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PRESENTS

MAXIMIZING REVENUE AND CONTRACTING WITH MCOS UNDER PENNSYLVANIA'S COMMUNITY HEALTHCHOICES FOR NURSING HOMES

AUGUST 4, 2017
9:00 -10:15 A.M.

Session Objectives

- What are Managed Care Organizations (MCO's) evaluating as a result of a move to capitated Medicaid Managed Care
- Review Rate Setting
- Changes to Medicaid process
- What to expect

Session Objectives (cont'd)

- Services
- Negotiations and Contracting

Community Health Choices: What we know

- CHC a/k/a Managed Long Term Care Services & Supports (LTCSS)
- 3 plans selected
  - AmeriHealth Caritas
  - Pennsylvania Health & Wellness
  - UPMC for You
- Phase-In: "Zones"
  - Southwest [January 2018]
  - Southeast [July 2018]
  - Northwest/Northeast/Lehigh Capital [Jan. 2019]

- # CHC DIFFERENT from Health Choices
  - **Dual Eligible: Medicare AND Medicaid**
    - CHC-MCO's will have to COORDINATE with Medicare to ensure that participants can access comprehensive services
    - - CHC-MCO's will be able to provide Medicare coverage (D-SNP's) to those who want Medicare and Medicaid provided by same entity
  - **Long-Term Services and Supports (LTSS)**
    - CHC provides to those who need level of care provided in NURSING HOME
    - Residents will have to CHOOSE PLAN
    - MCO'S and Providers to NEGOTIATE agreements

CHC DIFFERENT from Health Choices

- All MA residents currently receiving services in the nursing facility will transition to CHC effective the date of implementation in that county.
- There is a **continuity of care provision** which will allow residents in the nursing facility to continue to receive services in that nursing facility until such time that the services are no longer needed.
- The **MA resident** will be required to **choose a CHC-MCO plan** as well as a **Service Coordinator** who will have the responsibility of managing the resident's care plan.
- All services that are currently paid by Medicaid as part of the nursing facility's per diem rate will be billed to and **paid by the CHC-MCO plan**.
- Nursing facilities will continue to be responsible for collecting the **resident's patient pay liability**. The CHC-MCO will be given the responsibility to **audit** all deductions from the resident's patient pay liability.

CHC DIFFERENT from Health Choices

- Nursing facilities will be given the opportunity to participate in claims testing as part of the Department's readiness re-view process.
- All applications for MA eligibility will be required to be submitted through COMPASS or through the Independent Enrollment Broker (IEB), under contract with the Department. **Paper applications will no longer be accepted by the County Assistance Offices (CAO) after CHC implementation in the county.**
- Nursing facilities should work with their ancillary providers to ensure they are part of the CHC-MCOs network of providers.
- Assisted Living Residences have the potential to play a role in CHC as a home and community based service setting, with details being largely left to the MCO by DHS.

Goals

- Enhance opportunities for Community Based Living
- Strengthen health care and LTSS delivery systems (including dual-eligible individuals)
- Allow for new innovations
- Promote the health, safety, and well-being of enrolled participants
- Ensure transparency, accountability, effectiveness, and efficiency of the program

WHO MAY PARTICIPATE?

- Any Willing Provider
  - MCO's will be required to contract with all interested Nursing Facilities enrolled in the Medical Assistance program for at least 18 months (originally 180 days) from the date of each phase implementation
  - DHS has agreed that they, SNF Associations and CHC-MCO's will discuss and recommend guidelines for network adequacy including facility quality and performance standards

WHO MAY PARTICIPATE? (CONT'D)

- DHS has agreed that facility quality and performance standards will not rely on any **one** criterion (e.g. the CMS Five-Star rating system or a facility's state survey(s)
- It is anticipated that a streamlined Provider **credentialing** process will be developed by DHS in conjunction with the CHC-MCO's
- "Awareness Flyers" and "Aging Well Events" to be sent and held SOON as will discussions with residents about CHC
- Service Coordinators begin reaching out to 'participants'

MCO's: Rates and Services

- How will rates be calculated
  - DHS has agreed to a 36-month RATE FLOOR
    - calculated at the facility specific level
    - averaging the facility's four quarterly case-mix rates in effect prior to CHC phase of implementation

Rates (cont'd)

- Rates to be ultimately negotiated between Nursing Facilities and CHC-MCO
  - Facilities and the CHC-MCO can enter into a mutually agreed upon alternative payment structure to the rate floor methodology
  - Agreements between the nursing facility and the CHC-MCO to waive the rate floor must be in writing and signed by both parties

Rates (cont'd)

- While Rate floor will NOT be adjusted:
  - DHS will instruct their actuaries, who calculate the CHC-MCO rates, to account for any rate increases that might be obtained through the budget process
  - DHS will also instruct their actuaries to account for any assumed increases in costs due to mandates on staffing, wages or related cost drivers

RATES (CONT'D)

- Due to federal rules, DHS cannot mandate that the CHC-MCO's will increase provider rates
- However, they will require the CHC-MCO's to demonstrate that the impact of increased nursing facility costs was considered during rate negotiations between the provider and the CHC-MCO

RATES (CONT'D)

- DHS presentation June 7
- Contact Mike for copy
- Contains CHC Financial Overview, Rate Development Process, Status & Next Steps
  - Rates developed under MA Managed Care Final Rule May 6, 2016 along with actuarial Firm Mercer Gov't Human Services Consulting

Medicaid – Changes with CHC?

