Illinois' Move to Managed Care

Life Services Network of Illinois
March 20 & 21, 2013

Management Performance Associates

Speakers

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  - Vice President, Management Performance Associates

Points We Will Cover Today

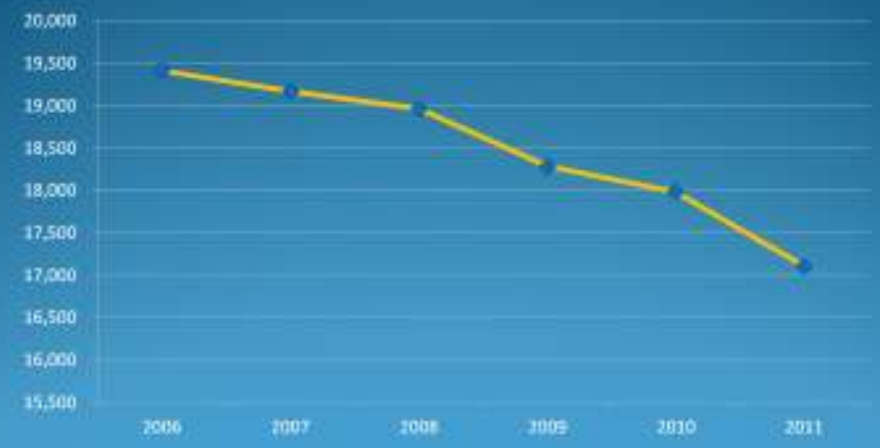
- Structure & strategy of managed care
- Creating strategic advantage
- Adding value for the payer
- Price pressure under managed care
- Approaches to contract negotiations
- Using outcome measures
- Reimbursement

Environmental Issues

- 1 in 6 in U.S. covered by Medicare
- 50% have incomes below $22,000
- 40% have at least 3 chronic conditions
- 23% have mental health impairments
- 10% account for 57% of Medicare spending
- Cost reimbursement: long ago; far, far away
- Medicare rate cuts, rule changes
- Illinois Medicaid: Unaffordable in current form

Illinois SNF Utilization Trend

Resident Days per 1,000 Population



Source: State of Illinois Health Facilities and Services Review Board

Quick Review

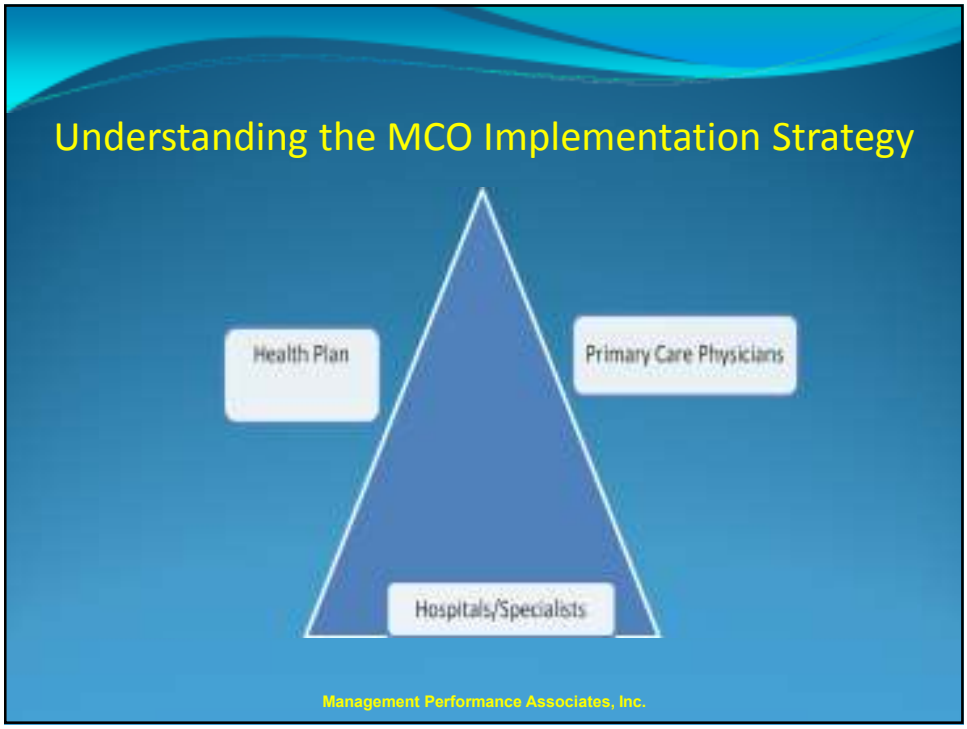
- Health system has two fundamental parts:
  - Finance
  - Delivery
- Cost = Price x Utilization
- Managed delivery – align payment and utilization incentives
- Quality measures added to payment formulas
- Long term care services now integral to delivery

