Navigating ACOs and Managed Care Programs

LeadingAge Iowa Spring Conference 2015

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LeadingAge

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Overview

• What can LeadingAge providers expect?

• What can LeadingAge providers do?
What can LeadingAge providers expect?

“Opportunity paged me, beeped me, linked me, e-mailed me, faxed me, and spammed me. But I was expecting it to knock!”
Pennsylvania's Medicaid Managed Care Organizations have recently developed a detailed recommendations paper relating to the implementation of a MLTSS program model in Pennsylvania. This paper has been shared with the Administration and provider and advocacy groups, with the goal of promoting the implementation of this innovative and successful model in Pennsylvania. A copy of this document may be found here.
The New Reality

Shorter lengths of stay

Increased movement toward home and community based services

Narrowing networks and impact on referrals

Clinically complex patients required advanced clinical skills

Necessity for highly skilled, highly competent staff

Greater involvement from other healthcare entities involved in a patient’s care – deployment of care managers, care coordinators, third party entities

Imperative to know your own data and outcomes as well as other healthcare partners in your community

Requirements for IT connectivity, communication and data exchange

<table>
<thead>
<tr>
<th>Function</th>
<th>Traditional FFS</th>
<th>Managed Care</th>
<th>Risk</th>
<th>Opportunity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Adequacy/Participation</td>
<td>1. Any willing provider meeting State standards of participation.</td>
<td>1. Contract with providers to develop a network that meets State standards. State/MCO agreements can include “any willing provider” provisions.</td>
<td>1. Simply meeting State requirements is no longer a guarantee of network participation. Providers must demonstrate quality and efficiency with data.</td>
<td>1. If you are a high quality provider in a narrow network you could experience increased volume based on your participation. 2. Opportunity to focus clinical competencies in the areas of need for the MCO.</td>
</tr>
</tbody>
</table>
### Contracting

**Traditional FFS**
1. No provider contract needed, just meet state requirements.

**Managed Care**
1. State contracts with MCO. MCO contracts with provider. Provider now has multiple contracts with varying provisions.
2. Provider must be more savvy in analyzing, negotiating, implementing and evaluating multiple contracts and educating staff at all levels.

**Risk**
1. Administrative complexity related to varying contractual provisions (reimbursement, billing, authorizations, quality measures).
2. Increased expense if consultants are hired to assist in contract review.
3. Some MCOs use "boiler plate" contracts and there is little to no room for negotiation – "take it or leave it" strategy.

**Opportunity**
1. Under traditional FFS there is no negotiation of rates. High quality providers are paid the same as sub par providers. In managed care environments high quality providers and/or providers in rural areas could see increased reimbursement based on MCO need.
2. New models of payment can also be options – pay for performance, gain sharing, capitation. New opportunities for business growth.

### Quality Monitoring

**Traditional FFS**
1. States and Feds monitor provider quality.
2. States and Feds will now also monitor MCO quality which will include provider outcomes and additional measures.

**Managed Care**
1. Many MCOs will incorporate the current provider quality measures into their oversight programs.
2. Additional measures will be added to ensure they meet their contractual requirements and financial incentives with the State and Feds. Examples of new measures include functional outcome scores, hospital admissions and readmissions, length of stay.
3. States will need to educate and add staff to ensure sufficient MCO monitoring is in place.

**Risk**
1. States may lack staffing and sophistication for quality oversight. Sub par plans may remain under contract.
2. Providers may experience increased administrative burden from collecting and reporting new measures. Could see lack of consistency among plan reporting requirements. Data collection for new measures may be burdensome, largely manual processes.

**Opportunity**
1. Sophisticated providers have the opportunity to differentiate themselves and potentially get higher reimbursement for their quality.
### Function

