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Succeeding Under Managed Delivery

Strategies for the Coming Revolution

advocate educate innovate

Speaker

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Points We Will Cover Today

- What is managed delivery, how does it work?
- Structure & strategy
- Price pressures
- Pros & Cons of different reimbursement models
- Effective contracting

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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

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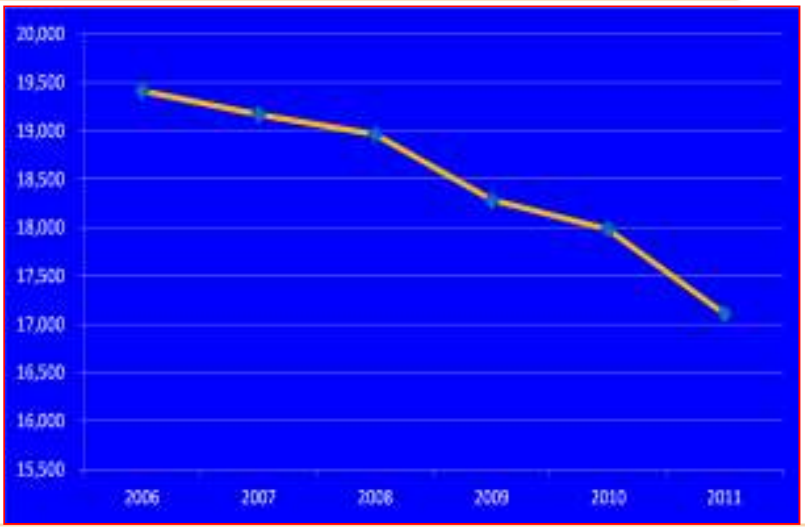
Illinois SNF Utilization Trend
Resident Days per 1,000 Population



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Quick Facts

- 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

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Basic Concepts: How the health system is organized and how it functions

The health care system has two fundamental elements:

Finance	Delivery
Payers including-----	Providers including ----
Medicare	Physicians
Medicaid	Hospitals
Commercial Insurers	APNs
Health Plans	Home Health
HMOs	Outpatient
MCOs	Ambulatory Surgery
Regulatory Agencies	LTC (absent in earlier years of MCD)

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Cost Formula

- Cost = Price x Utilization
- Deceptively Simple
- A root cause in the escalation of health care costs

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Overview of Healthcare Reform

- Current system
  - –Fee for service
  - –More services, more revenue
- No incentives for efficiency
- No incentives for quality
- Fragmented delivery system

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Overview of Healthcare Reform

- New Healthcare System
  - Align quality with payment incentives
  - Provide financial incentives to improve cost efficiencies – save $$
  - Improve coordination of care between providers

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Managed Care Defined
Several Working Definitions

- A variety of techniques intended to reduce the cost of providing health benefits and improve the quality of care
- Systems of financing and delivering services to enrollees organized around managed care techniques and concepts ("managed care delivery systems")
- An administrative system that controls cost, quality, and access
- Change clinical behavior by integrating payment with service delivery and outcome

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What Is Different in Today's Version of Managed Care?

- Management of chronic disease is included in ACA and is a central theme in any ACO's strategy
- Risk models include chronic disease
- Quality receives heightened emphasis; reimbursement depends upon achieving measurable quality goals. Prior iterations of MCD had few, if any, quality measurement tools. Quality measures got better over time. If providers cannot prove quality, the plan controls the debate and can hammer price.
- Significant aspect of health reform: Value Based Payment, where payment is tied to performance

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Objectives of Managed Care
Cost and Utilization

- Control/reduce cost
- Reduced utilization of high cost services
  - controlled access
  - alternate settings
  - alternate services
  - alternate providers
- Improved clinical outcomes and patient satisfaction

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Roles of Key Players - MMAI

State of Illinois, acting through HFS and CMS/Medicare:

- creates the system for managed delivery by defining the benefit package;
- determining the actuarial models and financing package needed to support the benefit package;
- contracting with managed care organizations (health plans) to administer the program – network build-out and provider contracting, case management, payment of provider claims, reporting to HFS.

