



## A Managed Care Readiness Toolkit for LeadingAge Members

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Health care reform has spurred significant changes to the health care market across the country. In response, LeadingAge, in collaboration with CliftonLarsonAllen LLP, is pleased to provide members with our [Managed Care Readiness Toolkit](#) (full version).

This toolkit provides skilled nursing facilities, supportive service providers, CCRCs, independent and assisted living, and aging service providers, in general, with the resources to:

- Understand key health care reform trends.
- Explore the concept of managed care and how it has crept into the long-term care world.
- Recognize how managed long-term care and dual integration programs work in other states and consider how managed care will change provider behaviors.
- Discover what managed care hopes to achieve and why it is both inevitable and unavoidable.
- Prepare for change.

Every organization, regardless of what role it has in health care delivery, will need to decide how to strategically position themselves for managed care and the evolution of care and payment delivery under health reform.

Here are the sections of the toolkit, which we believe will help LeadingAge members better prepare for managed care:

- [Determining Your Readiness for Managed Care.](#)
- [Managed Care Terms.](#)
- [Developing your value proposition.](#)
- [What metrics you should be tracking.](#)
- [How to prepare for discussions about contracting with Managed Care Organizations.](#)
- What managed care contracts look like (coming soon).
- [Legal contracting due diligence.](#)

**Please note that the full toolkit and the individual toolkit sections are for LeadingAge members only; you will need to sign in to [My.LeadinAge.org](#) to access the files.**

# Managed Care Readiness Toolkit

## Introduction

Health care reform has spurred significant changes to the health care market across the country. In response, LeadingAge, in collaboration with CliftonLarsonAllen LLP, is pleased to provide its members with “The Essentials for Aging Service Providers in the Reforming Health Care Environment.” This toolkit provides skilled nursing facilities, supportive service providers, CCRCs, independent and assisted living, and aging service providers, in general, with the resources to:

- Understand key health care reform trends.
- Explore the concept of managed care and how it has crept into the long-term care world.
- Recognize how managed long-term care and dual integration programs work in other states and consider how managed care will change provider behaviors.
- Discover what managed care hopes to achieve and why it is both inevitable and unavoidable.
- Prepare for change.

## Health Care Reform

National health care reform was passed in 2010, and rapid efforts to shift health care delivery from a system driven by volume to a system driven by value are underway. As of July 2012, there are over 100 Medicare-certified Accountable Care Organizations (ACOs) in 38 states. ACOs are responsible for managing the total cost of care for a designated population. Numerous commercial and Medicaid ACOs have evolved across the country as well. Massachusetts, Minnesota and California are all states with a notable presence of ACOs. Other examples of payment and care delivery reform include bundled or episodic payments, value-based payment and Medical Homes.

Preventable readmissions and chronic disease management remain important issues for the post acute space. In August 2012, CMS issued the first round of readmission penalties to hospitals. Hospitals with lowest quartile performance received penalties of up to 1 percent of their Medicare inpatient program reimbursement.

Perhaps even more noteworthy, commercial payers are rolling out total cost of care contracts (TCOCs), while states around the country seek to implement programs for the dual eligible population under the Center for Medicare and Medicaid Innovation Center’s Financial Alignment Initiative. The Financial Alignment Initiative established an opportunity for states, for the first time, to pursue dual integration programs and benefit from by sharing in any savings achieved by these programs.

In the past, if a state established a dual integration program to provide more seamless, better quality care for dual eligibles, often the state Medicaid program ended up paying more as dual eligible beneficiaries, while Medicare raked in the resulting savings. This is because in better coordinating care for duals and improving outcomes (e.g., reduced hospitalizations), typically, a dual utilizes more preventive care or Medicaid covered services.

Now, 26 states have applied to be able to implement dual integration programs under one of two models – Capitated Integration or Managed Fee-For Service. Most states have proposed paying managed care organizations, or integrated care organizations to coordinate and provide the care under their proposed dual integration programs. Whether it is ACOs, MCOs or TCOC arrangements, it will be crucial for long term and post acute care (LTPAC) providers to develop competencies in contracting that were not essential in prior fiscal years.

Nationwide, a clear shift away from volume-based reimbursement to value-based reimbursement is underway. Healthcare providers, employers, and insurers are faced with a cultural shift that will require upfront investments and decrease near-term reimbursements to ensure long-term success. Patient-centered care will be the lynchpin for success in this shift from volume to value.

### **Managed Care in the Health Care Reform Era**

Managed care previously failed to reduce cost and coordinate care delivery, but it's back! It's back because state Medicaid budgets are strained, the Innovation Center presented states the opportunity to share in any resulting savings, and CMS has embraced that the way forward is to deliver the Triple Aim – Better Care, Better Health and Reduced Costs. What is different about how it is being deployed now is that providers and plans cannot benefit financially by just reducing costs or achieving savings, they have to also achieve certain patient outcomes. We believe managed care, especially for long term care, is here to stay. See [this presentation](#) for a more detailed overview of managed care, what is different this time around and what to expect.

*Taking the next steps in preparing for managed care:*

- [Determining Your Readiness for Managed Care](#)
- [Managed Care Terms](#)
- [Developing your value proposition](#)
- [What metrics you should be tracking](#)
- [How to prepare for discussions about contracting with Managed Care Organizations](#)
- What managed care contracts look like (coming soon)
- [Legal contracting due diligence](#)

### **Preparing for Managed Care and Defining Your Value Proposition**

Every organization, regardless of what role it has in health care delivery, will need to decide how to strategically position themselves for managed care and the evolution of care and payment delivery under health reform. Identify what your organization can do to:

- Identify efficiencies and remove waste.
- Embrace evidence-based medicine.
- Measure outcomes.
- Manage different reimbursement methods in the near- and mid-term.
- Select strategic partners.
- Determine IT needs.
- Create a culture of change that honors patient choice.

### **In conclusion...**

There are four strategic priorities for aging services providers:

1. In each market in which you operate, position your organization to be #1 or# 2 for your key referral sources and collaborative partners.
2. Develop / coordinate / collaborate to create a full continuum of capabilities in each market.
3. Continue to invest in technology and update physical plants to meet contemporary requirements.

4. Improve your operating performance and build your balance sheet.

**Overall focus:** *assemble basic performance data – tighten pre- and post-acute network – focus on developing relationships with providers that will ultimately control or influence the flow of funds.*

## **ARE YOU READY?**

### **ASSESSING YOUR ORGANIZATIONS READINESS TO OPERATE IN A REFORMED HEALTH CARE ENVIRONMENT**

#### **Do You Know Your Organization's Value Proposition?**

##### **TOP 10 QUESTIONS**

1. Do you track the rate of readmission of residents to the hospital from your facility? (yes, no)
2. Do you know how you compare to other facilities in your area on readmission s? (yes, no)
3. Do you routinely review your organizations Nursing Home Compare Metrics? (yes, no)
4. Do you evaluate your organizations cost of care and know how you compare with peers with comparable quality? (yes, no)
5. Does your organization have electronic health records? (yes, no)
6. Do you partner with other providers in the community? (yes, no)
7. Do you have a relationship with the hospital(s) in your area? (yes, no)
8. Have you collaborated with your hospital on any programs or services? (yes, no)
9. Would you describe your organization as innovative and open to change? (yes, no)
10. Do you achieve high levels of resident satisfaction? (yes, no)

#### **Can You Demonstrate that You Deliver High Quality at a Lower Cost**

1. Can you prove (through data) that your organization delivers value (high quality/lower cost)? (yes, no)
2. Do you have quality dashboards that help identify trouble areas ? (yes, no)
3. Can you identify how your quality provides value/savings? (yes, no)

**If you answered "no "to any of the above questions, what significant changes must be made in your organization regarding quality measurement and data analysis.**

## **Impacts of Managed Care/Health Care Reform on Aging Service Providers by Provider Type**

### **CCRC/CCRC look-a-likes**

- Managed Care Organizations (MCOs) will assume responsibility for case managing their enrollees, determining whether and to what extent services will be authorized.
- Transfer decisions to another level of care (higher or lower) will be made by third party payers beyond the control of the CCRC.
- Coordination of health care for nursing home residents will be directed by physicians affiliated with the resident's MCO.
- Residents will be discharged earlier from the hospital and may be sicker/need higher levels of care to meet their health care needs.
- If resident's MCO does not contract with the CCRC, they may be discharged to another skilled nursing facility.
- Potential CCRC market may decrease. Customers may question need for a CCRC and multi-level of care if their enrollment in a MCO will reduce their future health care costs and provide the care they need.
- Extending services to non-residents may be necessary to help build and protect referral sources, which may increase the CCRC's value to the MCO due to having a larger senior market.

