Medicaid Home Care: Adjusting to the Changes Successfully

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Financing and Care Delivery Reforms Affecting Medicaid Home Care

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CMMI’s 41 “Innovation Models”

• Accountable Care (9)
• Bundled Payments (8)
• Primary Care Transformation (7)
• Medicaid and CHIP Initiatives (5)
• Medicare-Medicaid Initiatives (2)
• Initiatives to Speed the Adoption of Best Practices (5)
• New Payment and Service Delivery Models (5)

CMS’s MLTSS Recommendations

• Technical assistance, contract negotiation technical support for LTSS providers;
• “Neutral forums” where LTSS providers and MCOs can educate each other and share information;
• Reasonable timelines so that LTSS providers can successfully prepare;
• Practice billing sessions between MCOs and LTSS providers;
• MLTSS agreements with continuity of care provisions;
• Allow high-performing LTSS providers to become MLTSS contractors;
• MCOs should use LTSS specific, uniform billing practices;
• MCOs should each have a staffed LTSS specialist.
Medicare-Medicaid Initiatives

• Financial Alignment Initiative for Medicare-Medicaid Enrollees—the “Duals Demos”
• Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents
  – Population: Long-stay nursing facility residents who are enrolled in Medicare and Medicaid

Overview of Duals Demos

• “Duals Demos” run out of the Medicare-Medicaid Coordination Office, headed by Melanie Bella
• Purpose of the Demos
  – Remove financial misalignment between Medicare and Medicaid
  – Integrate primary, acute, behavioral health and LTSS
• Two Models
  – Capitated
  – Managed Fee for Service (only in WA)
• Readiness review required prior to implementation
Provider Transitions

• Plans required to have a transition period (i.e. 180 days) where enrollees can maintain previous providers
• Plans can transition enrollees earlier if certain conditions met, i.e.:
  – the enrollee agrees to this expedited transition;
  – transition care plan in place
  – comprehensive assessment/health screening

Enrollment

• Method varies
  – Active, then passive: IL, OH, MA
• Advanced notice to beneficiaries about passive enrollment
• Opting out, disenrolling options in some instances
Network Adequacy

- Geographic coverage varies widely
- Set standards for LTSS, home care, and home health
- Number of providers
  - Specific number OR
  - “Sufficient number,” etc. OR
  - Must offer contracts to “all qualifying providers”:
    - IL

### Duals Synopsis

<table>
<thead>
<tr>
<th>State</th>
<th>Covered Population</th>
<th>Enrollment</th>
<th>Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>WA</td>
<td>Full benefit high cost/risk duals eligible for health home services</td>
<td>Beneficiaries automatically enrolled in health home network but retain choice about whether to receive services</td>
<td>Adds health homes to current benefits</td>
</tr>
<tr>
<td>IL</td>
<td>Full benefit duals</td>
<td>Initial voluntary enrollment followed by 6 month passive; passive enrollment capped at 5k/plan/month</td>
<td>All Medicare and Medicaid, excluding Medicare hospice</td>
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<tr>
<td>MA</td>
<td>Full benefit duals</td>
<td>Initial voluntary enrollment followed by 2 passive enrollment periods</td>
<td>All Medicare and Medicaid services except Medicare hospice and Medicaid MH and DD case mgmt</td>
</tr>
<tr>
<td>CA</td>
<td>Full benefit duals</td>
<td>Passive enrollment in all counties except LA where enrollment is voluntary for first 3 months; LA is capped at 200k</td>
<td>All Medicare and Medicaid services except Medicare hospice and some MH and SA; and DD: Vision and dental included</td>
</tr>
<tr>
<td>VA</td>
<td>Full benefit duals</td>
<td>Initial voluntary enrollment period followed by passive enrollment</td>
<td>All Medicare and Medicaid covered services except Medicare hospice</td>
</tr>
<tr>
<td>OH</td>
<td>Full benefit duals</td>
<td>Initial voluntary enrollment period followed by 3 passive periods</td>
<td>All Medicare and Medicaid except Medicare hospice, Medicaid Habilitation, and targeted case mgmt for DD</td>
</tr>
</tbody>
</table>

Source: PWC
New York withdrew its FFS Proposal only.