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<tr>
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<tr>
<td>Case Management</td>
<td>1. Case management fragmented. Each individual provider responsible for managing their piece. Coordination left to patient/family. 2. Provider by default can end up coordinating care beyond their four walls without adequate reimbursement. 3. Provider not priviledge to each others’ information.</td>
<td>1. Pre authorization required and length of stay can be reduced. 2. Need to understand prior auth requirements, documentation requirements, assessment requirements. 3. Some assessments and case management will take place on site some telephonically 4. MCO has robust warehouse of data on each member that cuts across provider settings</td>
<td>1. Administrative burden associated with prior authorization, pre payment documentation submission and follow up, post payment review and billing requirements. 2. Reduction in overall length of stay resulting in decreased reimbursement. 3. MCO staff in care settings – disruption</td>
<td>1. Look to get case management delegated for current residents and/or specific populations</td>
</tr>
<tr>
<td>Reimbursement</td>
<td>1. Fee schedule set by State or Feds 2. Little opportunity for improvement</td>
<td>1. Reimbursement can vary by MCO (FFS, RUGs, levels of care). 2. Payment timeliness can vary. Contractually MCOs usually follow Medicare prompt payment rule of 30 days. 3. Some MCOs have onerous pre payment documentation review that can lengthen time to reimbursement. MCO not always clear about what documentation is required. 4. Post payment review can take place. 5. Reimbursement level can be determined by the MCO, not based on or loosely based on the facility MDS. 6. Pre authorization required and length of stay can be reduced.</td>
<td>1. Lower reimbursement rates than under FFS. 2. Frequency of high level reimbursement can be drastically reduced. 3. Cash flow can be negatively impacted by less than Medicaid/Medicare timely payment, pre payment and post payment review. 4. Administrative burden associated pre payment documentation submission and follow up, post payment review and billing requirements. 5. Reduction in overall length of stay resulting in decreased reimbursement. 6. Potential inability to recoup Medicare bad debt payment.</td>
<td>1. Reimbursement could increase based on higher acuity patients and services. Shorter length of stay can lead to greater turnover and overall number of skilled days. 2. If bad debt included in reimbursement could be included in claim vs cost report settlement. 3. MCO could have responsibility for collecting patient pay. 4. MCO could assist in facilitating collection of patient pay for provider. 5. New value based models provide for enhanced reimbursement for high quality/efficient providers</td>
</tr>
</tbody>
</table>
What Can LeadingAge Providers Do?

Data driven
Patient Centered
Focus on Communication

Key Elements

Clinical Capability
Efficiency
Partnerships

Expanding the world of possibilities for aging.
1. Market Position Reports by Avalere
2. Ask the Avalere expert
3. Quality Metrics
4. LeadingAge Survey and Certification Reports
5. Ask the MDS Expert
6. Ask the Housing Expert

Market Position Reports by Avalere

- **Readmissions Report**
  - Building-level readmission data for Medicare providers in market area
  - Market-level view of how care settings as a whole are performing

- **Market Share Report**
  - Key hospitals’ top five most commonly DRGs
  - Top discharge destinations from key market hospitals

- **Length of Stay Report**
  - Building-level length of stay data for Medicare providers in market area
  - Market-level view of how care settings as a whole are performing on length of stay measures
Environmental Assessment:

1. Medicare Advantage penetration
2. Integrated health systems/ACOs
3. State/federal innovation
4. Medicaid managed care
5. State plans for Medicaid/long term care
6. Who are the health plans? (commercial, medicare, medicaid, quality, enrollment)
7. What does State Medicaid budget look like (growing, stable, underfunded)
8. Who are the largest long term care players?
9. Legislative views on ltc, managed care, medicaid
10. What are neighboring states doing?
11. Successful models of managed long term care (policies/provisions/outcomes)
12. Federal incentives (ACA demonstration programs, waiver flexibility etc)

Resources:

1. Kaiser Family Foundation State Health Facts
   http://kff.org/medicare/state-indicator/enrollees-as-a-of-total-medicare-population/ CMS Medicare/Part D Enrollment Data
2. CMS Innovation Center ACOs
   http://innovation.cms.gov/initiatives/ACO/
3. CMS Innovation Center
   http://innovation.cms.gov/
4. State Medicaid website, Kaiser Family Foundation State Health Facts
   http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/,
   CMS Medicaid Enrollment Report

