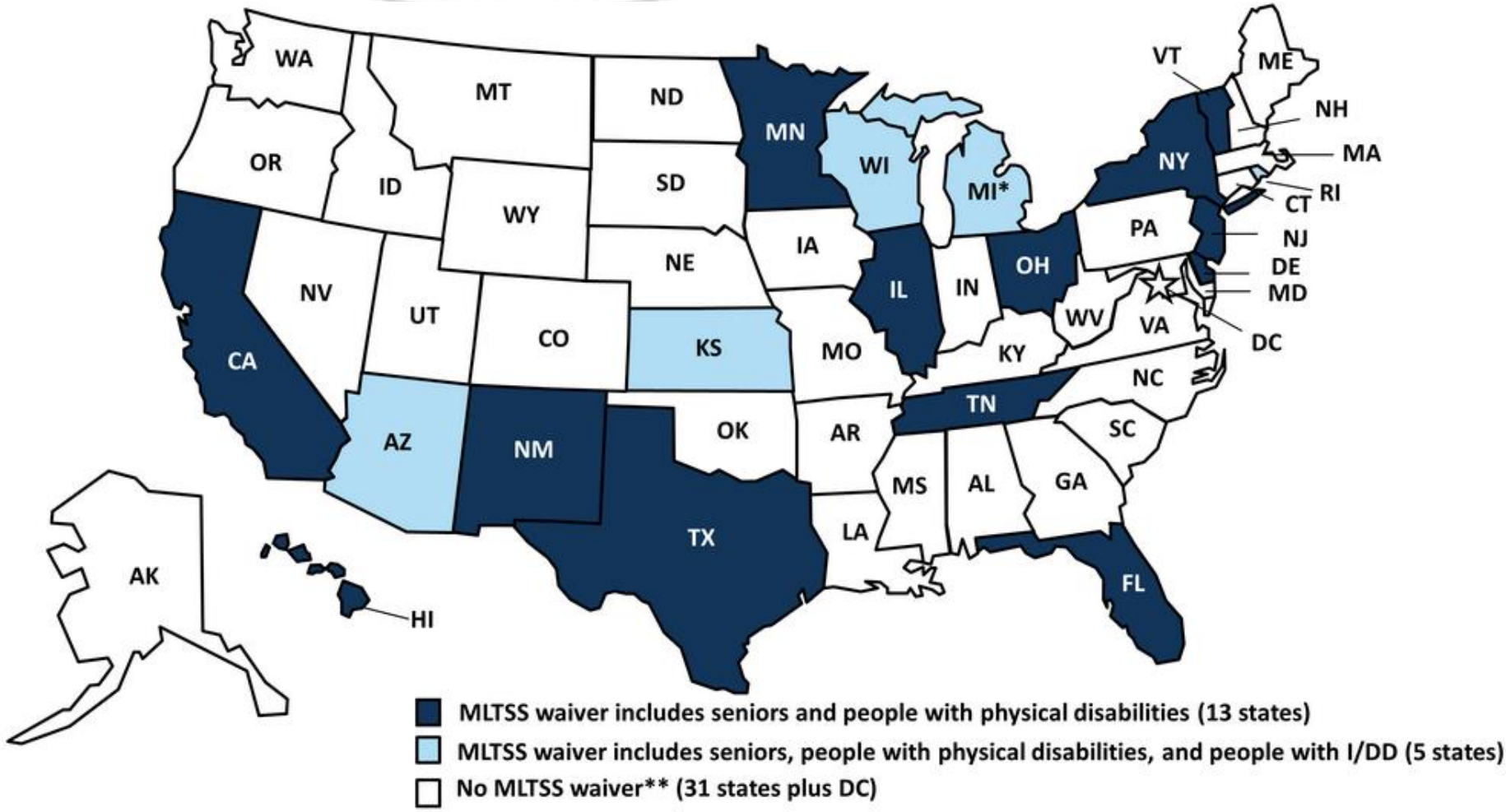
Source: Government Accountability Office. Medicaid: States' Use of Managed Care. August 2012

Use of Medicaid MCOs- 2013



Source: Manatt Health Solutions Analysis of Medicaid Managed Care Prevalence Across States. 2013

States Implementing MLTSS



Source: Kaiser Family Foundation. Rebalancing in Capitated Medicaid Managed Long-Term Services and Supports Programs: Key Issues from a Roundtable Discussion on Measuring Performance. January 2015