### **Nursing Homes (NHs)**

- NHs will need to help MCOs achieve goal of providing care at lower cost.
- MCO will want to negotiate the lowest rate for patient care with NHs in their network.
- NHs will need to reduce costs in order to remain a competitive alternative to other long term care settings.
- Staff will be expected to work to the top of their license.
- MCO will case manage NH residents, NH staff may need to adjust to different protocols to comply with the requirement of the MCO in which their residents are enrolled. This may pose challenges where the protocols vary among MCOs. Therefore, NHs should attempt to define the best practice protocols for care and targeted conditions in order to increase the ability of their staff to comply and produce better outcomes.
- Residents will be discharged earlier from the hospital and may be sicker/need higher levels of care to meet their health care needs.
- MCOs may ask NHs to "treat in place" instead of sending a resident to the hospital, for which the NH may be paid a higher rate to provide more intensive services.
- NHs will need enhanced information system capabilities and cost accounting competencies.
- NHs will need to measure resident care and outcomes.
- NHs will want to build alliances with other long term services and support providers (e.g., adult day services, assisted living) to expand referral sources, as hospitalizations are reduced more referrals may come from the community over time than the hospital.

- NHs may want to form alliances with other NHs to be attractive partners to MCOs, or physician/hospital organizations who are willing to assume risk for providing skilled care.

### **Assisted Living Facilities (ALFs)**

- MCOs may want to contract with ALFs who will need to offer competitive prices and demonstrate quality.
- ALFs will need to help MCOs achieve goal of providing care at lower cost and may want to demonstrate when they are a more cost effective alternative to nursing home care.
- MCOs will want to negotiate the lowest rate for patient care with ALFs in their network.
- MCOs will case manage residents, ALF staff may need to adjust to different protocols to comply with the requirement of the MCOs in which their residents are enrolled. This may pose challenges where the protocols vary among MCOs. Therefore, ALFs should attempt to define the best practice protocols for care and targeted conditions in order to increase the ability of their staff to comply and produce better outcomes.
- ALFs will need enhanced information system capabilities and cost accounting competencies.
- ALFs will need to measure resident care and outcomes.
- ALF residents will be discharged from the hospital earlier and sent home needing a higher level of care that used to be provided by a nursing home. The MCO will determine the amount of care to be provided, which may be less than under fee-for-service.
- ALFs may see the demand for their services increase from the Medicaid and dual eligible populations if they are a lower cost option than nursing homes, as the emphasis in many of the state dual integration programs is on increasing care provided in home and community based settings.
- ALFs may want to form alliances with other long term care providers to deliver/expand services to residents.
- ALFs may develop/provide services on their own (e.g., day services, home care).

### **Housing**

- Delivery of services in housing will be increasingly important in meeting the needs of residents. On-site services may be part of MCO network.
- Housing residents will be discharged from the hospital the earlier and sent home needing a higher level of care that used to be provided by a nursing home. The MCO will determine the amount of home and community based services to be provided, which may be less than under fee-for-service.
- Residents in MCOs may be required to use only certain providers requiring the housing provider to open their doors to multiple providers serving multiple health plans.
- Residents may seek guidance from the housing manager on whether to join a MCO.
- Residents may seek the housing manager's help in advocating with the MCO on their behalf.
- Housing providers may want to form alliances with other long term care providers to deliver/expand services to residents.
- Housing providers may develop/provide services on their own (e.g., day services, home care).

- MCOs may want to contract with housing and service providers who will need to offer competitive prices, demonstrate quality and may be asked to provide additional services in their settings .

### **Adult Day Services (ADS)**

- Medicaid MCOs may purchase adult day services (ADS) requiring the ADS provider to offer competitive prices and demonstrate quality.
- MCOs may look to ADS centers to function as delivery sites for health care services either through contractual arrangements or other providers.
- Care coordination will be increasingly important as MCOs look to ADS programs to coordinate medical and social needs of participants.
- MCOs may not look to ADS or other home and community based care providers unless they can accommodate 24 hour admission/discharge services as nursing homes.
- Medicaid reimbursement may be provided through the Medicaid MCO. ADS programs will need to be part of contracting networks or have separate relationships with several MCOs to insure an adequate volume of participants.
- ADS programs will need to find ways to garner a larger private pay market to provide financial stability. This could include marketing to employer groups as a service for employee caregivers and retirees.

### **Home Care**

- MCOs will be paid a fee for providing a bundle of services that may cause them to limit the amount of Home Care services provided. However, many state dual integration and managed Medicaid LTC programs seek to incent MCOs to provide more services to consumers in the community than institutions. As such, demand for home and community based services is expected to be high.
- MCOs will determine the tipping point at which nursing home care becomes more cost effective than the provision of the required amount of home care services for an individual.



## **General Impacts of Managed Care/Health Care Reform on Aging Services Providers (Notes from CliftonLarsonAllen PowerPoint Presentations)**

### **Define Your Organization's Value Proposition**

Aging Service Providers will need to demonstrate their value proposition, how they can help MCO lower total costs. You'll want to share how your organization can/will:

- Reduce admissions...eliminate avoidable admissions/readmissions
- Improve patient-centered care/experience
- Improve care transitions
- Share/exchange health information
- Enhance prevention/wellness...eliminate potential preventable conditions (e.g., never events, health care acquired conditions)
- Manage chronic care
- Lower total cost of care through reduction/elimination of duplication, improved coordination
- Be a needed partner in the provision of quality, cost effective care

Aging Service Providers will want to Bend the Cost Curve to play in today's managed care environment. It is important to remember that while one part of bending the cost curve is lowering per unit costs, the other part of the equation is changing how your organization delivers care so that higher cost services are reduced or eliminated (e.g., hospitalizations, readmissions). In other words, "think globally" about the total care needs of the individual, but "act locally" to improve the care.

- Provide cost efficient care
- Eliminate duplication
- Reduce/eliminate unnecessary care
  - Hospital readmissions
  - Health care acquired infections
  - Improve care transitions/care coordination
- Provide same service in lower cost setting
- Use best practices consistently
- Manage chronic conditions
- Reduce/eliminate medication errors, preventable conditions

### **Measurement Matters:**

#### **Tools to Track and Trend Data**

- To become value-based providers, we must develop platforms for both capturing and trending outcome data
  - Surveillance tools to monitor readmission issues, identify high-risk patients and establish protocols for intervention
  - Effective surveys or consumer interfaces to gather real-time (or near-to-real-time) data about patient perception of care and quality
  - Systems that can measure and report actual patient improvement from admission to discharge:  
functional status improvement

## Readmissions

Readmissions and “avoidable hospitalizations” are key measurements

- Tracking and avoiding acute readmissions/unplanned hospitalizations is an urgent strategy for all long term and post acute care (LTPAC) providers.
- MedPAC estimates that 28 - 40% of such admissions might be reduced through higher quality SNF care
- Readmission rates for 5 preventable conditions have been increasing
  - Electrolyte imbalance
  - Congestive heart failure
  - Respiratory infection
  - Urinary tract infection
  - Sepsis

A Readmission Surveillance Tool should be used daily

- Integrate as key component of patient care management protocol
- Should be used in evaluating any patient considered for hospital admission
- Ideally employed “in-situ” to capture most reliable and meaningful data
- May also require implementation of evidence-based tools for patient assessment and management – like [Interact II](#)

Readmission Causes Vary

- Readmission Issues in the SNF may have multiple root causes:

- Nursing staffing levels, nurse skill set and turnover
- Implementation of assessment and management protocols
- Physician/APRN coverage and support
- Affiliation with acute organizations
- Geography
- Time of day, day of the week
- Hospital length of stay prior to discharge

Strategies for addressing readmissions:

- Avoid generics with narrow-therapeutic index medications
- Develop strategic plans of care for each patient diagnosis
- Use algorithm for nurses to ensure assessment and interventions are complete
- Require weekly family meetings and pre-admission family meeting with hospital case manager
- Employ liaison to serve as transition point of care between SNF and acute
- Require medical director on-site 4 days/week  
(Source: Case Management Monthly, January 2010)

## Resident Satisfaction

Resident input is a critical measurement to track. Resident perceptions equate to reality for residents.

