Managing within Managed Care:
Lessons Learned in Home Care

MITCH MOREL AND LYNNE HEBERT

Tremendous Opportunities Exist to Better Manage Patient Care for Patients Discharged From Acute Care Hospitals

Currently there are 47.6 million Medicare beneficiaries with an estimated 9,100 individuals added to the program each day. (1)

Source: U.S. Census Projections
Source: RTI, 2009: Examining Post-Acute Care Relationships in an Integrated Hospital System

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Home Care is uniquely positioned to change the Post-Acute Care value proposition within the Managed Care Industry

**Managed Care Industry Dynamics**

**Old Paradigm**
- Siloed delivery systems and settings
- Fee-for Service
- Payment based on service type, intensity and volume
- Limited, if any, coordination and/or risk-sharing among providers
- Payment regardless of outcome
- Broad provider networks

**Interim Steps**
- Test different payment models, including P4P and Shared Savings
- Begin aligning financial & clinical incentives (e.g. reduced ALOS, Re-admits, etc.)
- Ramp up Care Management and care coordination
- Financial analytic capabilities to assess opportunity across an episode of care to support contracting and shared savings

**New Paradigm**
- Coordinated Care and Clinical Integration
- Shared Risk payment models
- Payment based on defined population and services
- Aligned financial incentives across provider types (i.e. Physicians, PAC Providers, etc.)
- Outcomes influence finances
- Narrow “high performing” Networks

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**Creating Value for the Patient and Managed Care Company**

**Improve Outcomes**
- Reduce Avoidable readmissions
- Improve Patient Satisfaction

**Evidence-Based Care**
Managed Care “Liabilities”

- Financial Liability
  - Beyond Rates and Reimbursement Arrangement

- Clinical and Outcome Liability
  - Impact on care planning
  - Impact on patient outcomes and experience
  - Clinical staff satisfaction

Types of Non-Medicare Payers

- Commercial Insurance
- Medicare Advantage Plans
- TPA – Third Party Administrators
- ACO
- VA
- Medicaid
Types of Non-Medicare Payers

- Capitated
  - Focused on reducing utilization
  - Contract with lowest cost provider
  - Clinical outcomes normally not a priority
- Fee For Service / Shared Savings
  - Focused on clinical outcomes
  - Works with high quality/efficient providers
  - Working to reduce utilization but not to the extent it affects clinical outcomes such as re-hospitalizations

Why Contract with Managed Care Organizations

- Expand Market Share
- Increase Revenue/Income
- Leverage Referral Sources
- Participate in hospital rotations
- Align yourself with large referral groups
- Employ excess capacity in clinical staff
- Offset seasonal fluctuations
Choosing the MCO that fits your Company

- Number of covered lives in service area
- Acceptable visit rates and rate structure
  - Episodic or per visit
  - Combined visit or individual visit rates
- Co-pays and Deductibles
- Provider physicians and hospitals
- Billing requirements

What you must know before negotiating with MCO’s

- How are you going to pay your clinicians?
- Do you have adequate cash flow?
- How many additional patients can you support?
- Do you have the ability to attract experienced billing personnel?
- Do you know your cost per visit by discipline?
What you must know before negotiating with MCO’s

- MCO FFS rate structure
  - Set rate per visit
  - Percentage of charges
  - Percentage of LUPA rates
- Co-pays/Deductibles
- Payment Type – Electronic or Paper
- Routine/non-routine supplies
- Timely filing requirements
**What you must know before negotiating with MCO’s**

- Authorization Process
  - Electronic/Phone
  - Number of authorizations at admit
  - Documentation requirements
  - Response time

**Additional Cost of Working with MCO’s**

- Agency staff
- Billing staff
- Intake/Utilization review
- IT / Contract Management
- Sales staff
- Software Changes
- Recruiting
Software Needs

- Schedule by discipline
- Authorization tracking
- Ability to change payors
- Contract management
- Claim filing / clearinghouse
- Payor revenue codes
- File claim on appropriate form
- Electronic posting of payments

- AR tracking
  - Net claim or charges
  - Transfer of patient resp.
  - Bad debt write-offs
- Fully adjudicated claims report

Workflow For Commercial Payers

- Workflow occurs at multiple points:
  - New Admission/Start of Care
  - New Orders
  - Add-on Events
  - Re-authorisation
  - Discharge
Managing Medicare Managed Care Expectations