Strategy Questions

- Is there a provider surplus in the market?
- How does managed care delivery (MCD) work when objectives are not aligned?
- What makes my position different from any other provider?
- Do I have core strengths that will help the managed care organization (MCO) achieve its objectives?
- How much does the MCO need me as a provider?
- How much do I need the MCO?
- How much leverage will a single SNF have with the MCO?

Understanding Risk in a Nutshell

- Shared Risk
  - Plan capitates the medical group
  - Plan keeps risk and contracts with institutional providers
  - Plan shares any institutional risk pool savings with the medical group
- Full Risk
  - Plan capitates the medical group
  - Plan capitates the institutional providers, usually dealing through a hospital or health system


Understanding the MCO Implementation Strategy
Health Plan
Primary Care Physicians
Hospitals/Specialists
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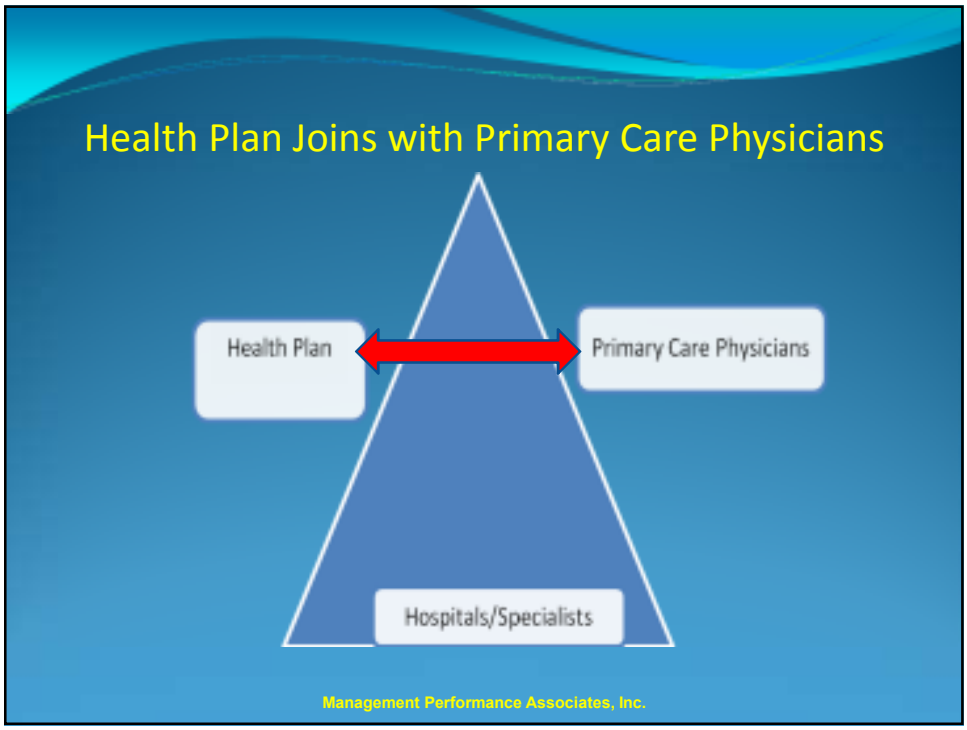
Health Plan Joins with Primary Care Physicians
Health Plan
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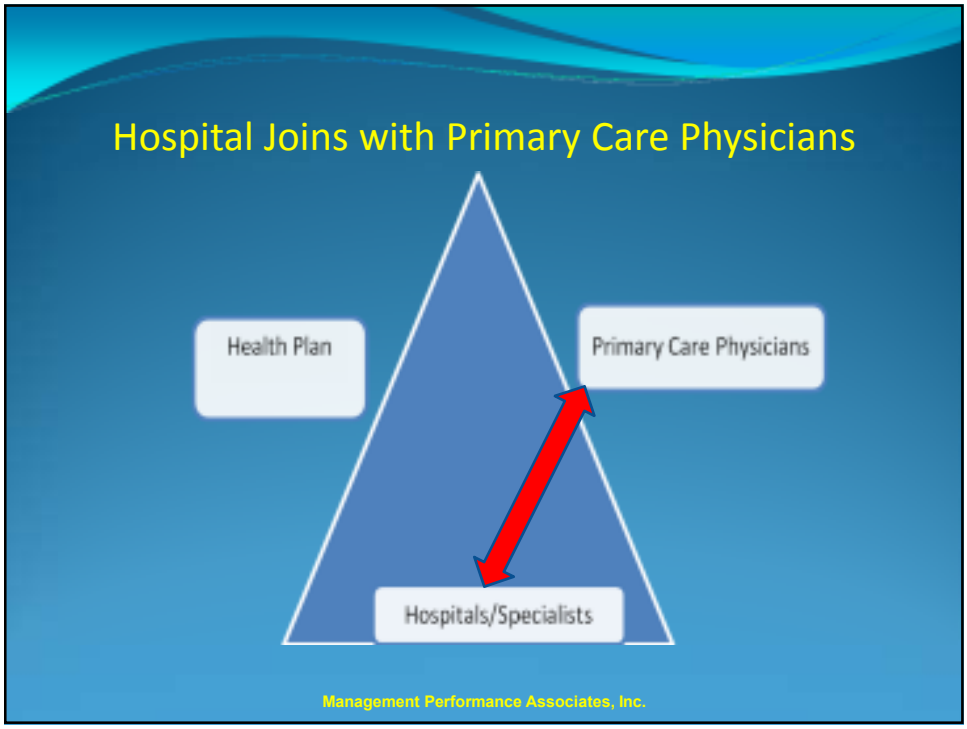