- If we listen (i.e., document) to resident concerns, we can learn a great deal – staff interaction, impressions of service, perceived outcomes.
  - Satisfaction is not the same as quality of life.
  - HOW you ask the questions matters.
- Utilize short-stay discharge surveys, rather than the annual satisfaction survey alone
- Use a small tool – only 15-20 questions with simple rating scale (i.e., 1 to 5, excellent-good-poor)

- Simplicity is key for two reasons:
  - Ease of patient completion
  - Ease of data entry and management for staff
- Tool should be employed on the day of discharge as part of standard discharge practice

### **Functional Status Improvement**

Measure improvements in functional status by looking at resident status at admission and again at discharge to “measure” what you have accomplished

- Variety of different measurement scales (i.e., Functional Independence Measurement scale primarily used within inpatient settings, but has been adapted for use by some rehab-intensive SNF organizations)
- Providers can develop their own measurements and benchmarks:
  - Patient’s need for assistance by number of ADLs
  - Patient’s capacity for mobility or self-ambulation – get out of bed, toileting, etc.
  - Patient’s ability to ambulate a certain distance
  - Patient’s ability to manage care
- Many proprietary organizations are already marketing to outcomes, preparing for VBP

### **Rate of Community Discharge**

Measure/monitor the percentage of short-stay (Medicare) patient discharged to the community (home or community-based care setting)

- Monitor potential acute returns if SNF discharge is less than 30 days after acute discharge
- Also, monitor potential acute returns if SNF discharge is less than 90 days after acute discharge, given proposed Hospital Value Based Purchasing rules for FY2014
- **Continued management of patients after discharge will play an important role**
  - Home health/assisted living
  - Care transitions intervention or health coaching

### **Building Stronger Relationships**

- Relationships are mandatory going forward, providers need to grow new relationships and not operate as an island in the future

- What is the role and function of business development in your organization?
- How well do you really KNOW your major referring organizations? Who really holds the relationships?
- Are there other providers with whom you can collaborate or partner?
- With whom are you willing to share risk?

### **Grow Clinical and Patient Management Skill**

- Develop clinical pathways for common patient types, like CHF, COPD, pneumonia, stroke and other diagnoses
- Increase or evolve current physician strategies to support around-the-clock coverage
- Adopt evidence-based protocols, like INTERACT II, to better manage high acuity patients
- Evolve to or partner to provide post-discharge management: care transitions, health coaching or geriatric care management

**Detailed understanding of operating costs and expenses will be essential for potential risk-sharing or gain-sharing relationships with ACOs, hospitals and MCOs.**

LTC will be particularly challenged when it comes to individual costs of patient care

- Can your current financial system support expense management at the patient level?
- What are your costs for a typical hip replacement or a CHF patient?

## MANAGED CARE READINESS TOOLKIT

**Please note:** *The following managed care definitions reflect a general understanding of the terms. It will be important to read managed care contracts very carefully as they may define these terms differently within that context and will be the definition that will prevail.*

### GLOSSARY OF TERMS

**Accountability:** Physicians, as well as health plans, are more explicitly responsible for the cost and quality of health care in managed care compared to the traditional fee-for-service system. When physicians, individually and in groups, share in the responsibility for the costs of care, they accept financial accountability for resources utilized. This is in contrast to the traditional indemnity insurance system where the insurer, but not the provider, was accountable and faced losses if expenses exceeded revenues. Physicians become accountable for quality of care when their performance is subject to assessment and measurement, with the results made public in the health care marketplace to other providers, purchasers, health plans and consumers. As accountability increases, there is a decrease in physician autonomy; physicians face financial and competitive consequences of their clinical actions and decisions.

**Accreditation:** The process by which an organization recognizes an institution as meeting predetermined standards

**Actuarial Soundness:** The requirement that the development of capitation rates meet common actuarial principles and rules.

**Adjusted Average Per Capita Cost (AAPCC):** The estimated average fee-for-service cost of Medicare benefits for an individual by county of residence. It is based on the following factors: age, sex, institutional status, Medicaid, disability, and end stage renal disease status. CMS uses the AAPCCs as a basis for making monthly payments to TEFRA contractors.

**Adverse Selection:** The problem of attracting members who are sicker than the general population, specifically, members who are sicker than was anticipated when developing the rates of reimbursement for medical costs.

**Affiliated Provider:** a health care provider or facility that is part of the Managed Care Organization's network, usually having formal arrangements to provide services to the MCO's member.

**Alternative Delivery Systems:** A phrase used to describe all forms of health care delivery except traditional fee-for-service, private practice. The term includes HMOs, PPOs, IPAs, and other systems of providing health care.

**Ambulatory Care:** All types of health services that are provided on an outpatient basis, in contrast to services provided in the home or to persons who are hospital inpatients.

**Benefits:** The payment for, or health care services provided under terms of a contract with a MCO.

**Capitation:** A fixed dollar amount established to cover the cost of health care services delivered for a person during a specified length of time. The term usually refers to a negotiated per capita rate to be paid periodically to a health care provider by a MCO. The provider is then responsible for delivering or arranging the delivery of

all health services required by the covered person under the conditions of the provider contract. This term may also refer to the amount paid to a MCO by CMS or a State.

**Care Coordination:** A function that supports information-sharing across providers, patients, types and levels of service, sites and time frames. Its goal is to ensure that patients' needs and preferences are achieved and that care is efficient and of high quality. It is most needed by persons who have multiple needs that cannot be met by a single clinician or by a single clinical organization, and which are ongoing, with their mix and intensity subject to change over time

**Carve Out:** One or more services excluded from those required to be provided under the capitation rates. These services may be paid on a fee-for-service or other basis.

**Case Management:** A process and technique to manage the care of specific health care needs (often multiple) in a way that is designed to achieve the optimum patient outcome in the most cost-effective manner.

**Case Manager:** A nurse, doctor, or social worker who works with patients, providers and insurers to coordinate all services deemed necessary to provide the patient with a plan of medically necessary and appropriate health care.

**Closed Access:** A managed health care arrangement in which covered persons are required to select providers only from the plan's participating providers.

**Coinsurance:** A cost-sharing arrangement in which a member pays a certain percentage of the charges for a specified service (20% of negotiated rate for a hospital stay), after a deductible has been paid. The insurance company pays the remaining percentage.

**Competitive Medical Plan (CMP):** A status, established by TEFRA and granted by the Federal government, to an organization that meets specific requirements enabling that organization to obtain a Medicare risk or cost based contract.

**Complex case management:** The coordination of care and services provided to members to facilitate appropriate delivery of care and services. The goal is to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

**Copayment:** A cost-sharing arrangement in which a member pays a fixed dollar amount for a specified service (e.g., \$10 for an office visit). The member is usually responsible for payment at the time the service is rendered.

**Cost Contract:** A TEFRA contract payment methodology option by which CMS pays for the delivery of health services to members based on the HMO's reasonable cost. The plan receives an interim amount derived from an estimated annual budget, which may be periodically adjusted during the course of the contract to reflect actual cost experience. The plan's expenses are audited at the end of the contract to determine the final rate the plan should have been paid.

**Cost Sharing:** A general set of financing arrangements in which a covered member must pay a portion of the costs associated with receiving care. (See also copayment, coinsurance and deductible).

**Credentialing:** A review procedure where a potential or existing provider must meet certain standards in order to begin or continue participation in a given health care plan, on a panel, in a group, or in a hospital medical staff organization. The process of reviewing a practitioners credentials, i.e., training, experience, or demonstrated ability, for the purpose of determining if criteria for clinical privileging are met. The recognition of professional or technical competence. The credentialing process may include registration, certification, licensure, professional association membership, or the award of a degree in the field. Certification and licensure affect the supply of health personnel by controlling entry into practice and influence the stability of the labor force by affecting geographic distribution, mobility, and retention of workers. Credentialing also determines the quality of personnel by providing standards for evaluating competence and by defining the scope of functions and how personnel may be used. In managed care arenas, one hears of a new basis for credentialing, referred to as financial credentialing. This refers to an organization's evaluation of a provider based on that provider's ability to provide value, or high quality care at a reasonable cost.