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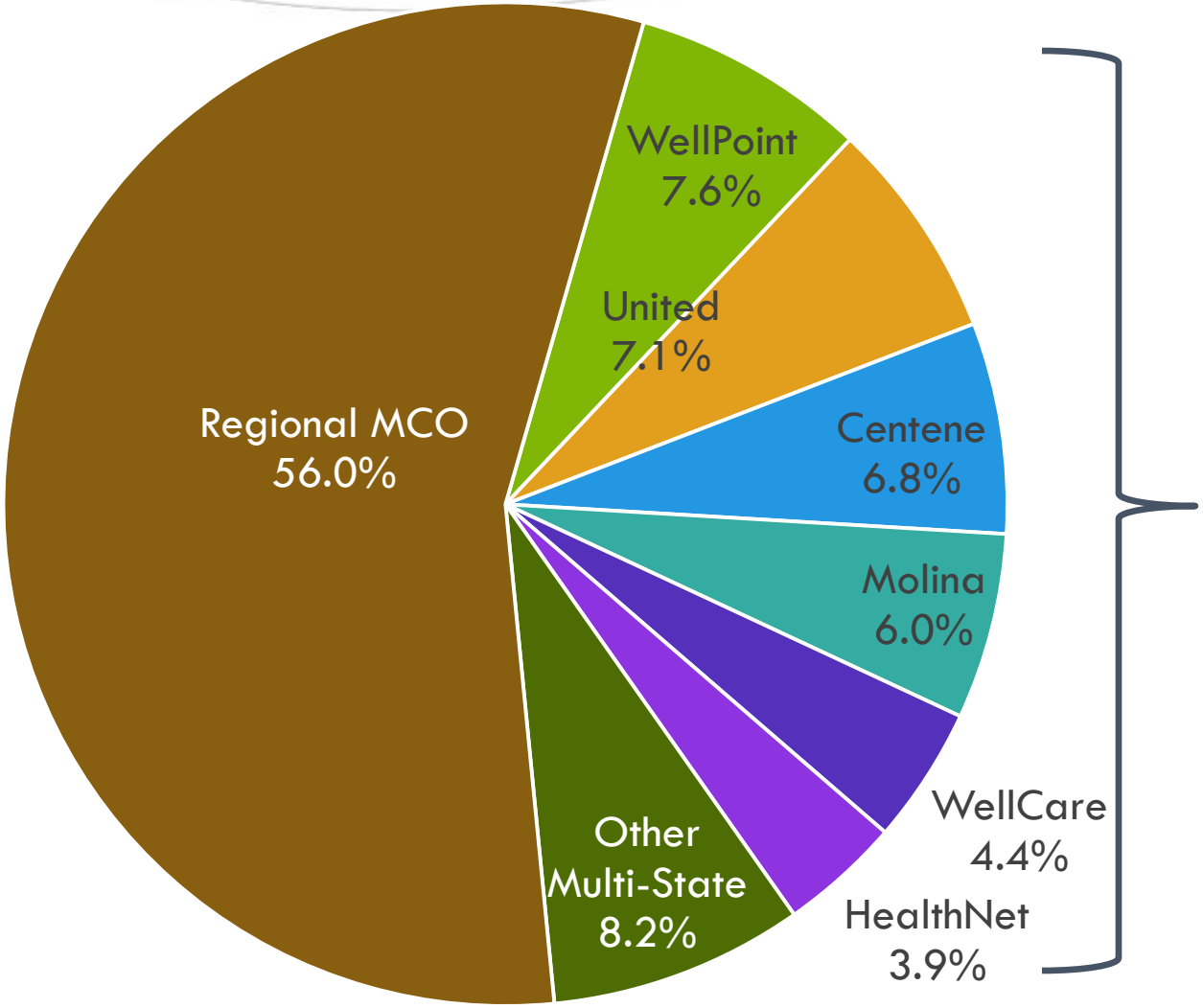
Enrollment Largely Concentrated in Public Fortune 500 Companies