Hospital Joins with Primary Care Physicians
Health Plan
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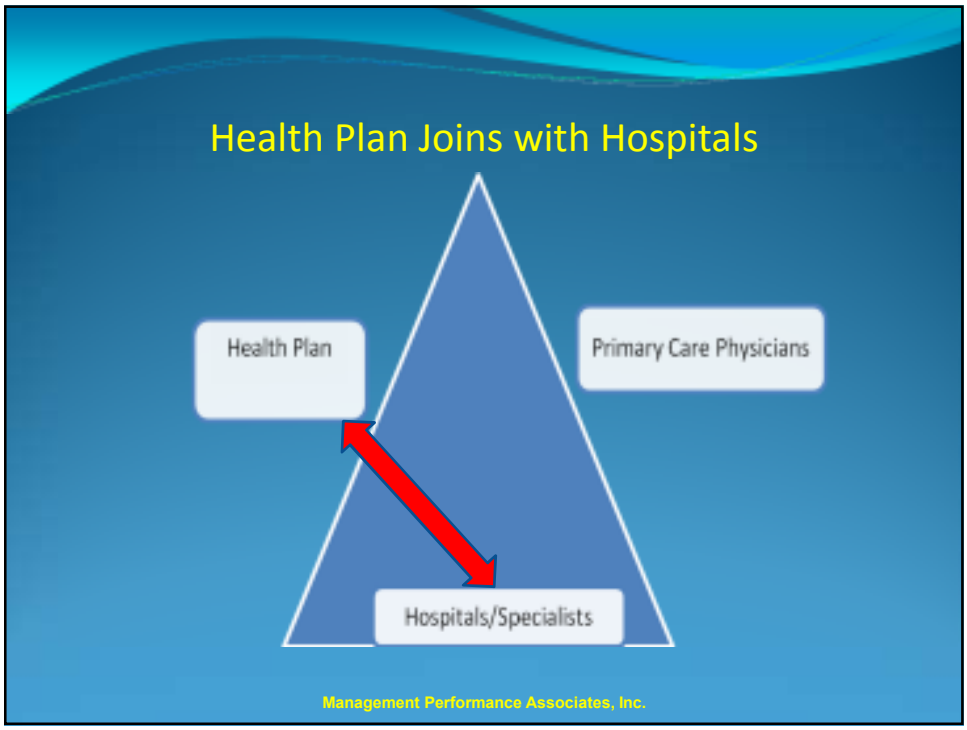
Health Plan Joins with Hospitals
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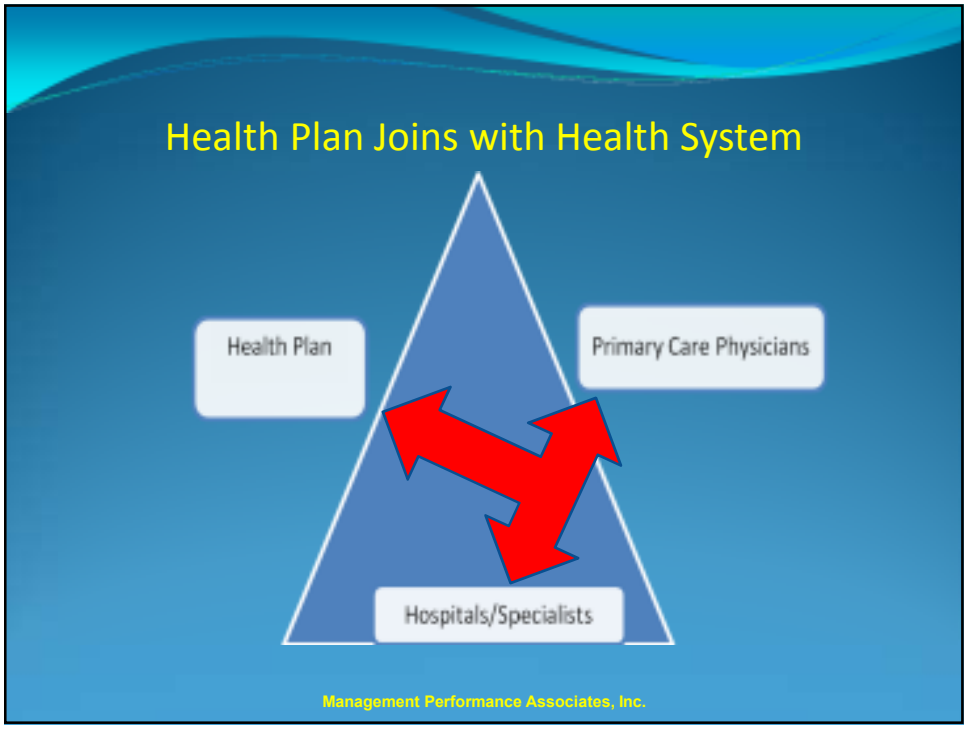
Health Plan Joins with Health System
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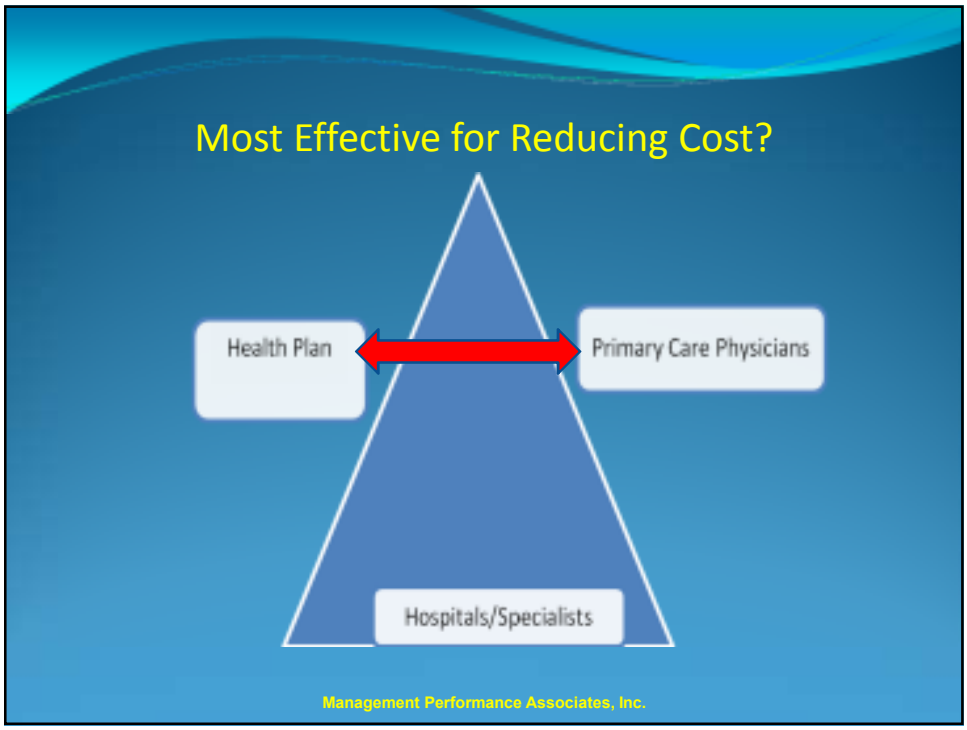
Most Effective for Reducing Cost?
Health Plan
Primary Care Physicians
Hospitals/Specialists
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Most Effective for Improving Quality?