Iowa Medicare ACOs

<table>
<thead>
<tr>
<th>Organization</th>
<th>Program</th>
<th>Provider Affiliation</th>
<th>Service Area</th>
<th>Assigned Beneficiaries</th>
<th>Risk Track</th>
<th>Shared Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trinity Pioneer ACO</td>
<td>Pioneer ACO</td>
<td>UnityPoint Health</td>
<td>Northwest Central Iowa</td>
<td>10,600</td>
<td>One, upside only</td>
<td>None in year one</td>
</tr>
<tr>
<td>Univ of Iowa Affiliated Health Partners</td>
<td>MSSP</td>
<td>Mercy Medical Center – Cedar Rapids, IU Healthcare</td>
<td>East Central Iowa</td>
<td>20,262</td>
<td>One, upside only</td>
<td>None in year one</td>
</tr>
<tr>
<td>Mercy ACO</td>
<td>MSSP, Commercial</td>
<td>Mercy Medical Center – Des Moines</td>
<td>Greater Des Moines</td>
<td>27,662</td>
<td>One, upside only</td>
<td>$4,426,331</td>
</tr>
<tr>
<td>Iowa Health Accountable Care L.C.</td>
<td>MSSP</td>
<td>UnityPoint Health</td>
<td>Iowa and Illinois</td>
<td>86,134</td>
<td>One, upside only</td>
<td>None in year one</td>
</tr>
<tr>
<td>Genesis Accountable Care Organization</td>
<td>MSSP, Commercial</td>
<td>Genesis Health System</td>
<td>Eastern Iowa and Western Illinois</td>
<td>19,855</td>
<td>One, upside only</td>
<td>None in year one</td>
</tr>
<tr>
<td>Alegant Health Partners</td>
<td>MSSP</td>
<td>Alegant Health</td>
<td>Iowa and Nebraska</td>
<td>23,852</td>
<td>One, upside only</td>
<td>None in year one</td>
</tr>
<tr>
<td>Accountable Care Clinical Services</td>
<td>MSSP</td>
<td>Iowa, California, Connecticut, Massachusetts, Pennsylvania</td>
<td>19,637</td>
<td>One, upside only</td>
<td>$10,526,169</td>
<td></td>
</tr>
</tbody>
</table>
# Iowa Commercial ACOs

<table>
<thead>
<tr>
<th>ACO Program</th>
<th>ACO Name</th>
<th>Website</th>
<th>ACO Type</th>
<th>Member Entities</th>
<th>Providers</th>
<th>Beneficiaries</th>
<th>HQ Location</th>
<th>Approximate Service Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>Family Health Care of Siouxland</td>
<td><a href="http://www.fhcd.com/">www.fhcd.com</a></td>
<td>IPA</td>
<td>Agreement with Wellmark Blue Cross and Blue Shield</td>
<td>N/A</td>
<td>N/A</td>
<td>Sioux City, IA</td>
<td>IA</td>
</tr>
<tr>
<td>Commercial</td>
<td>Iowa Clinic</td>
<td><a href="http://www.iowclinic.com/">www.iowclinic.com</a></td>
<td>IPA</td>
<td>Agreement with Wellmark Blue Cross and Blue Shield</td>
<td>150</td>
<td>11,000</td>
<td>West Des Moines, IA</td>
<td>IA</td>
</tr>
<tr>
<td>Commercial</td>
<td>McFarland Clinic of Ames</td>
<td><a href="http://www.mcfarlandclinic.com/">www.mcfarlandclinic.com</a></td>
<td>IPA</td>
<td>Agreement with Wellmark Blue Cross and Blue Shield</td>
<td>N/A</td>
<td>N/A</td>
<td>Ames, IA</td>
<td>IA</td>
</tr>
<tr>
<td>Commercial</td>
<td>Mercy Medical Center-Cedar Rapids &amp; University of Iowa Hospitals</td>
<td><a href="http://www.mercycare.org/">www.mercycare.org</a></td>
<td>IDN</td>
<td>Agreement with Wellmark Blue Cross Blue Shield of Iowa</td>
<td>N/A</td>
<td>N/A</td>
<td>Iowa City and Cedar Rapids, IA</td>
<td>IA</td>
</tr>
<tr>
<td>Commercial</td>
<td>Wheaton Franciscan Healthcare Iowa</td>
<td><a href="http://www.wheatonfranciscan.org/">www.wheatonfranciscan.org</a></td>
<td>IDN</td>
<td>Agreement with Wellmark Blue Cross Blue Shield of Iowa</td>
<td>N/A</td>
<td>N/A</td>
<td>Waterloo, IA</td>
<td>IA</td>
</tr>
<tr>
<td>Commercial</td>
<td>One Care, LLC (Mercy ACO)</td>
<td><a href="http://www.mercydesmoines.org/">www.mercydesmoines.org</a></td>
<td>IDN</td>
<td>Wellmark is collaborating with this ACO and Mercy Health</td>
<td>402</td>
<td>N/A</td>
<td>Des Moines, IA</td>
<td>IA</td>
</tr>
<tr>
<td>Commercial</td>
<td>Unity Point Health Partners</td>
<td><a href="http://www.unitypoint.org/aco">www.unitypoint.org/aco</a></td>
<td>Physician led</td>
<td>Agreement with United Healthcare. 2,500 independent and employed physicians.</td>
<td>2,500</td>
<td>36,000</td>
<td>West Des Moines, IA</td>
<td>IA</td>
</tr>
</tbody>
</table>