Six MCOs account for ~36% Medicaid MCO enrollment nationwide

Source: KFF Medicaid Managed Care Market Tracker

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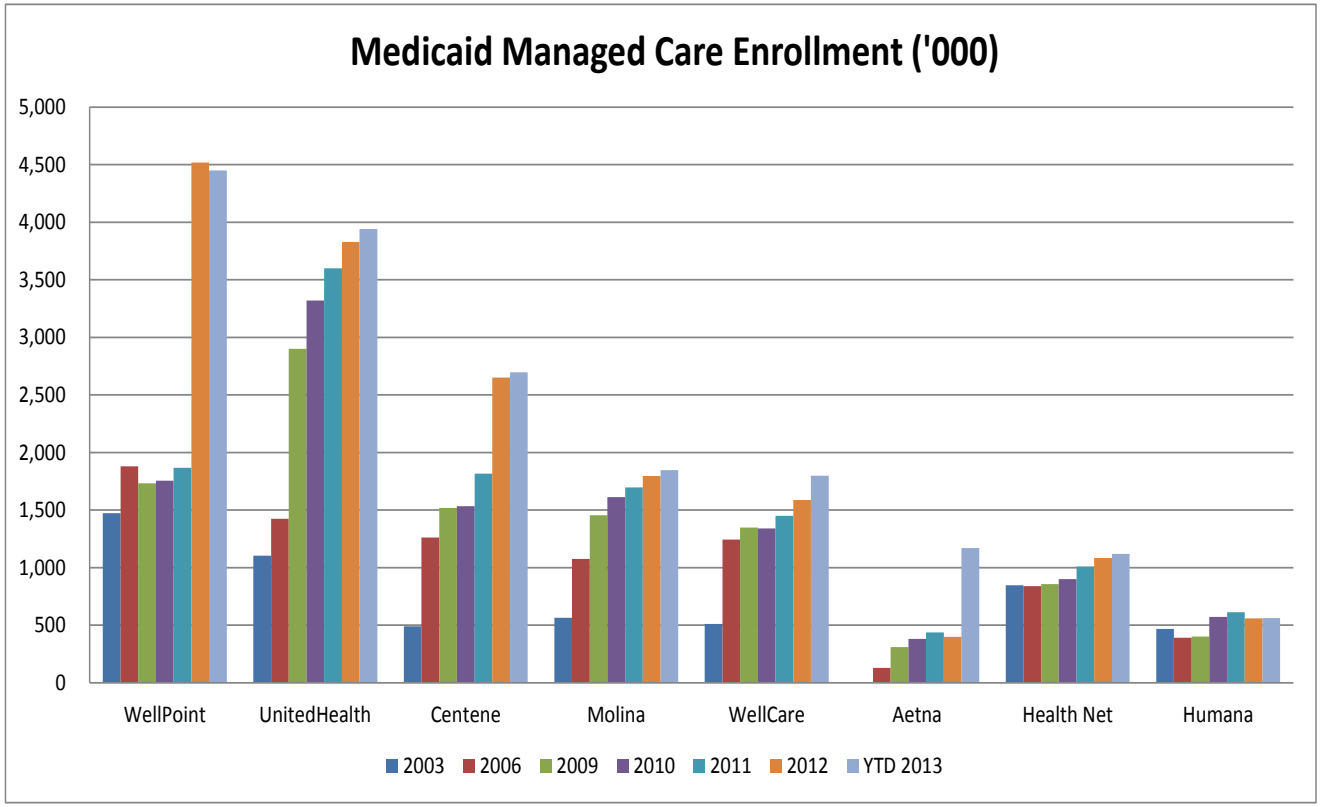
Public MCO Medicaid Enrollment Growth