- Medicare Managed Care Manual
  - Enrollment and Disenrollment
  - Marketing
  - Quality
  - Organizational Compliance
  - Grievances, Determinations and Appeals
  - Plan Types
  - Payment Principles
  - Risk Adjustment Models

OASIS Data Collection by Payor Type

- Comprehensive assessment requirement currently applies to all patients including Medicare, Medicaid, and Medicare managed care (Medicare Advantage) (non-Medicare and non-Medicaid patients suspended)
- Exceptions: patients under the age of 18, patients receiving maternity services, patients receiving only chore or housekeeping services, and patients receiving only a single visit in a quality episode.
- HIPPS code generation requirements for MA Claims
- Non-Medicare Assessment Data Collection – Migration to “Medicare like” documentation
Clinical Management

- Care planning by authorization verses clinical scoring
- Specific vs. holistic approach
- Outcome impact
- Communications demands with payer source
- Post payment review by MA plans
- Clinical training

Clinical Management

- Supply management
- Weekend staff and authorizations
- Higher acuity patients
- Documentation demands
- Longer duration visits
- Fewer visits per patient
MCO issues you will encounter

- Patient churn
- Making visits without authorizations
- Friday rush hour
- Payer changes
- Delayed payments
- Collecting co-pays and deductibles
- Reduced Medicare referrals from referring physicians
Post Payment Review and Audit

- Post Payment Reviews from multiple MA plans
  - “Recovery like” reviews becoming more common
- Clinical Record Review
  - Patient Type
  - Discipline Type
  - Diagnosis Group

Financial Reporting

- Record MCO revenue and cost separately on income statement
- Track each MCO’s revenue and cost individually on subsidiary ledger or spreadsheet
- Track direct cost by discipline
- Record contractual allowance
- Bad debt experience
### Humana

- Low rates are non-negotiable
- Referral – from Humana to branch by fax
- 8 Authorizations at admit
- Additional authorizations take 2 to 3 days
- Must send 485 & eval to justify authorizations
- Must send all clinical documentation to request additional authorizations
- Timely billing 45 days
- Retro authorizations up to one year
- Humana HMO – referral comes from PCP and PCP must request all authorizations

### United Health Care

- Low rates
- Referral – from PCP to branch
- 5 authorizations each (SN/therapy) at time of referral
- Breakout rates between RN and LPN
- Additional authorizations take 1 to 2 days
- Timely billing 45 days
- Retro authorizations – 3 days
- Additional documentation for ST and must have correct diagnosis
### Univita / TPA

- Negotiable rates
- Referral – from TPA to branch via fax
- 2 authorizations each (SN/Therapy) at time of referral
- Additional authorizations take up to 1 week and must be accompanied by all clinical documentation
- 45 day timely billing
- Retro authorizations – 48 hours
- Time consuming to work with

### CareCentrix / TPA

- Negotiable rates
- Distribute patients to lowest rate provider who will take the patient
- Breakout rates between RN/LPN and PT/PTA
- Referral – From TPA to branch electronically
- Additional authorizations take up to 2 weeks
- 45 day timely billing
- Retro authorizations – 1 week
- Blue Card patients take up to 3 weeks for authorization
VA

- VA rate schedule/negotiable
- Referral – From VA case manager to branch with pending authorization
- Authorizations can take up to 1 year
- 6 months timely filing

Patient Financial Proforma

<table>
<thead>
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<th>Visit Type</th>
<th># of Visits</th>
<th>Rate/Visit</th>
<th>Revenue</th>
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<tr>
<td>Therapy</td>
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Total: 13 visits, $1,230 revenue

- Bad Debt/Non-billable (5%) $62, 5.0%
- Income $153, 12.4%

Cost

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Total: 13 visits, $1,016 expense
Successful MCO Strategy

- Know your cost and what rates you will accept
- Be willing to walk away
- Focus on intake and scheduling
- Use LPN, PTA and OTA when appropriate
- Centralize intake and utilization review

Managing Overall Reimbursement

- Create a “Payor Mix Strategy”
- Seek leverage opportunities across your operation
- Prepare to evolve from fee-for-service reimbursement to some form of value-based payment system
- Start now!