### Duals Demo Enrollment

**Size and Start Dates**

<table>
<thead>
<tr>
<th>State</th>
<th>Enrollment Size</th>
<th>Earliest Possible Start Date</th>
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<tbody>
<tr>
<td>Washington</td>
<td>22,000</td>
<td>July 2013</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>109,000</td>
<td>Oct. 2013</td>
</tr>
<tr>
<td>Illinois</td>
<td>135,000</td>
<td>Jan. 2014</td>
</tr>
<tr>
<td>California</td>
<td>456,000</td>
<td>Jan. 2014</td>
</tr>
<tr>
<td>Virginia</td>
<td>78,500</td>
<td>Feb. 2014</td>
</tr>
<tr>
<td>Ohio</td>
<td>115,000</td>
<td>Mar. 2014</td>
</tr>
<tr>
<td>Total</td>
<td>915,500</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Breakdown**

- Washington
- Massachusetts
- Illinois
- California
- Virginia
- Ohio
Delays Abound

• Implementation dates keep getting pushed back
  – CA delayed at least four times
  – IL announced delay earlier this month
• 14 of 26 states that submitted proposals are dropping or delaying Demos

EXPECT DELAYS

Seven Withdrawals

• Arizona: 4/2013
• New York: 3/2013 (from FFS)
• Hawaii: 2/2013
• Tennessee: 12/2012
• Oregon: 10/2012
• New Mexico: 8/2012
• Minnesota: 6/2012
Common Reasons for Withdrawals

• Poor Reimbursement or Financial Unviability (TN, MN, OR)
• Start Dates too Aggressive (AZ, HI)
• Conflicting Priorities (AZ, NY)

Stakeholder Suggestions

• Reduce Size of the Demos
• Set Realistic Timelines
• Simplify Enrollment Process
• Explicitly Include HCBS Waiver Services
• Improve Ombudsman/Consumer Assistance
• Improve Network Adequacy and Readiness
Making the Move to Managed Care: Obstacles and Opportunities

Bob Creamer, Chairman, Loving Care Agency, Inc.
Michelle Martin, Director of Policy

Managed Long Term Services and Supports

- Some states are opting to move LTSS into Medicaid managed care
- By 2014, 26 states are projected to have MLTSS programs
- Services included in MLTSS differ from state to state
- There is no cookbook for moving to MLTSS
Obstacles

- **Timeline**
  - How long is the transition?
  - Will all providers be accepted by the managed care health plan for a period of time during the transition?
    - If yes, how long?
    - If no, how and when will existing patients be transferred to a participating provider?

- **Communications**
  - Who will be disseminating what information? State? Health plan? Provider?
  - What information will be communicated with patients?
Obstacles

- **Process**
  - How will patients be moved into managed care? All at one time or will the transition occur in phases?
  - Will all providers continue to provide care during the transition period?
  - Will providers be required to provide any new or different information during the transition period?
  - Will care continue at current levels during the transition period?
  - Will providers be expected to take on new Medicaid patients during the transition period?
  - Define the conflict resolution process
  - What are the reporting requirements during the transition?
  - Fully understand when and how patients can switch payers (process and frequency)

Obstacles

- **How will the claims process change?**
  - Where will claims be sent? State? Health plan?
  - What format will claims need to be in? Electronic? Paper?
  - What is the timeframe for submitting a claim?
  - What is the timeframe for getting a claim paid?
Obstacles

- Will the payment rate stay the same? If not, how will it change?
- Will the coding process change?
- What is the appeals process during transition?
  - Timeframe for submitting an appeal?
  - What documentation is required?
  - What is the timeframe for a decision on an appeal?

Opportunities

- According to the Kaiser Commission on Medicaid and the Uninsured, in each of 26 states, over half of the Medicaid beneficiaries are enrolled in comprehensive risk-based plans
- Medicaid managed care is growing as a way to manage high need populations—either through Duals Demonstrations or MLTSS—and seems like it is here to stay
Opportunities

• Educate health plans
  – Early and often
  – Meet with as many stakeholders as possible. They all have different needs and views
  – Continue process post implementation
• What health plans want to know:
  – What range of services does the provider offer?
  – What assurances can a provider offer that the right people, with the right training will show up at the right time?
  – What quality metrics can a provider offer?
  – How reliable are the caregivers? How is reliability measured?
  – Pricing. How will prices be negotiated?