- ✓ 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



Source: Company documents

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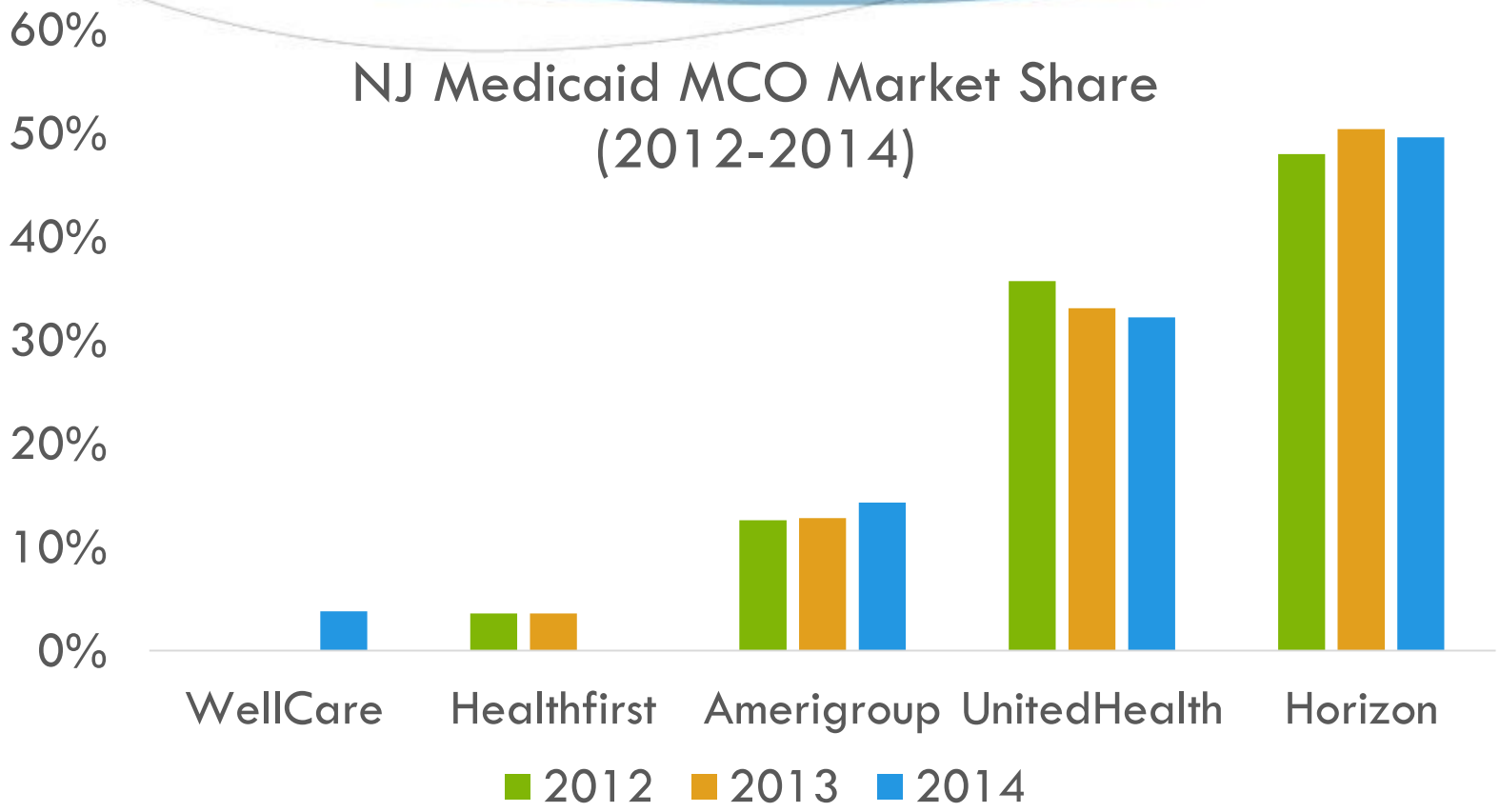
In NJ, Horizon Accounts for Approximately Half of MMC Enrollment



