Know Your Worth: Negotiating LTSS Rates with Health Plans

Gary Cook, MA, MBA, Chief Operating Officer

Susan Sigmon, BASW, Vice President, Long Term Services & Supports

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A Brief History

- Originally a three year demonstration project that integrates Medicare and Medicaid services into one program, operated by a Medicare Medicaid Program
  - May 1, 2014: MyCare Ohio went live in its first region (Medicaid only mandatory)
  - July 1, 2014: MyCare Ohio was live in all regions
  - January 1, 2015: Full integration occurred (Medicare)
  - August 2015: Submitted formal request to extend the Demonstration for two years, which was approved

*Information derived from ODM presentation

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MyCare Ohio

- MyCare Ohio includes both traditional managed health care covered services AND Long Term Services and Support (NF-based level of care)
- Medicaid-Medicare-Waiver-LTSS-BH (all-in)
- A 3-way contract between CMS, ODM, and the managed care plans outlines responsibilities, monitoring activities, and expected outcomes for CMS, ODM, and the Medicare-Medicaid plans.
- Ohio also maintains a separate provider agreement with MCPs for Medicaid-only enrollees
- Individuals can only “opt-out” on the Medicare side; enrollment in Medicaid is mandatory in Ohio

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MyCare Ohio

- *Eligibility Requirements:*
  - Eligible for all parts of Medicare (Parts A, B, and D), fully eligible for Medicaid, and
    - Over the age of 18
    - Reside in one of the demonstration counties
- *This Includes:*
  - Individuals in nursing facilities and some home care programs (PASSPORT, Ohio Home Care, Assisted Living Waivers)
  - Those who are receiving behavioral health services in community settings

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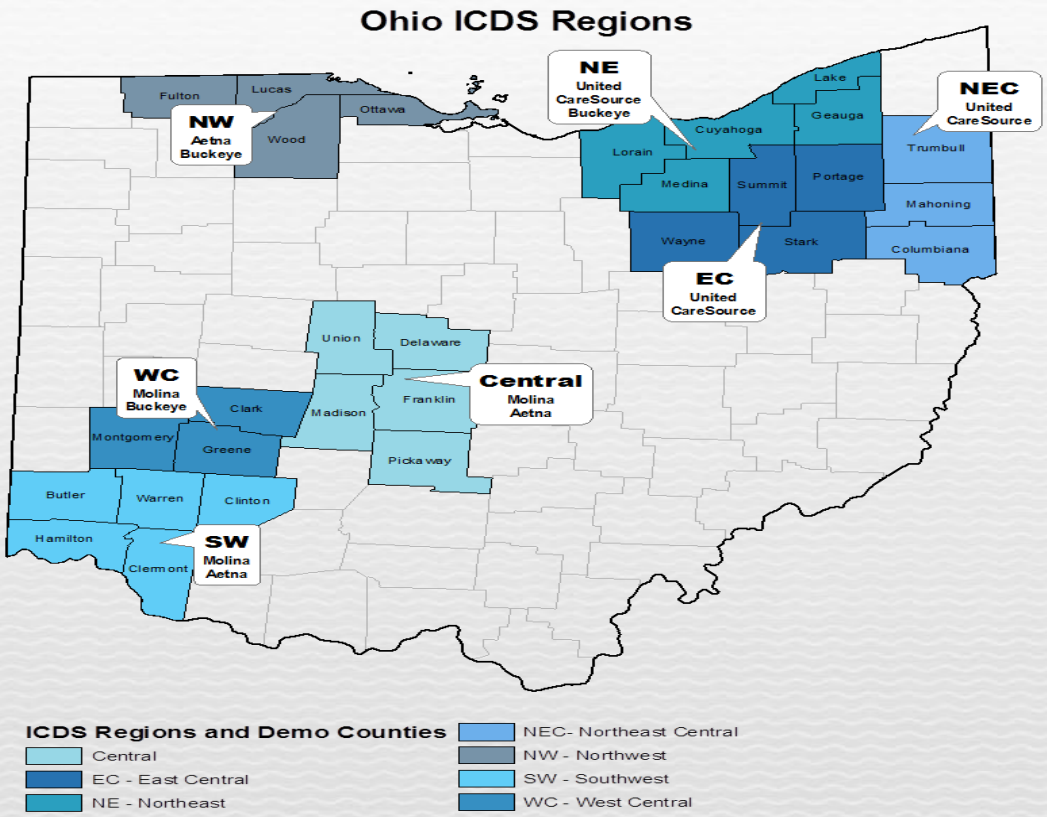