- Still searching……

  For an excellent model, look at Kaiser

Managed Care Tools

- Provider networks/panels/contracts
- Financial incentives
  - Full versus shared risk versus fee for service
- Information systems
  - Care protocols
  - Algorithms
- Case management

Hot Buttons

- Provider surplus??????
- Pricing for services rendered
- Contract terms & conditions – as important as price
- Market share = bargaining power
- Payer mix
- Reliable & replicable results
- Remember: only physicians deliver medical care

Potential Contracting Pitfalls

- "lower of……."
- Utilization review, retro denials, eligibility
- Case management procedures
- Non-payment or suspension of payment during regulatory proceedings
- Right to adjust opns to conform to regulation
- Service matrix and carve –outs
- Disclosure of claims/incidents "out of plan"
- Definition of a "clean claim"

How the Dollars Flow Under Capitation

- General funds flow:
  - 30% primary care physician
  - 45-50% hospital
  - 5%+ pharmacy
  - 15-20% administrative and general
- Must know: provider service matrix, how plan will fund risk pool, impact of carve-outs
- What follows is for demonstration purposes only!

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How the Dollars Flow Under Capitation

Premium Dollars:
Plan deducts A&G

100 Pct: $120

80 Pct: $100

Physicians	Hospitals	Misc	Reserves
30 pct: $36	45 pct: $54	2.5 Pct: $5	2.5 pct: $5
PCPs	Institutions	Pharm	IBNR
Specialists	Hosps	OOA	Contingency
ED	SNFs??	Transplant	
ASC??	ASC??		
Imaging?	Imaging?		
SNFs??			

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How the Model Works

- Payment Characteristics
- Enrollees: 50,000
  Member months 600,000
  Net premium dollars $60,000,000
- Current Days/1,000 500 Non-Medicare
  Hospital per diem $1,500
  Current costs $37,500,000
- Target 250
  Hospital per diem $1,500
  Target costs $18,750,000
- Savings 50 percent

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Market Share & Strategic Advantage

- More geography, more facilities are better
- Single provider = no leverage
- Price is a synonym for commodity, especially if supply exceeds demand
- Providers need volume, plans do not
- Add value: "we are experts at…….and here is our data"

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Contract Negotiations: Be Attractive

- Propose outcome measures you believe in and can support with data
- Can you propose a carve-out or specialty niche?
- What are you doing to replicate results, reduce variation?
- Make it easy for plan case managers to use your facility
- Recognize that some plans will welcome more education about long term care

Reimbursement

- Expect per diems, maybe some case rates
- Do not expect discounts from charges
- Expect pay-for-performance criteria including payment withholds or bonus
- Plan to control your clinical processes – too much variation will be costly
- Do not assume risk unless you can control the medical management of a large population

Medicare-Medicaid Alignment Initiative (MMAI) Recap of Proposed Delivery System

- Enrollment
- Covered services
- Care coordination/case management and risk assessments
- Transitions of Care
- Network Adequacy
- MCO reimbursement & financial incentives (for MCOs)
- Outcomes