Source: HMA New Jersey Medicaid Program Overview. November 2014

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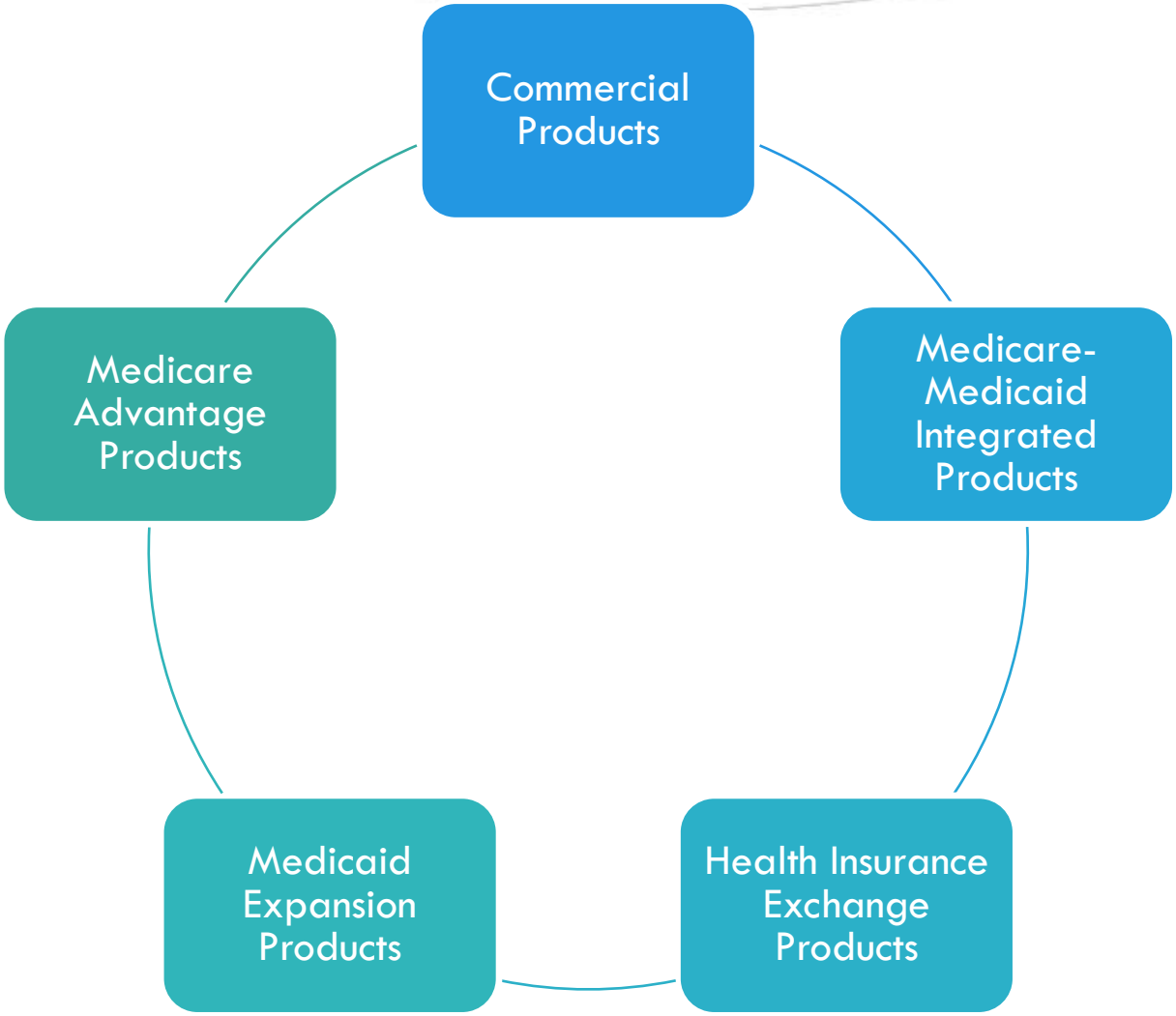
Alignment Across Markets Will Change the Managed Care Marketplace



- The state may apply similar standards across programs in key areas, including:
  - **Quality Standards**
  - **Provider Networks**
  - **Cost Sharing**

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Medicaid Managed Care Evidence and Future Considerations

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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
Duggan M, Hayford T. Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from state and local-level mandates. Cambridge (MA): National Bureau of Economic Research; 2011
Kaiser Health News. Jury Is Still Out On Medicaid Managed Care. June 2014.