- Providers still enroll as Medicaid providers
- Providers now CONTRACT with MCO's
- Providers now BILL MCO's
  - Each MCO may have its own payment processing system
  - Services prior to Jan 1, 2018 must be billed to DHS via PROMISE system
  - CHC-MCO's must adjudicate 90% of clean claims in 30 days, 100% in 45 days

What others have done:

- At least 20 states have privatized MTLSS programs (up from 8 in 2004)
- LTSS now accounts for as much of one-third of total Medicaid spending
- Number of people in MLTSS programs has grown from 105,000 in 2004 to 1.6 MILLION in 2014.
- Almost all users of MA funded LTSS over 65 are DUAL-ELIGIBLES

What others have done (cont'd):

- Texas
  - Switched to tier system based upon RUGS and nursing hours
  - Partnering with various housing agencies in a 'money follows the person' (MFP) program to seek opportunities to transition clients to HCBS
- Tennessee
  - Implemented Quality Improvement in LTSS (QuILTSS) to promote the delivery of high quality services
  - Defines quality from the perspective of the person receiving services and their family/caregivers, so the focus is less on clinical measures and more on areas the beneficiaries and families identify as influencing LTSS beneficiaries experience of care. It is a 'point system'
- New Jersey
  - Moved to MLTSS system effective July 1, 2014 after spending more than $3.5 BILLION on Long Term Care Services for seniors with disabilities under a 'fee for service' system.
  - 'Grandfathered' payment arrangement in place and added 'any willing provider' provision similar to PA
  - Expanded scope of practice for LPN's to allow additional services in order to lower costs
- California
  - Has a broad coordinated care initiative including MLTSS which Gov. Jerry Brown has stated is failing to save the state any money, and promising to end the program in 2018 if trends do not change

SERVICES

- DHS expects to continue to make payments for Healthcare-Associated Infections
- DHS also expects to continue the Non-public Medical Assistance Day One Incentive payment (MDOI)
- DHS will be working with the CHC-MCO's to **test their claims processing** prior to implementation of each phase of CHC

SERVICES (CONT'D)

- Nursing facilities of varying sizes, types and corporate structures will be solicited and included in the claims testing
- Facilities wishing to engage in claims validation will be able to do so before their phase of CHC begins

SERVICES (CONT'D)

- DHS requested resident census information from facilities located in any of the 14 Phase 1 counties to be submitted by May 31
  - Expect DHS to follow suit for all facilities located in Phase 2 & 3 counties
  - Copy of census form

SERVICES (CONT'D)

- Information will be used to help ensure that residents residing in facilities receive communication regarding the transition to CHCs
- Census data template requires facility to list the resident's SSN or Medical Assistance ID, name, date of birth, admission date and payor source

SERVICES (CONT'D)

- Identifying Needs
  - CHC-MCO's must screen, conduct comprehensive needs analysis, comprehensive assessment (conditional) and annual reassessments
- Care Management Plans
  - "Person Centered" Service Plans (PCSP)
  - To now include the Service Coordinators

SERVICES (CONT'D)

- PA Departments of Aging & Human Services recently announced an agreement with Aging Well (subsidiary of the PA Area Agencies on Aging (P4A) to partner on the implementation of Community HealthChoices for the assessment function
- Includes Functional Eligibility Determination (FED), Pre-admission Screenings (PASRR), annual re-evaluations and CHC outreach and education programs

SERVICES (CONT'D)

- As we move toward implementation of Community Health Choices, the Commonwealth will be providing a series of informational documents for providers. They can be found on this DHS page: http://www.dhs.pa.gov/citizens/communityhealthchoices/ForProviders/index.htm
- Check this site often for updates

PREPARE FOR MCO NEGOTIATION

- KNOW YOUR COSTS!!!!!
- How do you provide VALUE to the MCO's?
- Analyze Strengths/Weaknesses (from viewpoint of the MCO's)
- Streamline operations – 'lean & mean'
- Beware of 'hidden' or 'new' costs
- Develop RELATIONSHIP with MCO's – communicate EARLY and OFTEN

PREPARE FOR MCO NEGOTIATION

- Who will conduct the negotiations?
- Attorney involvement?
- Involvement by CPA/cost report preparer?
- Make sure those involved have ALL information available to them
- Will you contract with all MCO's?
  - Who has the stronger network (participants)?
  - Who pays best rates?
  - Who is best/easiest to deal with?

PREPARE FOR MCO NEGOTIATION

- At least one MCO (PA Health & Wellness) has done presentations with power point slides
  - Introduction and Contracting Orientation
  - Enrollment Process
  - Contracting
  - Credentialing
    - Provider Application, Licensure info, Insurances

Recap

- **What does the future bring?**
  - What happens after the 180 day "any willing provider" period?
  - Will rate floors be continued?
    - CHC is only in its infancy, not just in PA but nationally
  - What is Government going to do?
  - And what should the industry be doing?

QUESTIONS?

Questions ? Please contact:

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THANK YOU!!