HFS retains responsibility for eligibility determination, DON screening.

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Roles of Key Players- MMAI

MCOs:

- Perform functions as delegated by State HFS
- Develop provider contracting network and claims payment systems
- Provide case management to administer benefits that enrollees are authorized to receive
- Maintain quality monitoring systems and measures to satisfy objectives of State
- Administer appeals and inquiries from enrollees

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Roles of Key Players- ACO

- Finance & Delivery elements jointly create the ACO legal entity
- Health Plan joins with health/hospital system
- Health Plan joins with large physician organization
- Health Plan joins with medical home
- OWA (Other weird arrangements)

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Roles of Key Players

Providers:

- Provide health care services and accept compensation in the manner stipulated in the provider agreement;
- Options for providers are several. Providers can contract individually or as a group, the group being subject to anti-trust restrictions;
- As a general rule, individual providers have little leverage with MCOs.

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Aligned Incentives

- Incentives are aligned for *some* players…. *but not for all*

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Strategy Questions
Shaping the Revolution

- How does managed care delivery (MCD) work when objectives are not aligned?
- Is there a provider surplus in the market?
- 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?

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How Will the Revolution Develop?
What Can We Expect?

- Major impact in larger metro areas (Chicago)
- Utilization will drop (case management)
- Activity will move downstream (network build-out)
- Remaining volume = higher acuity (cost pressure)
- MMAI & ACOs will pressure pricing
- Fixed cost per unit of service will increase
- Access to capital (already tight) will decline
- Industry consolidation will likely begin
- Extraordinary opportunities for strategic visionaries will develop

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Revolution Wild Cards

- Will exodus from hospitals off-set downstream movement of ICF?
- Will Plans create sufficient network capacity to handle downstream volumes?
- Can providers off-set volume declines with other business?
- Will there be political & regulatory complications?

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Revolution Wild Cards

- Will the MMAI demonstration project be extended to cover other populations?
- State-wide full benefit duals – 250,600
- In demonstration project – 137,000
- Over age 65 – 119k (Chicago); 18k (central)
- 65+ with serious MI – 33,443

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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

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More on Risk

- MMAI is a full risk deal
- ACOs have several approaches to risk-sharing
  - Full risk
  - Risk-lite

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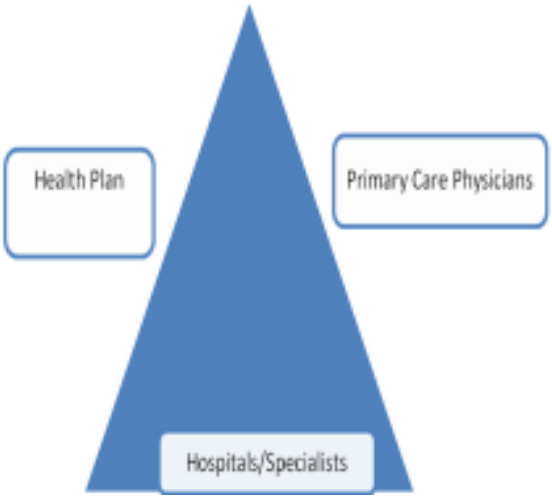
Understanding the MCO Implementation Strategy



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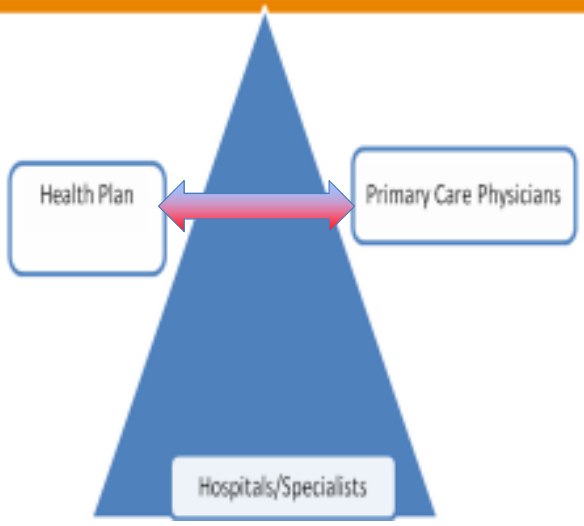
Health Plan Joins with Primary Care Physicians