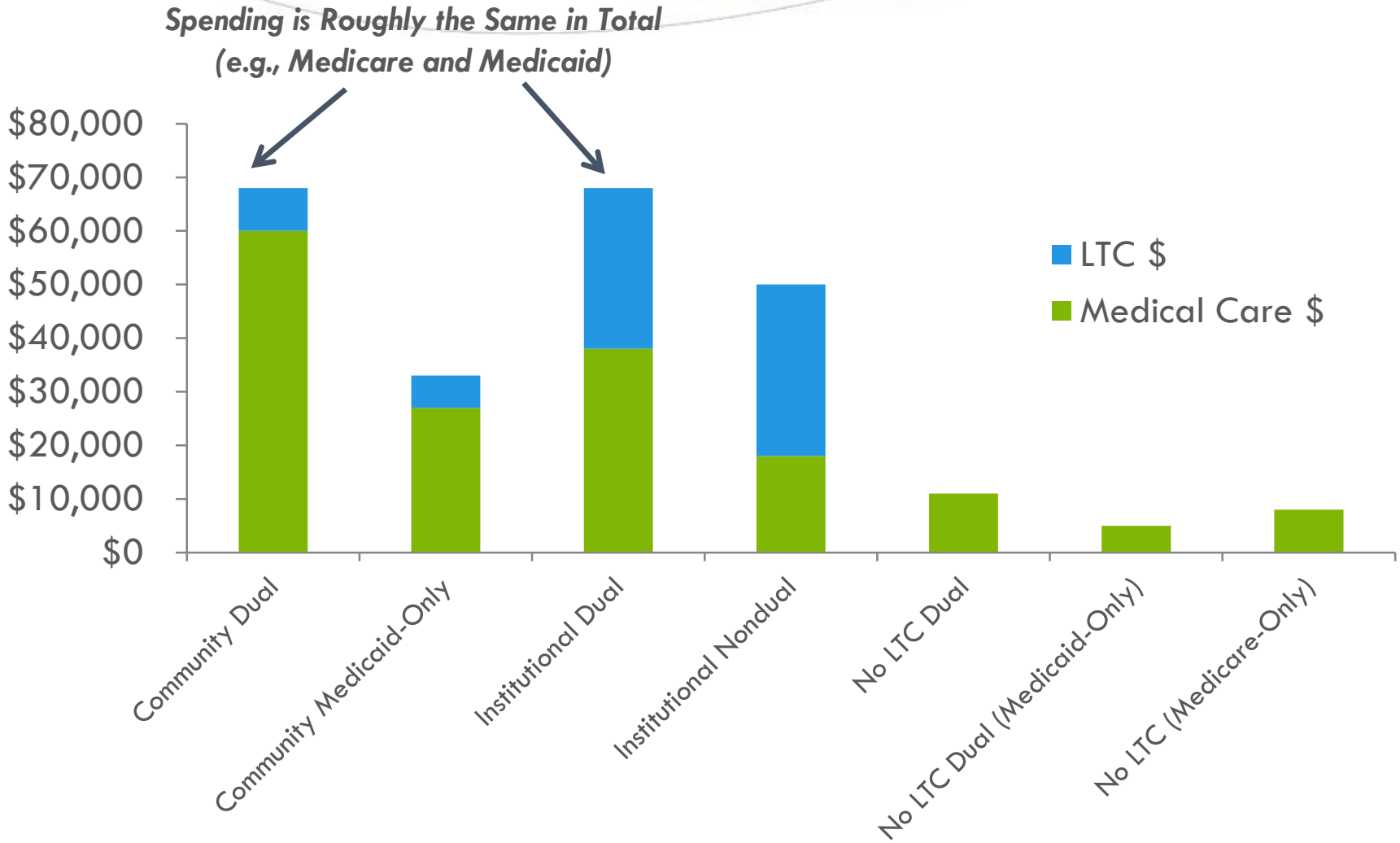
Shift to Community Does Not Guarantee Cost Savings

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"

Agency for Healthcare Research and Quality. Long-Term Care for Older Adults: A Review of Home and Community-Based Services Versus Institutional Care. November 2012; Grabowski, D. C. (2006). "The cost-effectiveness of noninstitutional long-term care services: Review and synthesis of the most recent evidence." Medical Care Research and Review, 61(1), 3-28.

Overall Spending in the Community is Roughly the Same as Nursing Center Care for Dual Older Adults



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.