## Tools/Resources

**Contract provision protections**

1. Any willing provider
2. Medicare and Medicaid reimbursement as the floor (including applicable bad debt)
3. Prompt payment in line with current Medicaid and Medicare processes
4. Standard clean claim definition
5. Claim submission timeframes
6. Timeframe for requests for additional information (received and reviewed)
7. Retroactive denials
8. Payment methodology – defined and standardized
9. Term and termination
10. Patient pay liability
11. Specialized care services
12. Use of contracted vendors (lab, pharmacy etc)
13. Credentialing
14. Quality reporting (measures and collection methodology)
15. Continuity of care provisions
16. Product lines included in contract
17. Lessor of clause
18. Prior authorization and determination of medical necessity
19. Assessment tool to be used
20. How to determine eligibility
21. Requests for additional information – timeframes, frequency, volume

**Resources:**

Managed Care: Preparing for Change, CliftonLarsenAllen, October 30, 2013, [http://www.leadingage.org/Managed_Care_Readiness_Toolkit.aspx](http://www.leadingage.org/Managed_Care_Readiness_Toolkit.aspx)
Questions

IT'S BEEN LOVELY BUT I HAVE TO SCREAM NOW

Expanding the world of possibilities for aging.

ACOs: Iowa
Trinity Pioneer ACO
PIO\(N\)ER ACO: IOWA SINCE 01/01/2012

- 802 Kenyon Road Fort Dodge, IA 50501; Phone: (515) 573-3101
- Web: www.trmc.org/aco.aspx
- Medicare Program: Pioneer ACO as of 01/01/2012
- Provider Affiliation(s): UnityPoint Health
- Service Area: Northwest Central Iowa
- Description: UnityPoint Health affiliates Trimark Physicians Group and Trinity Regional Medical Center of Fort Dodge have been selected to participate in the Pioneer Accountable Care Organization (ACO) Model. Trinity Regional Medical Center is a licensed 200 bed, non-profit hospital, serving Fort Dodge and the surrounding communities.
- Total Assigned Beneficiaries: 10,600
- Benchmark: N/A
- Risk Track: Track One (Upside only)*
- Shared Savings: None in year one*

University of Iowa Affiliated Health Partners
MSSP: IOWA SINCE 07/01/2012

- 1337 John Colloton Pavilion Iowa City, IA 52242; Phone (319) 356-1616
- Web: www.uimercyaco.org
- Medicare Program: MSSP as of 07/01/2012
- Provider Affiliation(s): Mercy Medical Center – Cedar Rapids, UI Healthcare
- Service Area: East Central Iowa
- Description: The University of Iowa Affiliated Health Providers is a collaboration between University of Iowa Health Care and Mercy Medical Center – Cedar Rapids. The ACO serves the Medicare Shared Savings Program effective July 1, 2012.
- Total Physicians: 1,791
- Total Assigned Beneficiaries: 20,262*
- Benchmark: $10,556
- Risk Track: Track One (Upside Only)*
- Shared Savings: None in year one*
Mercy ACO

**MSSP & COMMERCIAL: IOWA SINCE 07/01/2012**

- 207 Crocker St., Ste. 200 Des Moines, IA 50309; Phone (515) 643-4454
- Web: [www.mercydesmoines.org](http://www.mercydesmoines.org)
- Medicare Program: MSSP as of 07/01/2012
- Commercial/Other Program(s): Wellmark Blue Cross Blue Shield
- Service Area: Greater Des Moines
- **Description:** Mercy ACO serves the Wellmark BCBS accountable care arrangement and the Medicare Shared Savings Program. Mercy Medical Center – Des Moines is an 802-bed not-for-profit Catholic comprehensive health care system situated on three hospital campuses and in more than 40 facilities in Central Iowa.