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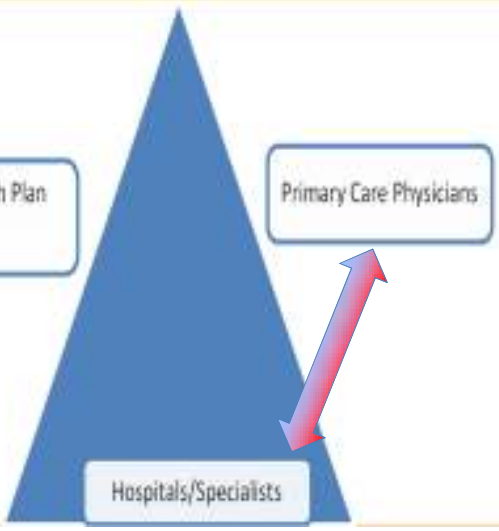
Hospital Joins with Primary Care Physicians



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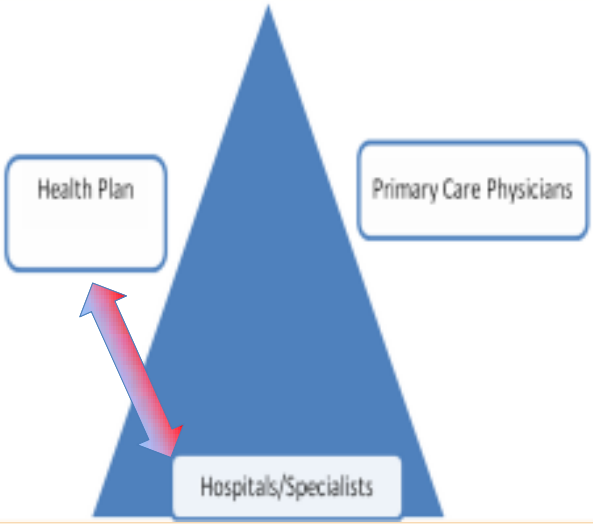
Health Plan Joins with Hospitals



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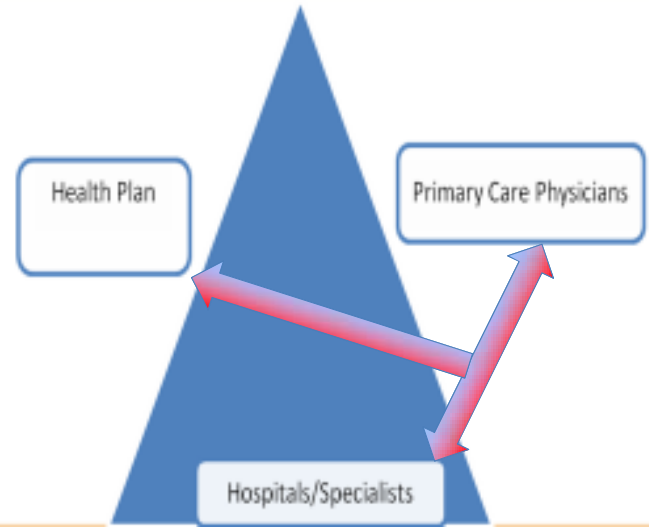
Health Plan Joins with Health System



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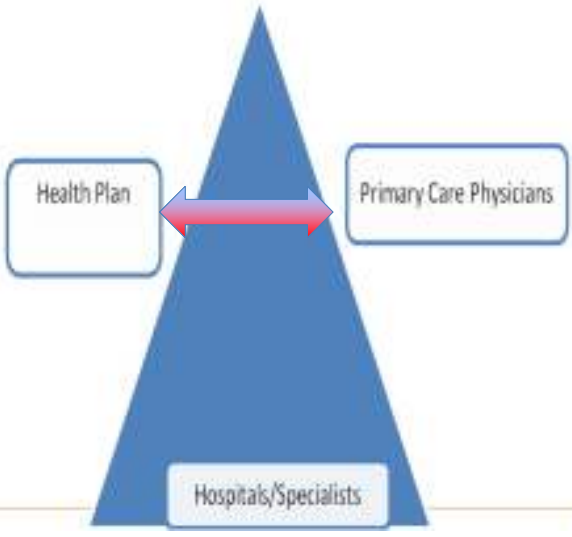
Most Effective for Reducing Cost?