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MyCare Ohio Goals and Benefits

- Single point of accountability and contact for enrollees
- Access to care management for all (integrated approach to care coordination for physical, mental and long-term services)
- Link payment to person-centered performance outcomes
- Long term program efficiencies

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MyCare Ohio

Care Management:

The Cornerstone of the MyCare Program

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MyCare Ohio Contract Requirements

- Identify eligible beneficiaries
- Conduct a comprehensive assessment
  - Physical, behavioral and psychosocial needs
- Assign to a risk stratification level
  - Monitoring, low, medium, high and intensive
- Develop an individualized care plan
  - Prioritized goals, interventions and outcomes, includes input from the beneficiary, family and providers

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MyCare Ohio Contract Requirements

- *Assign a Care Manager to lead a multi-disciplinary team and:*
  - Establish a trusted relationship with the beneficiary
  - Engage the beneficiary in the care planning process
  - Develop planned communication with the beneficiary
  - Help to obtain necessary care and critical community support; coordinate care for the member with the primary care provider, specialists, etc., collaborate with other care managers to avoid gaps/duplication in services
  - Conduct a care gap analysis between recommended care and actual care received
  - Implement, monitor and update the care plan

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MyCare Ohio Contract Requirements

- Continuously evaluate beneficiary's ongoing need for care management
- Apply evidence-based guidelines or best practices when developing and implementing interventions
- Maintain a care management system that integrates data with the Health Plan and facilitates information sharing in an effective and efficient manner

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Additional Care Management Supports

- Integration of waiver service coordination into comprehensive care management model
- Home visits by Care Managers
- Centralized enrollee record
- 24/7 Care Management access
- Medication management
- Aggressive management of transitions across care settings

