Managing within Managed Care:

Lessons Learned in Home Care

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KINDRED HEALTHCARE

Types of Non-Medicare Payors

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

- **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?
## CPV calculation

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### Per Visit cost

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### 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

Workflow For Commercial Payers

- Workflow occurs at multiple points:
  - New Admission/Start of Care
  - New Orders
  - Add-on Events
  - Re-authorization
  - Discharge
Additional Cost of Working with MCO’s

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

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.\(^1\)
Home Care is uniquely positioned to change the Post-Acute Care value proposition within the Managed Care Industry.

**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
  - Evidence-Based Care
  - Improve Patient Satisfaction

Evidence-Based Care
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

Medicare Advantage Penetration Slowed

Medicare Advantage Penetration Rate
August, 2012

Source: CMS.gov, Prepared By: Josh Tapley, Data-link.com
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
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

Evidence-Based Practices to Reduce Re-Hospitalization
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

Patient Financial Proforma

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Specific Challenges

- Humana
- United
- Univita/TPA
- CareCentrix/TPA
- VA

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!