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Most Effective for Improving Quality

- Still searching…….

For an excellent model, look at Kaiser

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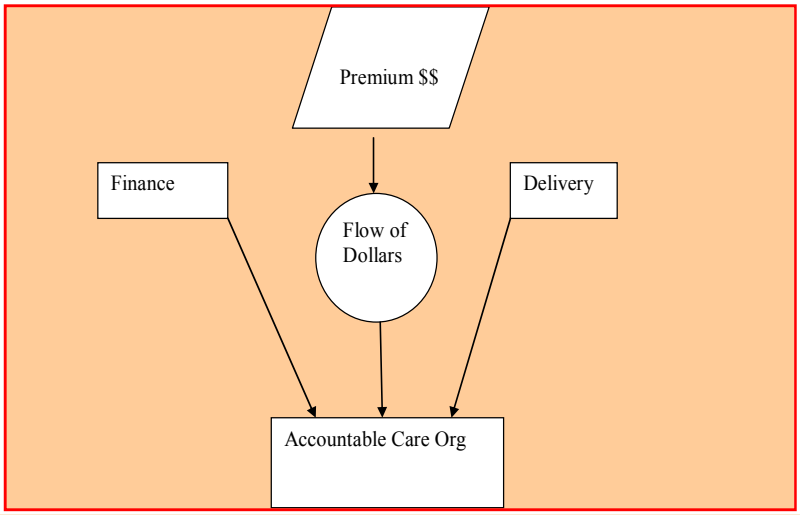
The ACO Twist



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Opportunity Grid
Open Spaces by Contract

	Primary	Specialty	Acute	Opt	SNF	SLF	HCBS
Med Grp	X	X		X			
Med Home	X						X
IPA	X	X		X			
Hlth System	X	X	X	X			
Other Weird Arrangement (OWA)					Open	Open	Open

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Managed Care Tools

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

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Pricing Under Managed Delivery

Method	Expect	Issue
Fee For Service (FFS)	No	No provider incentive to manage cost
Discount	No	Same as above
Per Diem	Yes	Provider at risk for daily cost
Case Rate	Yes	Provider now at risk for LOS
Capitation	No	No business reason to share upside with SNF ..?..

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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

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Strategic Advantage
How Do Providers Create It?

- Your MCO contract reflects your strategic importance
- If you can create strategic advantage, you increase the likelihood of getting the terms you want
- Nothing creates leverage with the Plan like market share, geographic coverage, credible quality and cost performance, customer satisfaction

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Strategic Advantage
Which Provider Is Stronger?

Large metro facility
Well located, easy access
Specialty niche in ALZ and renal dialysis
5-Star rating
Impeccable reputation
Consistently high occupancy
Financially stable
No trouble accessing capital
The Place to Be Seen

Association of 30 SNFs
Broad mkt coverage
5 and 4 Star rankings
ALZ & Diabetes mgt carve-out
Consolidated approaches to:
- medical & case mgt
- clinical protocols
- accreditation (JCAHO)
- rehab
- pharmacy
- compliance
- quality
- risk mgt
- training & education

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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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About Contracting

Success is far more than getting a contract – BUT- without a contract you cannot play

Success is a function of:

Identifying a competitive advantage (strategy)

Adapting that strategy to fast-paced change

Using the strategy to meet Plan needs

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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"

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

Managed Care Will Change 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 amount of rehab services = higher Medicare per diems
- Quality not an issue

…… Changing the Incentives for SNFs

Managed Care Incentives

- Reduce readmission rates
- Minimize Medicare length of stay
- Reduce rehab utilization
- Measurable outcome improvement
- Manage cost of clinical processes
- Receive more Medicare referrals
- Expect a fixed price – per diem or case rate