**Deductible:** A specified amount of money a member must pay before insurance benefits begin. Usually expressed in terms of an "annual" amount.

**Diagnosis Related Groups (DRG):** A system of classification for inpatient hospital services based on diagnosis, age, sex, and the presence of complications. It is used as a means of identifying costs for providing services associated with a diagnosis and as a mechanism to reimburse hospital and selected other providers for services rendered.

**Employer Mandate:** Under the Federal HMO Act, describes conditions when federally qualified HMOs can mandate or require an employer to offer at least one federally qualified HMO plan of each type (IPA/network or group/staff). (Sunsetted in 1995).

**EQRO (External Quality Review Organization):** States are required to contract with an entity that is external to and independent of the State and its HMO and HIO contractors to perform an annual review of the quality of services furnished by each HMO or HIO contractor.

**Exclusive Provider Organization (EPO):** A term derived from the phrase preferred provider organization (PPO). However, where a PPO generally extends coverage for non-preferred provider services as well as preferred provider services, an EPO provides coverage only for contracted providers; hence, the term exclusive. Technically, many HMOs can also be described EPOs.

**Experience Rating:** The process of setting rates partially or in whole on evaluating previous claims experience for a specific group or pool of groups.

**Federal Medicaid Managed Care Waiver Program:** The process used by States to receive permission to implement managed care programs for their Medicaid or other categorically eligible beneficiaries.

**Federal Qualification:** A status defined by the HMO Act, conferred by CMS after conducting an extensive evaluation of the HMO's organization and operations. An organization must be federally qualified or be designated as a CMP (competitive medical plan) to be eligible to participate in Medicare cost and risk contracts. Likewise, an HMO must be federally qualified or State plan defined to participate in the Medicaid managed care program.

**Fee-For-Service (FFS):** A payment system by which doctors, hospitals and other providers are paid a specific amount for each service performed as identified by a claim for payment.

**Fiscal Soundness:** The requirement that managed care organizations have sufficient operating funds, on hand or available in reserve, to cover all expenses associated with services for which they have assumed financial risk.

**Gatekeeper:** An arrangement, in which a primary care provider serves as the patient's agent, arranges for and coordinates appropriate medical care and other necessary and appropriate referrals.

**Group or Network HMO:** An HMO that contracts with one or more independent group practice to provide services to its members in one or more locations.

**Guaranteed Eligibility:** A defined period of time (3-6 months) that all patients enrolled in prepaid health programs are considered eligible for Medicaid, regardless of their actual eligibility for Medicaid. A State may apply to CMS for a waiver to incorporate this into their contracts.

**Health Maintenance Organization (HMO):** An entity that provides, offers or arranges for coverage of designated health services needed by members for a fixed, prepaid premium. There are three basic models of HMOs: group model, individual practice association (IPA), and staff model.

**HEDIS:** The Health Plan Employer Data and Information Set is a set of performance measures developed to support health plan and Medicaid agency efforts to improve the health status of Medicaid beneficiaries, support the strengthening of health care delivery systems for the Medicaid population, promote standardization of managed care reporting across public and private sectors, and promote the application of performance measurement technology across Medicaid programs.

**HIO (Health Insuring Organization):** An entity that contracts on a prepaid, capitated risk basis to provide comprehensive health services to recipients. A hybrid of a state-funded health plan and a health maintenance organization, it is usually a public corporation that pays for medical services in exchange for payment of a premium or subscription charges paid for by the corporation that assumes the underwriting risk.

**Independent Practice Association (IPA) model HMO:** An HMO that contracts with individual practitioners or an association of individual practices to provide health care services in return for a negotiated fee. The individual practice association, in turn, compensates its physicians on a per capita, fee schedule, or other agreed basis.

**Insolvency:** A legal determination occurring when a managed care plan no longer has the financial reserves or other arrangements to meet its contractual obligations to patients and subcontractors.

**Licensing:** A process most States employ, which involves the review and approval of applications from HMOs prior to beginning operation in certain areas of the State. Areas examined by the licensing authority include: fiscal soundness, network capacity, MIS, and quality assurance. The applicant must demonstrate it can meet all existing statutory and regulatory requirements prior to beginning operations.

**Lock-in:** A contractual provision by which members, except in cases of urgent or emergency need, are required to receive all their care from the network health care providers.



**Managed Care:** A system of health care that combines delivery and payment; and influences utilization of services, by employing management techniques designed to promote the delivery of cost-effective health care.

**Managed Care Organization:** A health plan that seeks to manage care. Generally, this involves contracting with health care providers to deliver health care services on a capitated (per-member per-month) basis. For specific types of managed care organizations, see also health maintenance organization and independent practice association.

**Managed Health Care Plan:** An arrangement that integrates financing and management with the delivery of health care services to an enrolled population. It employs or contracts with an organized system of providers which delivers services and frequently shares financial risk.

**Medical Home:** The medical home, also known as the patient-centered medical home (PCMH), is a team-based health care delivery model led by a physician, physician assistant, or nurse practitioner. that provides comprehensive and continuous medical care to patients with the goal of obtaining maximized health outcomes (American College of Physicians) (American Academy of Family Physicians).

**Medicare Supplement Policy:** A health insurance policy that pays certain cost not covered by Medicare such as coinsurance, deductibles.

**Network Model HMO:** A health care model in which the HMO contracts with more than one physician group or IPA, and may contract with single and multi-specialty groups that work out of their own office facility. The network may or may not provide care exclusively for the HMO's members.

**Open Access:** A term describing a member's ability to self-refer for specialty care. Open access arrangements allow a member to see a participating provider without a referral from another doctor. Also called open panel.

**Open Enrollment Period:** A period during which subscribers in a health benefit program have an opportunity to select among health plans being offered to them, usually without evidence of insurability or waiting periods.

**Outcome measurement:** A process of systematically measuring individual or collective clinical treatment and response to that treatment.

**Out-of-pocket expenses:** Costs borne by the member that are not covered by health care plan.

**PCCM (Primary Care Case Management) program:** A Freedom of Choice Waiver program under the authority of section 1915(b) of the Social Security Act. States contract directly with primary care providers who agree to be responsible for the provision and/or coordination of medical services to Medicaid recipients under their care. Currently, most PCCM programs pay the primary care physician a monthly case management fee in addition to receiving fee-for-services payment.

**Peer Review:** The evaluation of the quality of the total health care provided by Plan medical staff by equivalently trained medical personnel.

**Peer Review Organization (PRO):** An organization established by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to review quality of care and appropriateness of admissions, readmissions and discharges for Medicare and Medicaid. PROs' name was officially changed to QIOs in 2002.

**PHP (Prepaid Health Plan):** An entity that either contracts on a prepaid, capitated risk basis to provide services that are not risk-comprehensive services, or contracts on a non-risk basis. Additionally, some entities that meet the above definition of HMOs are treated as PHPs through special statutory exemptions.

**Point-Of-Service Plan:** Also identified as open-ended HMO. A plan combining the features of an HMO with an indemnity insurance option. The member uses the plan like an HMO and receives HMO coverage; but the member may exercise "freedom of choice" and seek care outside the HMO system with additional charges (higher copayments and deductibles, and submission of claims forms). Members choose how and from whom to receive services at the time they need them.

**Preferred Providers:** Physicians, hospitals, and other health care providers who contract to provide health services to persons covered by a particular health plan.

**Preferred Provider Organization:** A health care delivery system that contracts with providers of medical care to provide services at discounted fees to members. Members may seek care from non-participating providers but generally are financially penalized for doing so by the loss of the discount and subjection to copayments and deductibles.

**Premium :** Money paid out in advance for insurance coverage.

**Prepayment:** Negotiated and prospective payment made to a health care provider for specified services to a specified group of insured persons prior to the provision of medical care. Unlike fee-for-service reimbursement, prepayment rates are negotiated up front and not adjusted after the fact for actual service or resource consumption levels.