Source: State of Illinois Solicitation Document (RFP) & Memorandum of Understanding (MOU) between CMS and the State of Illinois (February 22, 2013)

Medicare-Medicaid Alignment Initiative – Recap Health Plan Reimbursement

- Health plans will be paid a capitated rate – per member per month
- Based on baseline spending in both Medicare and Medicaid programs and anticipated savings that will result from the integration and improved care management
- Savings percentage

Year 1	1 percent
Year 2	3 percent
Year 3	5 percent

Medicare-Medicaid Alignment Initiative
SNF Reimbursement Rates

- SNFs will be paid current Medicare and Medicaid rates
- Costs = Price x Utilization
- Utilization must fall – New Sherriff is in town – Changing incentives to reduce SNF services and/or costs

Medicare-Medicaid Alignment Initiative - Recap
Health Plan Incentive Pool

- Incentive pool proposed
  - Year 1 1% holdback
  - Year 2 2%
  - Year 3 3%
- Plans will receive a percentage of the holdback based on achieving pay for performance metrics established by the State/CMS
- CMS metrics required for all demonstration programs nationwide
- State specified withhold measures

Medicare-Medicaid Alignment Initiative - Recap
SNF Quality Measures – Years 2 and 3

- 30 day Readmission Rate
- Transitions of members from LTC to waiver services
  - Report the number of members moving from institutional care to waiver services
- Long Term Care residents 0f prevalence of pressure ulcers – stage II or higher

Additional Outcomes Mentioned in Memorandum of Understanding

- Hospital admissions from long term care due to UTIs
- Hospital admissions from long term care due to bacterial pneumonia

Medicare Medicaid Alignment Initiative - Recap Network Adequacy

- For the first year of the demonstration (10/1/13 to 12/31/14) Demonstration Plans will be required to offer contracts to all nursing facilities and SLFs
- After the first year , Plans may establish quality standards and may contract with only those providers that meet such standards, as long as providers are informed no later than 90 days after the start of the first year of the Demonstration

Metrics Currently Used to Profile Skilled Nursing Facilities

Catholic Health Initiatives

73 hospitals in 19 states

- Length of stay
- 7- and 30- day readmission rates
- Functional independent measure (FIM) scores
- Patient and family satisfaction
- Emergency room visit rates
- Infection rates
- Interviews with primary care physicians, specialists and hospitalists

Kaiser Permanente Northwest

Northwest Oregon/Southwest Washington

- Patient satisfaction
- Readmission rates
- Functional independent measure (FIM) scores
- CMS 3 star rating or higher
- Emergency room transfer rates
- Low Medicare length of stay

The Methodist Hospital – Houston, TX

- Facility acquired pressure ulcers
- Unanticipated weight loss
- Restraint usage
- Dehydration
- Staffing levels
- State investigations
- Tenure of Administrator and Director of Nursing
- Medical Director qualifications
- Patient and family satisfaction

Satisfaction Surveys

- Resident/Family Satisfaction Surveys
  - "Would you recommend this facility to others?"
- Employee satisfaction surveys?
  - "Would you recommend the facility you work at to others?"

What do Hospitals/Health Plans Want from SNFs?

- Drive down costs for Medicare
- Reduce hospital readmissions
- Reduce hospital Medicare length of stay
- Ability to manage high case mix, fragile patients
- Good quality measures

Managed Care is Changing the Incentives for SNFs

- Current Incentives with Per Diems
  - More Medicare volume – referrals based on first come, first served
  - Maximize Medicare length of stay
  - Maximize the amount of rehab services = higher Medicare per diems
  - Quality not an issue

Managed Care is Changing the Incentives for SNFs

- Managed Care Incentives
  - Reduce readmission rates
  - Minimize Medicare length of stay (cost savings per resident)
  - Reduce rehab utilization (per diem cost savings)
  - Measurable outcome improvement (improve quality of care)
  - More Medicare referrals

SNF To Do List – Costs

- Track Medicare length of stay by diagnosis
- Rehab protocols by diagnosis
- Objectively show improvement in resident functional status from admission to discharge by resident by diagnosis