Opportunities

• Become a valued partner
  – YOU have the information that they need!
  – Ask each of the stakeholders what they need and offer solutions
  – How will the expansion of Medicaid eligibility and the shift to having financial responsibility for LTC impact their needs?
  – Throw out possible solutions to challenges they might not realize (Correspondence likely printed in English and Spanish, do they need help communication in Vietnamese or Mandarin (or what ever large ethnic population the state might have
Opportunities

• Becoming a network provider...
  – Will the health plan take all willing providers?
• Review the contract!
  – There will be a good deal of boilerplate language but some health plans will recognize the need for more specificity given the drastic change in services from clinical to LTSS
• Be prepared for definitions of commonly-used terms to change

Opportunities

• Credentialing processes are likely to be different from health plan to health plan
  – Be prepared to develop a system that allows staff to be sure that all necessary materials have been provided
• Watch for contract terms that are “incorporated by reference”
  – The entire provider manual is uniformly incorporated by reference
  – One health plan listed the appeals process in the provider manual instead of the contract
Opportunities

• Once in the provider network, be prepared for the steps that have changed from fee for service or even from the transition process
  – Are authorizations handled differently?
  – Have requirements of the referring physician changed?

Opportunities

• Submitting claims could change drastically
  – At least part of the claims process will be included in the contract; however the full process may be described in its entirety only in the provider manual
  – “Clean claims” will be required but what constitutes a clean claim can differ from health plan to health plan
  – Make sure to know what a clean claim requires from a technical standpoint—paper or electronic? Any coding changes?
Opportunities

• Knowing the appeals process could be key!
• Of course the process will change from health plan to health plan...and is likely to be explained briefly in the contract but more fully in the provider manual
  – In the contracts reviewed for this project, the appeals processes were quite different, in terms of levels of appeals and time allowed for making the appeal
• If the appeals process is over burdensome, make an effort to negotiate the terms with the health plan
  – A 30 day appeals timeline might work for a large health plan with a large team to handle the work, but may not work on the provider’s side

Opportunities

• Identify any reporting requirements that will be placed on providers by the health plan
  – What information has to be reported? When? By what method?
  – Do you, as a provider, have the capabilities of adhering to the reporting requirements or will you need to make changes to your systems?
• Be aware that audits/record inspections are permitted, per the contract
  – How often will the audits occur?
  – Do you have the capabilities to handle the audit?
Opportunities

• Define the conflict resolution process under the Medicaid managed care contract
  – Who, at the health plan, serves as the “tie-breaker” when conflicting information is provided?
• Quality
  – How is quality defined by the health plan? State?
    Whose definition wins?
  – Important to understand how parameters around quality can lead to an issue of conflicting information and the necessity of a tie breaker
    • Providers are currently dealing with this issue despite working under a managed care contract for more than a year

Opportunities

• Do you have the staff and tools in place to handle all of the changes?
  – Will current staff require additional training?
  – Will new staff be required to handle new processes (claims, appeals, authorizations)?
  – Are all of the technology pieces in place or is additional/different software required?
  – What kind of staff and training will new technology require?
Opportunities

• Help to create the communications process
  – See above example
  – Identify best practices for the health plans
    • Many stakeholders have agreed that face-to-face communications are the most effective
  – Work with the state and the health care associations impacted on a universal and clear communication process
    • Be prepared to help patients and their families navigate through the changes
    • Who will communicate with patients? Multiple communications coming from multiple sources can be confusing and frustrating for patients
  – Hold the MCOs to their committed dates
  – Provide patient feedback. Your staff likely has the most contact with their new members

Opportunities

• Pricing
  – Is there room for change in pricing (up or down)?
  – Add on opportunities
  – Understand total reimbursement (don’t underestimate the impact of reduced authorized hours per patient). It is not just about price per hour/visit.