**Preventive health care:** Health care that seeks to prevent or foster early detection of disease and morbidity and focuses on keeping patients well in addition to health them while they are sick.

**Primary Care Network (PCN):** A group of primary care physicians who share the risk of providing care to members of a given health plan.

**Primary Care Provider (PCP):** The provider that serves as the initial interface between the member and the medical care system. The PCP is usually a physician, selected by the member upon enrollment, who is trained in one of the primary care specialties who treats and is responsible for coordinating the treatment of members assigned to his/her plan. (See Gatekeeper)

**Professional Review Organization:** An organization which reviews the services provided to patients in terms of medical necessity professional standards; and appropriateness of setting.

**QARI (Quality Assurance Reform Initiative):** Unveiled in 1993 to assist States in the development of continuous quality improvement systems, external quality assurance programs, internal quality assurance programs, and focused clinical studies.

**QIO (Quality Improvement Organization):** Originally known as Peer Review Organizations (PRO), their name was changed in 2002. QIOs monitor the appropriateness, effectiveness, and quality of care provided to Medicare beneficiaries. They are private contractor extensions of the federal government that work under the auspices of the Centers for Medicare and Medicaid Services (CMS).

**Qualified Medicare Beneficiary (QMB):** A person whose income level is such that the state pays the Medicare Part B Premiums, deductibles and copayments.

**Quality Assurance:** A formal methodology and set of activities designed to assess the quality of services provided. Quality assurance includes formal review of care, problem identification, corrective actions to remedy any deficiencies and evaluation of actions taken.

**Reinsurance:** An insurance arrangement whereby the MCO or provider is reimbursed by a third party for costs exceeding a pre-set limit, usually an annual maximum.

**Risk Adjustment:** A system of adjusting rates paid to managed care providers to account for the differences in beneficiary demographics, such as age, gender, race, ethnicity. Medical condition, geographic location, at-risk population (i.e. homeless), etc.

**Risk Contract:** A contract payment methodology between CMS and an HMO or CMP that requires the delivery of (at least) all covered services to members as medically necessary in return for a fixed monthly payment rate from the government and (often) a premium paid by the enrollee. The HMO is then liable for those contractually offered services without regard to cost. (Note: Medicaid beneficiaries enrolled in risk contracts are not required to pay premiums.)

**Risk-Sharing:** A fundamental feature in managed care, whereby the managed care plan and its providers share financial risk for providing care to enrollees. The amount of risk incurred by the various parties depends on the specific contract between the health plan and its providers and the mechanisms for reimbursement.

**Shared Savings:** A provision of most prepaid health care plans where at least part of the providers' income is directly linked to the financial performance of the plan. If costs are lower than projections, a percentage of these savings are referred to the providers.

**Staff Model HMO:** This model employs physicians to provide health care to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary.

**Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA):** The Federal law that created the current risk and cost contract provisions under which health plans contract with CMS.

**Total Cost of Care:** The actual measurement of cost per member across the entire continuum of covered services. Through various attribution methodologies all of a member's care costs are aggregated and assigned to a particular provider, provider site and/or system. TCOC is commonly subjected to risk adjustment. Catastrophic cases are usually truncated (maximum TCOC limit assigned or omitted from TCOC calculations in some arrangements). The costs for all attributed members for that provider are combined and an average per member per month (PMPM) or per member per year (PMPY) TCOC is determined.

**Utilization Management (UM):** A systematic approach used by many health insurance companies, managed care organizations, delivery systems, hospitals and physician practices to: evaluate the necessity, appropriateness and efficiency of health services; determine and implement best practices to achieve high quality, cost-effective health care; and lower costs by discouraging unnecessary treatment.

**Utilization Review (UR):** A formal review of utilization for appropriateness of health care services delivered to a member on a prospective, concurrent or retrospective basis.

**References:**

\*\*US Department of Health and Human Services <http://aspe.hhs.gov/progsys/forum/mcobib.htm> Webpage accessed 10/4/12\*\*

\*\*Tufts Health Care Institute [http://www.thci.org/other\\_resources/glossarymc.html](http://www.thci.org/other_resources/glossarymc.html) Webpage accessed 10/4/12\*\*


\*\*ICSI Total Cost of Care Glossary,  
[http://www.icsi.org/total\\_cost\\_of\\_care\\_glossary/total\\_cost\\_of\\_care\\_glossary.html](http://www.icsi.org/total_cost_of_care_glossary/total_cost_of_care_glossary.html) as accessed 10/5/2012

\*\*National Committee for Quality Assurance, <http://www.ncqa.org/>

## Defining Your Organization's Value Proposition

**Section I: Defining Your Organization's Value Proposition:  
Post Acute Provider of Choice**

<b>Low/no hospital readmissions</b>	<b>High Quality</b> <ul style="list-style-type: none"><li>• Top of Class in Nursing Home or Home Health Compare or other industry measures</li><li>• High patient satisfaction</li><li>• Robust continuous quality improvement</li><li>• Innovative care delivery approaches</li><li>• Good community reputation</li></ul>
<b>Meaningful Use of Electronic Health Record</b>	
<b>Past success partnering with other providers</b>	
<b>Demonstrated patient-centered approach to care</b>	<b>Cost of care is lowest in comparison to peers with comparable quality.</b>

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Before going into any MCO negotiation, providers must understand and be able to explain their organization's value proposition and understand its risk tolerance. These two things will help you determine what you think your organization should be paid (what the rate should be) for the services it provides and how you're willing to be paid (e.g., pay-for-performance, capitated payment, etc.).

In developing your organization's value proposition, you need to view your organization's strengths and offerings through the lens of what your potential partner (e.g., MCO, ACO, other payor) needs to achieve their goals (e.g., make a profit, manage care for a high risk population, achieve certain performance metrics). View your value proposition as the presentation of your strengths or best attributes as an organization. Value proposition answers the question: "What does my organization bring to the table to meet the objectives or goals of the program, the contract, etc.?" While your goal in contract negotiations is to put your best foot forward through your value proposition, you must also be prepared to answer the tough questions or explain any weaknesses your organization may have (e.g., survey deficiencies, higher costs, etc.)

The following series of questions will walk you through the types of information you might include in your value proposition. In some cases, you may cover many of these things but more often, you will pick and choose those items that demonstrate your value from your potential partner's perspective. Keep in mind potential partners aren't likely looking for volumes of information on your organization but instead a concise description of why they should contract with you, pay you a certain rate, and how you can help them achieve their goals. What is compelling about your organization and why should they consider paying you any more than fee for service?

### ***Developing Your Value Proposition***

#### **Element I: Tell Your Story and Care Delivery**

- Tell your story: Explain what services you provide, the type of resident and geography you serve currently.
  - Discuss the non-profit difference and demonstrate through metrics how your outcomes prove your non-profit value.
- Care Delivery
  - What is your model of care? Discuss your staffing model
  - What best practice protocols or evidence-based medicine do you employ in your organization?
  - Describe any innovative care or payment delivery models you have used in the past.
  - Describe your approach to providing person-centered care.
  - Describe any care coordination or care transition programs/services you provide today

### Element II: Quality/Performance

- Continuous quality improvement: Describe your quality improvement processes
  - Do you conduct root cause analyses when you identify a problem?
  - How do you identify and resolve issues?
- Share your [performance on key quality and performance metrics](#)? May include:
  - Resident satisfaction scores
  - Readmission rate for residents to the hospital
  - Falls rate
  - Medical errors resulting in hospitalization
  - Occurrences of pressure ulcers, weight loss and infections

### Element III: Costs and Reimbursements

- Describe how your organization and the services it provides are cost effective alternative to a higher cost setting (*e.g., if you're a SNF, how are you a better value than a hospital; if an assisted living, how can you attain the same patient outcomes in your setting less expensively than a nursing home, etc.* )
  - Explain what your current Medicaid rate is and typical services provided for that rate
  - Describe steps you've taken to provide cost effective care
- Describe services that you could provide that produce better outcomes for patients at a lower cost
  - Example: caregiver support following patient discharge from SNF to reduce rehospitalizations, or need for institutional level services
  - Example: Serving clinically complex patients. Would you be willing to add service/staff appropriately so these individuals could be maintained in your setting if paid a higher rate by the MCO?
  - Discuss additional services willing to provide to maintain the resident and negotiate different rate for that package of service

- Consider exploring **alternative reimbursement models**. (e.g., bundled payment, P4P, PMPM, shared savings)

#### Element IV: Communication and Partnerships

- Does your organization have an **electronic health record**?
  - Share dashboards on quality outcomes to tell your story
  - If no EHR currently: talk to the plan to see if they have any resources that could help you invest in this important technology, which could help you improve care transitions and better manage patient populations.
- Discuss any current care transition processes to/from hospital or home that you have in place today. Inquire about their preferred approach and how they could help you establish these processes if there are no current protocols.
- Describe any current or past provider partnerships that you have participated in to improve care or outcomes for the people you serve.
- See if there are grants available through the MCO foundations or companies that support testing new approaches to care delivery in general or for targeted populations.