- **Total Physicians:** 402
- **Total Assigned Beneficiaries:** 27,662*
- **Benchmark:** $10,158
- **Risk Track:** Track One (Upside only)*
- **Shared Savings:** $4,426,331*

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Iowa Health Accountable Care, L.C.

**MSSP: IOWA AND ILLINOIS SINCE 07/01/2012**

- 1776 West Lakes Parkway West Des Moines, IA 50266; Phone (515) 241-6161
- Web: [www.unitypoint.org/organized-system-of-care.aspx](http://www.unitypoint.org/organized-system-of-care.aspx)
- Medicare Program: MSSP as of 07/01/2012
- Provider Affiliation(s): UnityPoint Health
- Service Area: Iowa and Illinois
- **Description:** UnityPoint Health has relationships with 26 hospitals in metropolitan and rural communities and more than 200 physician clinics. With annual revenues of $2.8 billion, UnityPoint entities provide patient care in Illinois and Iowa and employ greater than 24,000 employees.

- **Total Physicians:** 1,551
- **Total Assigned Beneficiaries:** 86,134*
- **Benchmark:** $11,082
- **Risk Track:** Track One (Upside only)*
- **Shared Savings:** None in year one*
Genesis Accountable Care Organization, LLC

**MSLP: IOWA AND ILLINOIS SINCE 07/01/2012**
- 1227 E. Rusholme Street Davenport, IA 52803; Phone (563) 421-1000
- Medicare Program: MSSP as of 07/01/2012
- Commercial/Other Program(s): Wellmark Blue Cross Blue Shield
- Provider Affiliation(s): Genesis Health System
- Service Area: Eastern Iowa and Western Illinois
- **Description:** The Genesis ACO serves the Medicare Shared Savings Program effective July 1, 2012 and an accountable care arrangement for Wellmark BCBS, Genesis Health System, its affiliates and partners offer a full continuum of health care services for a 12-county region.
- Total Physicians: 312
- Total Assigned Beneficiaries: 19,855*
- Benchmark: $10,158
- Risk Track: Track One (Upside only)*
- Shared Savings: None in year one*

*Alegant Health Partners, LLC

**MSLP: IOWA AND NEBRASKA SINCE 01/01/2013**
- 7261 Mercy Road Omaha, NE 68124; Phone (402) 255-1620
- Web: [www.uninet.com](http://www.uninet.com)
- Medicare Program: MSSP as of 01/01/2013
- Provider Affiliation(s): Alegant Health
- Plan/Admin Affiliation: UniNet Healthcare Network
- Service Area: Iowa and Nebraska
- **Description:** Alegant Health Partners, LLC is serving the Medicare Shared Savings Program effective January 2013, in affiliation with UnitNet Healthcare Network and Alegant Health.
- Total Assigned Beneficiaries: 23,852*
- Benchmark: $8,146
- Risk Track: Track One (Upside only)*
- Shared Savings: None in year one*
Accountable Care Clinical Services, PC

MSSP: CALIFORNIA, CONNECTICUT, IOWA, MASSACHUSETTS, PENNSYLVANIA SINCE 01/01/2013

- One Monarch Place, 1414 Main Street Springfield, MA 01144
- Web: www.acafirst.com
- Medicare Program: MSSP as of 01/01/2013
- Plan/Admin Affiliation: Accountable Care Associates
- Service Area: California, Connecticut, Iowa, Massachusetts, Pennsylvania
- Description: Accountable Care Clinical Services is serving the Medicare Shared Savings Program effective January 2013.
- Total Assigned Beneficiaries: 19,637*
- Benchmark: $10,757
- Risk Track: Track One (Upside only)*
- Shared Savings: $10,526,169*

*CMS website: https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/yuq5-65xt
Performance year 1 is a 21- or 18-month period for ACOs with 2012 start dates, and a 12-month period for ACOs with 2013 start dates