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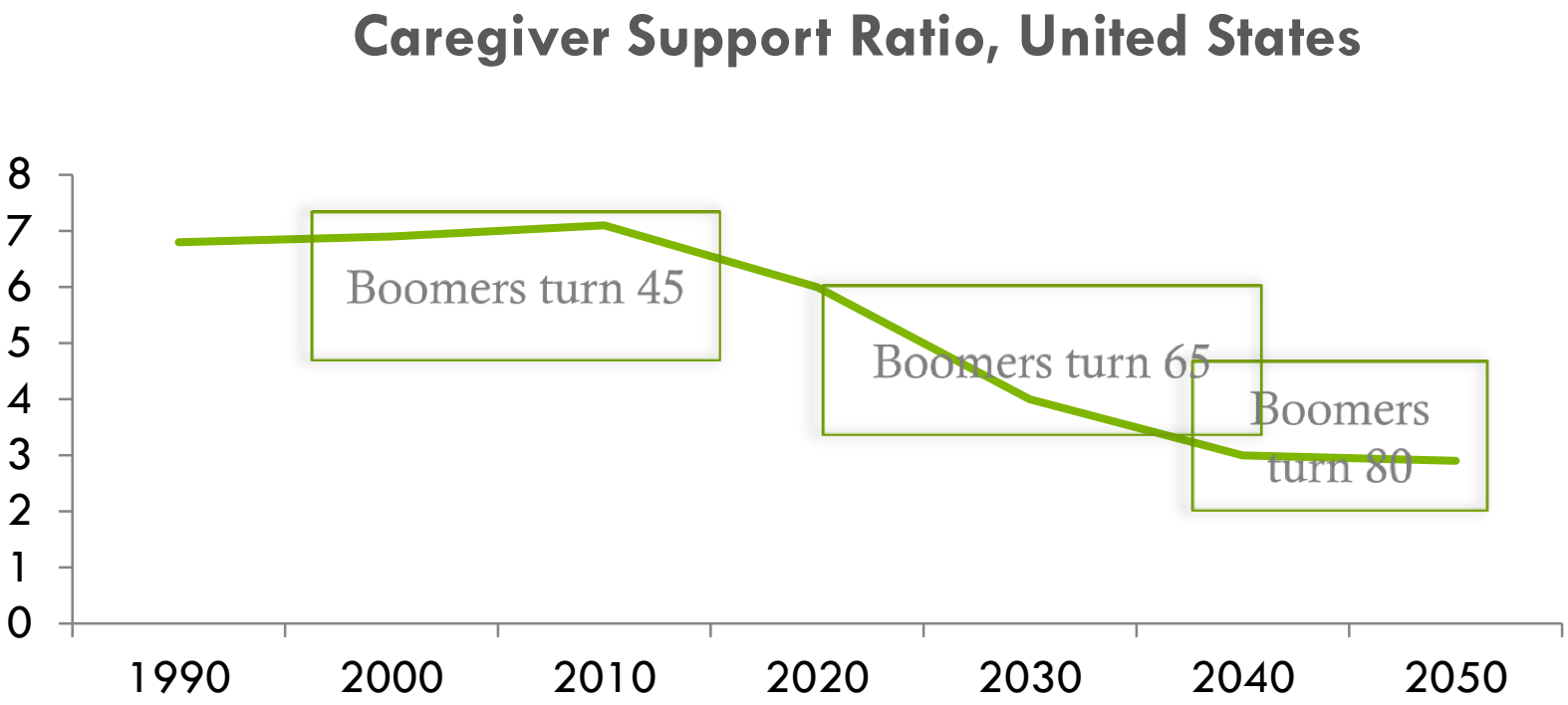
Higher Acute Care Costs in the Community

- ✓ 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

Sources: R. Tamara Konetzka, Sarita L. Karon, and D.E.B. Potter. Users Of Medicaid Home And Community-Based Services Are Especially Vulnerable To Costly Avoidable Hospital Admissions. Health Affairs, 31, NO. 6 (2012): 1167–1175;
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.

Caregiver Capacity Could Exacerbate Medical Care Challenges



Source: Redfoot, D., et. al. The Aging of the Baby Boom and Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers. AARP Public Policy Institute. Insight on the Issues 85, August 2013.