## Quality Measures for LTSS Providers Under Managed Care/Health Care Reform

The following “common” measures have been compiled from over ten quality measure sets for health care, including national measures such as NQF, LTQA, HEDIS, CMS, MDS, Advancing Excellence, and measures in use in states such as Florida, Rhode Island and Ohio, among others. Once compiled, the development team identified some 75 individual measures. Some of these were consolidated or grouped, resulting in a final total of 60 measures. These have been organized first into seven “domains” of quality measurement, as follows:

- Safety
- Patient- and caregiver-centered experience and outcomes
- Care coordination
- Clinical care
- Population or community health
- Efficiency and cost reduction
- Staffing

The first six domains come from Jordan VanLare and Patrick Conway, “Value-Based Purchasing — National Programs to Move from Volume to Value.” *NEJM* 367; 4, July 2012. The seventh domain, Staffing, comes from our assessment of the importance of staffing measures in producing high-quality outcomes of care in LTSS.

The next level of organization comes from a ranking of each measure into one of three priority groups: Primary (20 measures), Secondary (18 measures) and Tertiary (22 measures). Initially, these rankings were derived from the frequency each measure occurred across the measure sets the development team had compiled. If a measure occurred in three or more measure sets, it was included in the primary set; if it occurred between one and three times, it was included in the secondary set; and if it occurred in only one measure set, it was included in the tertiary set. The team made no judgments regarding the relative weighting of these measure sets, acknowledging only that each had a basis in evidence.

Recognizing that simple frequency was at best a mechanical criterion for ranking quality measures, the development team discussed each of the measures and came to consensus on moving a number of them up or down in the priority groups. The team also added the Staffing domain and the five measures within that domain for the reasons stated above.

What follows, therefore, is an initial set of quality measures that we believe LTSS providers should be aware of; the primary set of 20 are measures we feel all LTSS providers should be gathering data on for their communities, and using these data to prove their quality to managed care stakeholders. The secondary and tertiary sets, while important for quality outcomes, may not appear as stakeholder requirements, or at least not initially.

Finally, the development team felt that measures of compliance such as Five-Star rankings, survey deficiencies, and Nursing Home Compare scores, are not defensible measures of quality. However, regulators, payers and the consuming public are exposed to these metrics more than any others. Further, these are being grouped into “performance” metrics, which, rather than quality metrics, will increasingly become the norm for managed care value-based payment contracts. Therefore, it behooves LTSS providers to continue to improve their performance in these metrics.



## Quality Measurement Domains and Measures\*

<b>Legend:</b>
Primary measures - 20
Secondary measures - 18
Tertiary measures - 22

### Measure

#### Phase 1 domains:

##### Safety

- 1 Falls risk assessment screening
- 2 % 65+ who received 1 or 2 different high-risk meds
- 3 Restraint use
- 4 Antipsychotic medication use

1 Falls/incidents with injury

- 1 Resident hygiene / environment / safety measures

##### Patient- and caregiver-centered experience and outcomes

- 5 HCAHPS/NHCAHPS/Resident/family satisfaction survey used

2 Client Perceptions of Coordination Questionnaire

3 Getting Timely Care, Appointments, and Information

4 How Well Your Doctors Communicate

- 6 Shared Decision Making/Person-centered Planning & Decision Making

- 2 Family Evaluation of Hospice Care

- 3 Comfortable Dying

- 4 Assessment of Health-Related Quality of Life (using KDQOL)

- 5 Patients' Rating of Doctor

- 6 Access to Specialists

##### Care coordination

- 7 % of discharges 66+ with med reconciliation within 30 days

- 8 % of patients d/c home for whom transition record was transmitted w/in 24 hrs

- 9 Advanced Care Plan

5 3-Item Care Transition Measure

6 Follow-Up After Hospitalization for Mental Illness

- 7 Medical Home System Survey

- 8 HBIPS-6,7 Post Psych Setting Care Plan Created / Transmitted

- 9 Transcription / administration of physician orders

- 10 Use of HIT, including EHR

##### Clinical care

- 10 All Cause Readmission (risk-adjusted)\*

- 11 Change in daily activity in post-acute setting/ADL assistance increased

- 12 Screening for Clinical Depression / Follow-up Plan / Incidence

- 13 Pressure ulcers / skin assessment / change in skin condition

- 14 Pain Assessment\*
- 15 Optimal Diabetes Care\*
- 16 Immunizations (Influenza, pneumovax, TB, PPD/CXR, other)\*
- 17 Weight loss / weight assessment / change in weight
- 18 Adult Weight Screening and Follow Up

- 7 Change in mobility in post-acute care setting
- 8 % of patients who need urgent, unplanned care
- 9 Initiation / Engagement of Alcohol / Other Drug Treatment
- 10 Preventive Care Screening: BMI screening
- 11 Change in cognitive status
- 12 Hypertension: Screening & Controlling High Blood Pressure
- 13 Ischemic Vascular Disease\*
- 14 Coronary Artery Disease(CAD) Composite\*
- 15 UTIs/CAUTIs

- 11 Tobacco use assessment / intervention
- 12 Incontinence (bladder/bowel)
- 13 Indwelling bladder catheter
- 14 Return to community
- 15 Health Status/Functional Status
- 16 Ambulatory Sensitive Conditions (ASC) Admissions\*
- 17 Colorectal Cancer Screening
- 18 Mammography Screening
- 19 Heart Failure: Beta-Blocker for Left Ventricular Systolic Dysfunction (LVSD)

### Population or community health

- 20 Health Promotion and Education

### Staffing

- 19 RN staff hours/resident
- 20 All nursing staff hours/resident
- 16 Staff turnover
- 17 Consistent assignment of staff
- 18 Staff satisfaction survey used

### Phase 2 domain:

#### Efficiency or cost reduction

- 21 Medicare LOS
- 22 % of PCPs qualifying for an EHR program incentive payment

### Measures not used:

- State survey citations
- Five-star ratings

*\*Domains derived from VanLare, Jordan and Patrick Conway, NEJM 367;4, July 2012*

## Primary Measures for LTSS Providers Under Managed Care

### Safety

- 1 Falls risk assessment screening
- 2 % 65+ who received 1 or 2 different high-risk meds
- 3 Restraint use
- 4 Antipsychotic medication use

### Patient- and caregiver-centered experience and outcomes

- 5 HCAHPS/NHCAHPS/Resident/family satisfaction survey used
- 6 Shared Decision Making/Person-centered Planning & Decision Making

### Care coordination

- 7 % of discharges 66+ with med reconciliation within 30 days
- 8 % of patients d/c home for whom transition record was transmitted w/in 24 hrs
- 9 Advanced Care Plan

### Clinical care

- 10 All Cause Readmission (risk-adjusted)\*
- 11 Change in daily activity in post-acute setting/ADL assistance increased
- 12 Screening for Clinical Depression / Follow-up Plan / Incidence
- 13 Pressure ulcers / skin assessment / change in skin condition
- 14 Pain Assessment\*
- 15 Optimal Diabetes Care\*
- 16 Immunizations (Influenza, pneumovax, TB, PPD/CXR, other)\*
- 17 Weight loss / weight assessment / change in weight
- 18 Adult Weight Screening and Follow Up