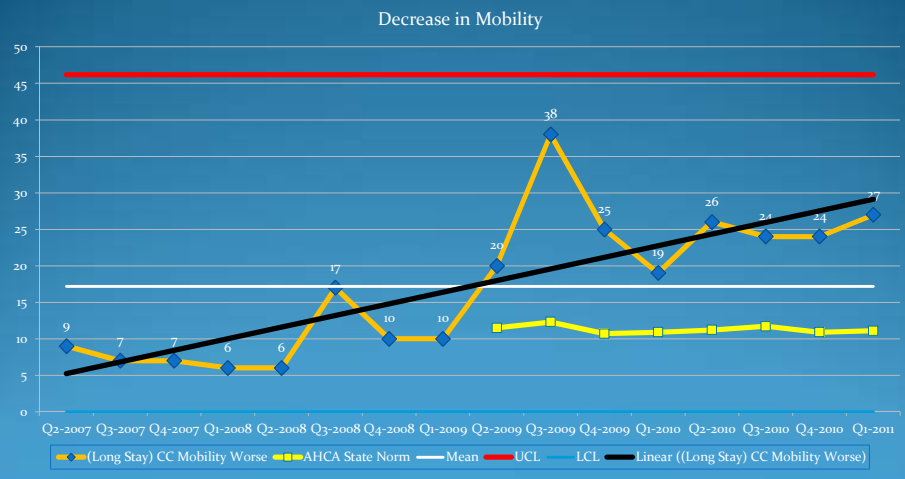
SNF To Do List – Quality Measures

- Improve your 5-star rating
- Patient and family satisfaction surveys
  - Independent survey versus facility survey

SNF To Do List - Readmissions

- Do you know your readmission rates?
- Track monthly readmission rates
- Track source, timing and causes of readmissions
- Specific resident characteristics?
- Emergency room transfers

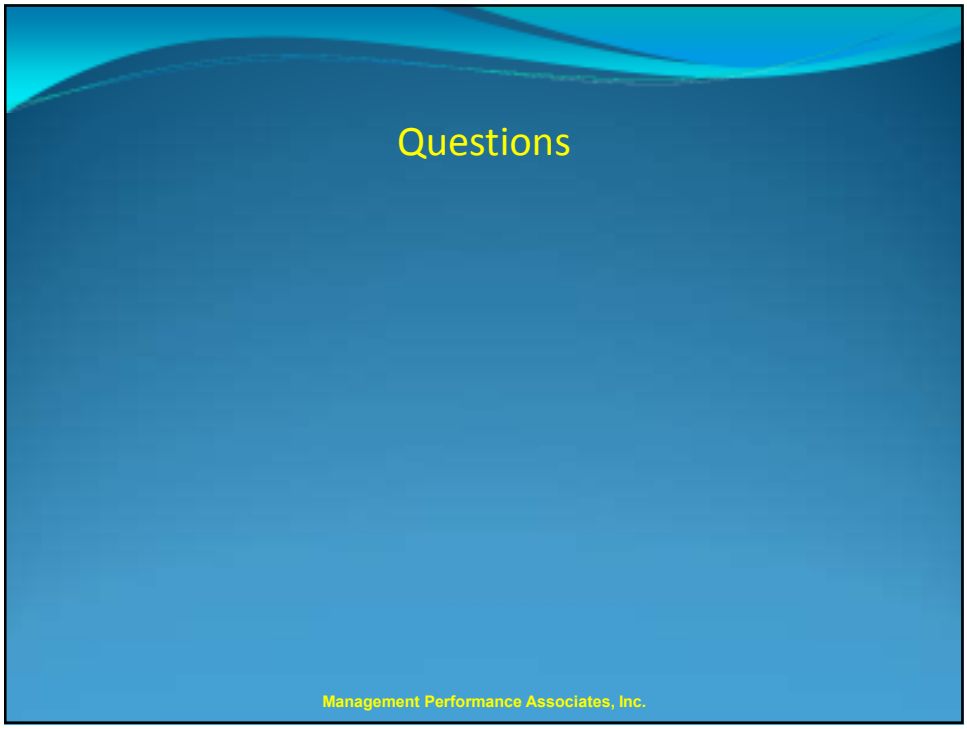
Quality Measure Profile Example



Final Thoughts

- Cost
- Quality
- Readmissions

Document and provide objective evidence that you are a quality provider


Questions
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