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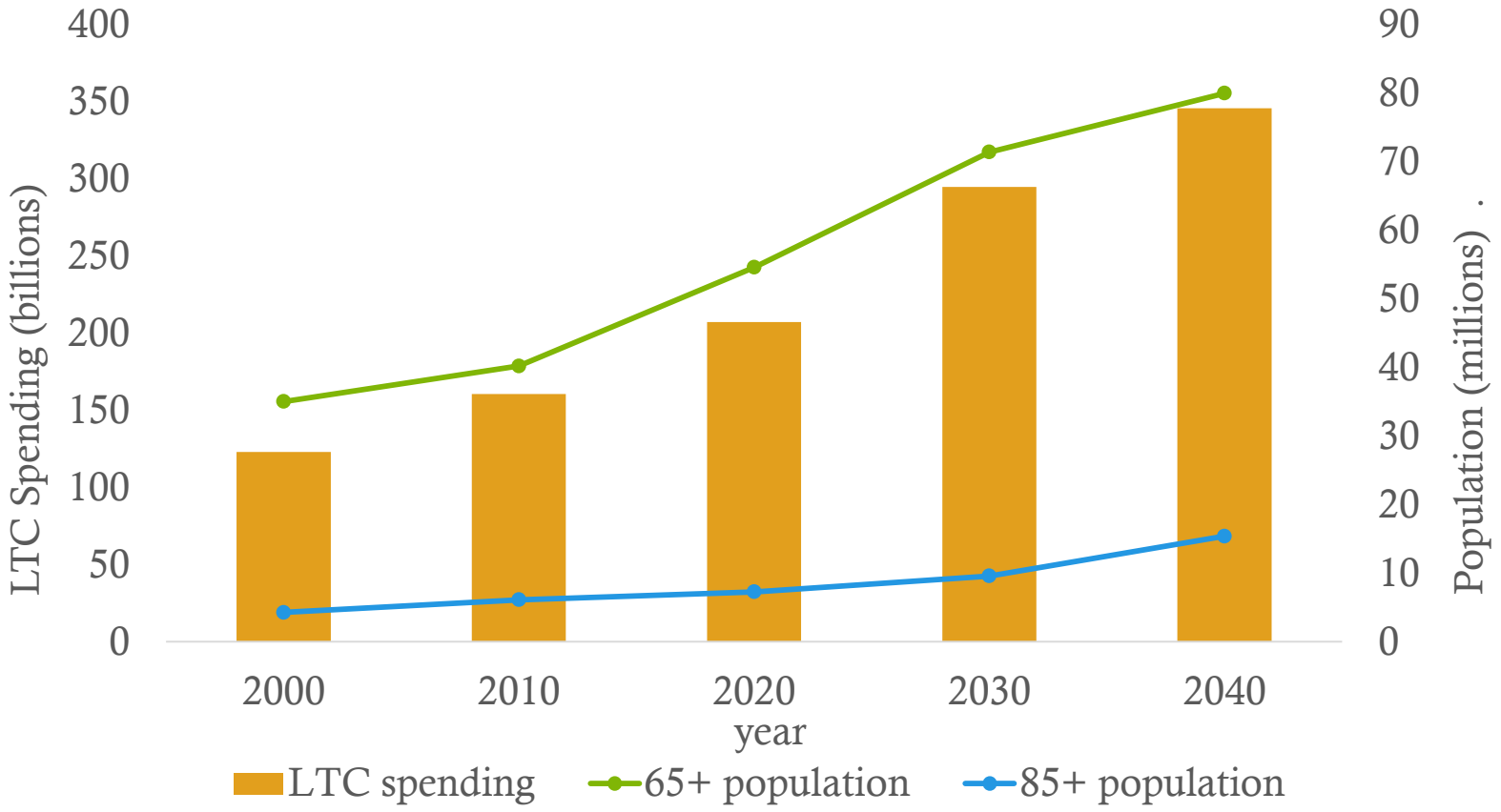
Volume will Come with Time: Elderly and LTC Spending, 2000-2040

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



Source: Grabowski, D., MD, PhD., Harvard School of Medicine

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State Experience with Medicaid Managed Care

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Approaches to MLTSS Programs and Policies Vary across States

Comparison of Key Characteristics of State MLTSS Programs

Level of Stakeholder Engagement	Ample opportunity for provider and beneficiary input throughout the process; input was well-received and incorporated into program design	Program implemented through 1115 with stakeholder collaboration; MLTSS program not addressed in state legislation	Limited opportunity for meaningful stakeholder input before and during implementation process; some protections incorporated through legislative process
Pace and Scope of Implementation	Program started small in scale as a pilot and gradually expanded over time	Once enacted, program was immediately implemented statewide	Program implemented in one region and then phased in to remaining regions over the course of one year
Plan Offerings	Under State law, only non-profits are permitted to provide health insurance of any kind	For-profit corporations	Mix of non-profit and for-profit organizations
Population Served	Elderly population only; pilot with disabled population proved to be unsuccessful	Elderly and disabled populations	Elderly and disabled populations
Plan Accountability	Plans are required to return excess reserves back to the state	Limited understanding transparency of plan accountability processes	Limited understanding transparency of plan accountability processes

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AHCA interviews with executives from Care Providers of Minnesota, Kansas Health Care Association, and Tennessee Health Care Association

Operationalizing MLTSS: Provider Challenges Across States

- ✓ 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

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Provisions Set to Expire in NJ MLTSS in 2016

Any Willing Provider

- 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).

Reimbursement Rates

- 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

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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

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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

Contract Is Greatest Source of Provider Leverage

- 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.

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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

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