### Staffing

- 19 RN staff hours/resident
- 20 All nursing staff hours/resident

## Secondary Measures for LTSS Providers Under Managed Care

### Safety

- 1 Falls/incidents with injury

### Patient- and caregiver-centered experience and outcomes

- 2 Client Perceptions of Coordination Questionnaire
- 3 Getting Timely Care, Appointments, and Information
- 4 How Well Your Doctors Communicate

### Care coordination

- 5 3-Item Care Transition Measure
- 6 Follow-Up After Hospitalization for Mental Illness

### Clinical care

- 7 Change in mobility in post-acute care setting
- 8 % of patients who need urgent, unplanned care
- 9 Initiation / Engagement of Alcohol / Other Drug Treatment
- 10 Preventive Care Screening: BMI screening
- 11 Change in cognitive status
- 12 Hypertension: Screening & Controlling High Blood Pressure
- 13 Ischemic Vascular Disease\*
- 14 Coronary Artery Disease(CAD) Composite\*
- 15 UTIs/CAUTIs

### Staffing

- 16 Staff turnover
- 17 Consistent assignment of staff
- 18 Staff satisfaction survey used

## Tertiary Measures for LTSS Providers Under Managed Care

### Safety

- 1 Resident hygiene / environment / safety measures

### Patient- and caregiver-centered experience and outcomes

- 2 Family Evaluation of Hospice Care
- 3 Comfortable Dying
- 4 Assessment of Health-Related Quality of Life (using KDQOL)
- 5 Patients' Rating of Doctor
- 6 Access to Specialists

### Care coordination

- 7 Medical Home System Survey
- 8 HBIPS-6,7 Post Psych Setting Care Plan Created / Transmitted
- 9 Transcription / administration of physician orders
- 10 Use of HIT, including EHR

### Clinical care

- 11 Tobacco use assessment / intervention
- 12 Incontinence (bladder/bowel)
- 13 Indwelling bladder catheter
- 14 Return to community
- 15 Health Status/Functional Status
- 16 Ambulatory Sensitive Conditions (ASC) Admissions\*
- 17 Colorectal Cancer Screening
- 18 Mammography Screening
- 19 Heart Failure: Beta-Blocker for Left Ventricular Systolic Dysfunction (LVSD)

### Population or community health

- 20 Health Promotion and Education

### Phase 2 domain:

### Efficiency or cost reduction

- 21 Medicare LOS
- 22 % of PCPs qualifying for an EHR program incentive payment

# The Four Knows and Tips of Contracting with Managed Care Organizations

October 7, 2012



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## The Four Knows of Contracting

1. Know the Rules
2. Know What the MCOs Need/Want?
3. Provider Know Thyself
4. Know your Contracting Strategy Options



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## 1. Know the Rules

- What does the state proposal to CMS for managed care for duals say?
- What does the State's Request for Proposal to the Managed Care Organizations say?
- What other information is available from the State agency administering the program about the program?



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### 1. Know the Rules: Program Basics

- When does the program start? Is it phased-in? If so, how/where?
- Who is the target population?
  - Medicaid only, full duals, certain geographies
- What are the target conditions (e.g., diabetes, COPD, CHF)?
- What are the requirements? How will the program work?
  - e.g., care coordination, medical home, risk assessments, etc.
- What are the state goals (e.g., reduce hospitalizations, reduce costs, etc.) ?




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### 1. Know the Rules: Network & Contracting Requirements

- Distance/Access requirements: What are the state requirements around beneficiary access to providers by provider type ?
  - e.g. LTC providers cannot be more than 20 miles away in urban settings, 60 miles or less in rural
- By what date, must MCOs demonstrate they have a sufficient network of providers? (component of state readiness review of the plans)
- Must MCOs contract with all Medicaid providers for the initial contracting period?




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### 1. Know the Rules: Reimbursement

- Did the state set a rate floor or can MCOs negotiate any rate with providers?
- Must MCOs consider alternative payment models beyond FFS?
- Are MCOs required to share any of their payment incentives with providers?




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### 1. Know the Rules: Metrics

- What performance and/or quality metrics are the MCOs held accountable for by the state?
- Which ones are tied to incentive payments, if any?
- What metrics are the state tracking via claims or requiring to be reported by MCOs and/or providers as part of the program?



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### 2. Know the MCOs or Plans: What do they want?

*They want what any accountable, financially at-risk organization wants, to:*

- **Meet their contractual obligations**
  - Provider network adequacy
  - Compliance with state contractual requirements (e.g. claims paid within prescribed time, care coordination, appeals process)
  - Perform on designated quality metrics tied to P4P incentive payments
- **Access to right care at the right place at the right time for their members**
- **Standard contracts with providers**



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### 2. Know the MCOs or Plans

- **Spend less on beneficiaries' health care costs than they receive from the state = Make a Profit**
  - **This is achieved by:**
    - Ensuring members get right care at the right time
    - Care management/coordination/preventive care
    - Interdisciplinary care teams
    - Redesigning care
    - Substituting lower cost care when it can achieve good patient outcomes
    - Avoiding higher cost care (e.g., hospitalizations)



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## 2. Know the MCOs or Plans

- What does their standard contract say?
- Do they pay on time?
- Will they help educate your office staff?
- What do other providers think of them?
- Is there a merger in the works?
- Are they financially stable?
- Can they use your name in their advertisements?



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## 2. Know the MCOs or Plans

- Are there any pending litigations with other providers?
- Ask other providers about the MCOs level of service and satisfaction



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## 2. Know the MCOs or Plans: Contract Terms

- **Medical necessity:** who determines it? Where are the criteria posted?
- What is the contract **term**? Is there an automatic renewal provision or annual rate negotiations?
- What are the **termination** provisions?
- What is the process for determining patient **eligibility for services**? (E.g., web, telephone)



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12

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## 2. Know the MCOs or Plans: Contract Terms

- Does the plan require **other information** beyond that submitted on a clean CMS1500 or UB92?
- Who is responsible for **coordination of benefits** – the plan or the providers?
- What are the **dispute resolution** provisions/ process?
- **What services can be billed to plan enrollees** (e.g. non-covered services, co-pays, deductibles)?



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13

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## 3. Provider Know Thyself

- What populations do you serve?
  - Chronic Conditions
  - Acuity
  - Geographies
- What services do you provide today?
- What other services are you willing to provide or populations would you serve, if reimbursed?



***“Tell them  
your story”***



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## 3. Provider Know Thyself

- What is your quality?
  - Performance
  - Dashboards
- What is your model of care?
  - Person-centered, social model, medical model
  - Best practices
  - Specialties
  - Staffing model



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### 3. Provider Know Thyself

- How much risk is your organization willing/able to take?
  - This will determine the types of reimbursement models you will want to negotiate
- What is your payer mix?
  - Do you need Medicare and Medicaid revenues?



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16

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### Provider Know Thyself (continued)

- **How much risk are you willing/able to take?**
- **What is your payer mix?**
  - Medicaid dependence
- **What are your key referral sources and physician doing? Which providers see your residents?**
  - MCOs should want all of you in the network
  - Possible partnerships → lower cost of care



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### 4. Know Your Options: Contracting Strategies

- Be vocal and proactive
- Read the MCO/State contract so you know your rights and the MCOs obligations
- Bring your own statistics about your organization and be prepared to discuss your value proposition

#### Where do you have leverage?

- **Network:** Are you the only provider in a given geography? Do they need you to meet network adequacy?
- **Quality:** Do you have the highest quality or value in comparison to others?



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### 4. Know Your Options: Contracting Strategies

- **Don't be defensive.**
  - Talk about desire to “partner”
  - The MCOs want to make a profit but remind them they need you to be solvent too.
  - Plans will contract with the easiest organizations and those that can deliver the greatest volume first.
- **Be Part of the Solution**
  - Who are the MCOs problem cases? Situations? (e.g., clinically complex patients, care coordination, etc.)
  - Consider approaching the plans’ foundations for grants to pilot certain services or care delivery redesigns



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### 4. Know Your Options: Contracting Strategies

#### Alternative Reimbursement Models *(to enhance your Medicaid reimbursement)*

1. **Pay for Performance** (sliding scale vs. all or nothing)
2. **Bundled payments**
3. **PMPM arrangement**
4. **Shared savings**

- **Propose alternative rates or additional services for which you can be reimbursed**

Escalate: If your contracting contact cannot approve alternate arrangements or language, talk to their Director or in certain circumstances talk to plan CEO/COO for your state.