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

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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

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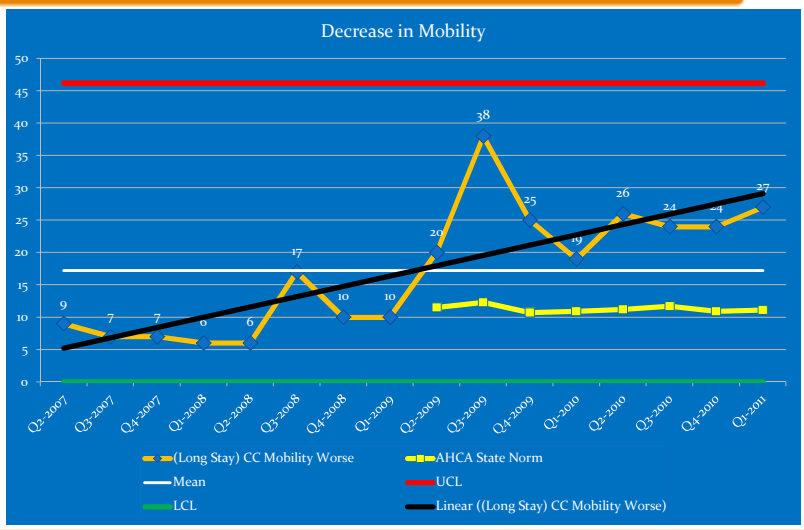
Quality Measure Profile Example



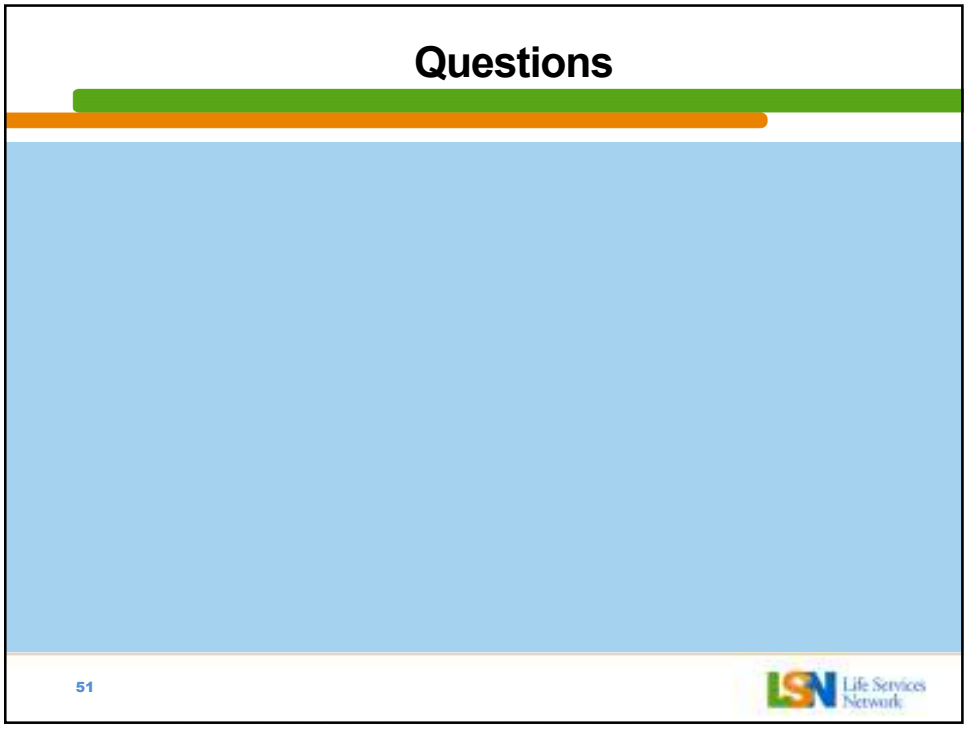
Final Thoughts

There is a clear strategy and structure to managed delivery.

The business model for the MCO could not be more different than what we are used to.

If managed delivery gains traction, its market forces can be very powerful.

Embracing the change and being proactive will make a difference in your organization.


Questions
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