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### 4. Know Your Options: Contracting Strategies

- **What are the consequences if you don't sign a contract?**
  - What are your key referral sources and physicians doing? Are they contracting?
  - Are you required to contract with MCOs by the state?
  - Would you have to accept a lower FFS rate?
  - Would you lose referrals?



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Tips for  
**THE NEGOTIATION & CONTRACT**



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**Bring to Negotiation**

- Your Value Proposition
  - Describe your organization and its non-profit value
  - Demonstrate Your Quality
    - Dashboards with performance metrics
- Your Questions
  - Ask what they are trying to achieve and how your organization might be able to help.



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23

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**Additional Managed Care Contracting  
 Tips - "Page One" Issues**

- **Caption**
  - Correct entity names-make sure both parties names are legally correct.
  - Effective date
- **Recitals**
  - High-level description of the purpose of the agreement
  - Courts may look to the recitals for context and the parties' in the event disputed terms are ambiguous
  - Incorporation into the agreement



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24

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## Managed Care Contracting Tips - Definitions

- **Plans, Payors and/or Clients.** Ensure these terms are not defined overly broad to avoid inadvertently agreeing to discounted rates for services furnished to broader scope of individuals than you intended.
- **Covered Services.** Your principal obligation under the agreement is to furnish "Covered Services" to the Plan's members. Ensure this term is carefully defined in light of the full scope of services you intend to provide and for which you expect to be paid. Where possible, consider listing and defining each service by developing a separate schedule.
- **Medical Necessity.** Ensure that the definition of "medical necessity" does not give the Plan the sole authority to determine what is medically necessary. Instead, the definition should rely upon the clinical judgment of the Provider and/or community standards.
- **Standard of Care.** Avoid provisions that impose a duty on you to furnish the "highest" or "best" quality of care. These types of provisions can enable Plans to prevail more easily in a breach of contract action, and they might give an easier path in medical malpractice claims.



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25

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## Managed Care Contracting Tips – Your Obligations

- **Delivery of Services.** Ensure that you not only know the scope of covered services under the contract but also any terms and conditions regarding the delivery of those services (e.g., prior authorization requirements, qualifications of the caregiver, etc.)
- **Records Requirements.**
  - Does the contract impose records maintenance and/or retention obligations that differ from your standard practices?
  - Consider negotiating a general provision stating that Provider must retain patient records for the period prescribed by applicable state and federal law.



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26

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## Managed Care Contracting Tips – Your Obligations (continued)

- **Policies and Procedures.**
  - Watch for provisions that are incorporated by reference such as the Plan's policies, guidelines or other standards. Obtain copies of any such documents before executing the contract.
  - Ensure that the contract does not permit the Plan to change those standards and enforce them under the contract without advance notice to you.
  - Ensure that you are aware whether the contract or the standards govern in the event of a conflict between the two.
- **Audits.**
  - Carefully review the Plan's rights to conduct audits and who pays for the audit.
  - Does the contract allow the Plan to use statistical methods to project alleged over-payments?



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27

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## Managed Care Contracting Tips – Your Obligations *(continued)*

### • Utilization Management.

- Understand who at the Plan performs utilization management (e.g., qualified clinicians).
- Understand how member eligibility is verified.
- Understand how much time the Plan has to respond to prior authorization requests.
- Know your appeal rights in the event you disagree with a Plan decision.



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28

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## Managed Care Contracting Tips – Claims Payment

- **Time Period and Process for Submitting Claims.** Compare to your standard practices and consider negotiating “special circumstances” provisions to permit you additional time in certain situations.
- **Who is Responsible for Paying You and What is the Timeframe?**
- **Nonpayment.** In addition to the right to terminate, the Provider would desire the right to suspend services and impose penalty fees in the event of non-payment by the Payor (or other entity responsible for payment).
- **Retroactive Denial of Claims.** Consider negotiating provisions that prohibit the Plan from retroactively denying claims that were positively adjudicated absent fault or fraud of the Provider. Consider also negotiating cut-offs for any look-back time periods.



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29

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## Managed Care Contracting Tips – Term/Termination

- **Contract Duration.** Ensure that it is clear. Future rate uncertainties might suggest a longer term.
- **“Without Cause” Termination.** Carefully review the terms of the proposed contract. Consider negotiating a mutual right to terminate without cause with reasonable advance notice periods and clear requirements for submission of prior claims post-termination.
- **For Cause Termination.** Consider including a cure period for any alleged “for cause” termination reason. For cause termination can have collateral impact for providers in certain situations, and therefore providers should ensure that the standards are clear.



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30

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### THE HOT POINTS

- Certification/Credentialing
- Case Management Coordination
- Audits/Overpayments
- Manuals and unilateral amendments
- Dispute resolution
- Encounter Data



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31

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### Hot Point: Certification/Credentialing

- **Licensure**-Why isn't licensure/Medicare/ Medicaid enough
- **Checklist**-ask for requirements
- **Time limit to make determination**-can take up to 6 months for approval once submitted
- **Provisional credentialing**-ask for "provisional" status so claims can be processed for payment while process for full credentials approval is pending.



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32

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### Certification/Credentialing: What is generally required?

- **Licensure** -State and Medicare/Medicaid provider information
- **Accreditation**- JCAHO, CARF, CHAP, CCAC etc.
- **Survey History**- State and Federal
- **Language competencies**
- **Verification of credentialing**- staff both Internal and Outsourced
- **Insurance certificates**
- **Attestations**- Malpractice and other negative events
- **Site Visits** – generally for nonaccredited facilities



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33

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### Hot Point:

#### MANUALS AND UNILATERAL AMENDMENT

- **Manuals:** Read the manuals for utilization criteria, authorization guidelines, quality measures, etc.
- The manual is the contract
- **Unilateral Amendments:** Look for negative notice provisions that require you to notify the MCO to opt out of future amendments to the agreement.
- **Incorporation of other contracts,** such as the state contract and other product lines



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34

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### Hot Point: Dispute Resolution

- Each MCO is different
- **Purpose:** To avoid going to court
- **Beware of contracts** that permit the MCO contract manager to make the final determination
- Make sure you **retain the right to go to court,** if the process fails you.



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35

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### Hot Point: Encounter Data/Reports

- Know **what is required**
- **Request your data-** You have the right to request your data and peer or other comparisons
- **Reimbursement-** How are they are going to use your data for the pricing mechanisms to be discussed
- **Reports-** Request the reports/ know your contractual rights to copies



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36

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### Quality Care Initiatives

- **Evolving concept** -will be the “guise” for cost control.
- **Buzz words** – “Benchmarks” and “Outcomes”
- **Don’t allow vagueness** – Know exactly what metrics are being measured
- **Be wary** of this being the basis for “medical necessity”
- **Benefit creep** – MCO pushing down State requirements



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37

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### Penalties

- Mostly a creature of the State Contract and law
- Pass through by the MCO
- Indemnification of MCO for penalties they receive.
- Can include attorney’s fees and investigative costs of the government agency



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38

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### Electronic Health Records

- **Cost item:** MCO may require your EHR be compatible with their system
- **Disparate systems:** Is there a mandate in the program for use of EHR and interoperability?
- **Security concerns:** Whole new level of HIPAA concerns
- **Stealth Audits:** Review of electronic records for compliance



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39

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## How do you Contract for what you want

- **Addendums:** MCO Contracts will have required provisions that must comply with State requirements. However, in order to add or modify contract provisions, prepare an addendum that reflects your desired changes to be incorporated as part of the Agreement.
- **Read the Manuals:** They are part of what you have agreed to via the Agreement
- **Know the State Contract** so you are knowledgeable of what is required or not required
- **Develop a relationship-** with your contract provider representative as they can provide assistance and make the relationship a win-win for all.



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## Additional Thanks!

- We would also like to thank Frank Rainer, Esq. of Sternstein, Rainer & Clarke, PA law firm in Tallahassee, Florida for their contracting tips.



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41

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