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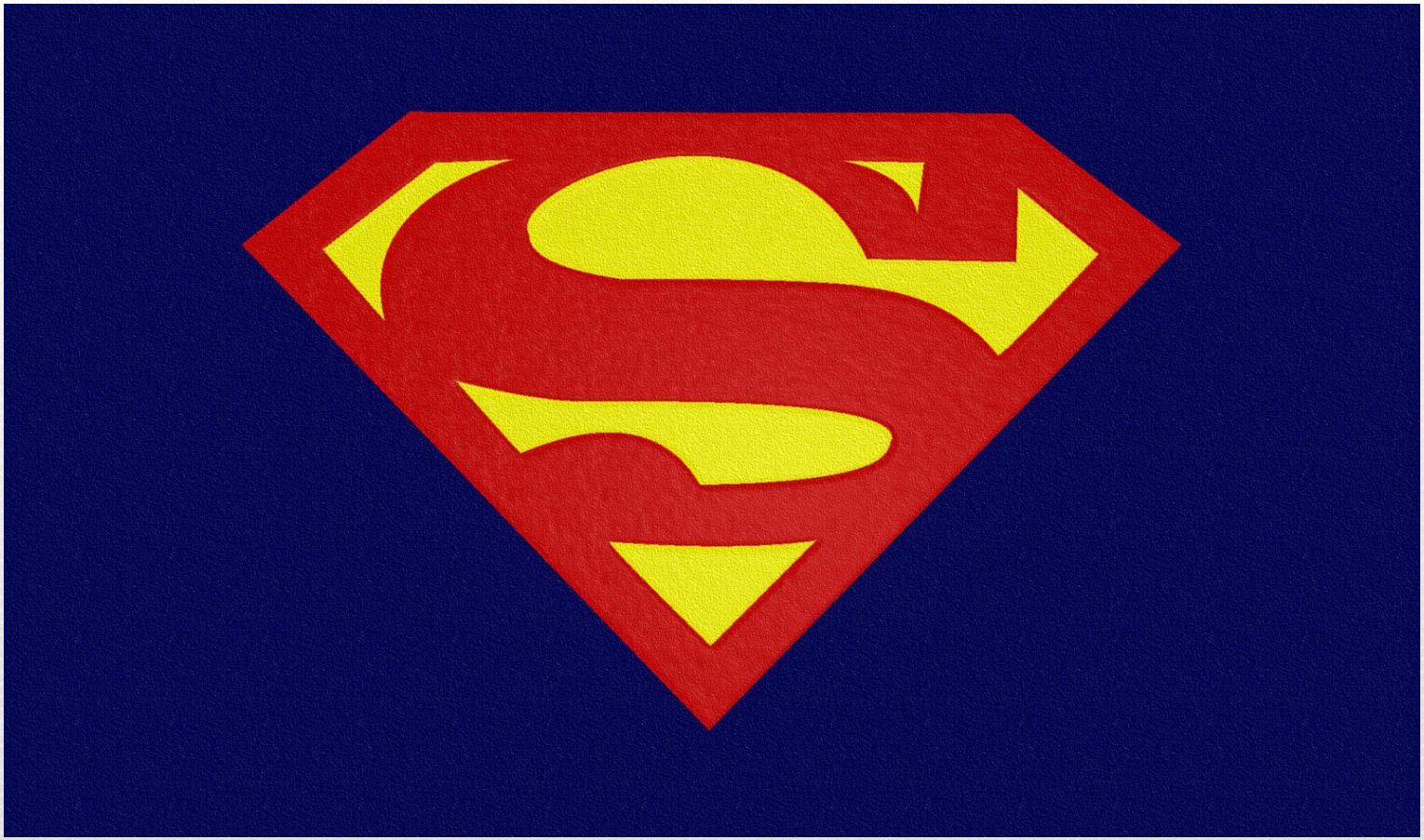

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Waiver Service Coordination

- Plans are required to contract for waiver service coordination with the AAAs as an option for individuals **over the age of 60** who are on the MyCare Waiver
- Members may select their Waiver Service Coordinator
- Plans may contract with the AAAs or other entities, or provide waiver service coordination themselves, for individuals **under the age of 60**
- **The Care Manager and the waiver Service Coordinator may be one and the same.**

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Care Coordination: Additional Aspects

- Plans can fully delegate the function of care coordination or choose to delegate only certain aspects (waiver services). Both models exist today in MyCare Ohio.

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External Quality Review Organization Audits

- Plans are audited quarterly on care management performance
- Examination of compliance with requirements around:
  - Risk Stratification
  - Individualized Care Planning
  - Waiver Service Provisions
  - Care Manager and Care Team
  - Contacts and visits

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Quality Oversight

- Examples of Quality Measure in MyCare Ohio:
  - Rebalancing Measure
    - Percentage of nursing facility residents discharged to a community setting from a nursing facility that did not return to the nursing facility
  - Long Term Care Overall Measure
  - Assessments
  - Access to Primary Care

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Negotiating Points

- Expected Outcome:
  - Relationship must be mutually beneficial

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Negotiating Considerations

- Establish LTSS Value Proposition
- Establish Mutually Accepted Contract Standards Up Front
- Understand your true All-in-Costs
- An acceptable base Per-Member/Per Month rate (PMPM)
- Pay for Performance (P4P)
- Data availability and integrity
- Measurement and Reporting
- Inflation Escalators
- Cash Flow

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❖ Value Added: LTSS Care Management

- ***Non-medical interventions*** yield cost savings and improved consumer outcomes.
- ***Population Health*** is a health care system trend and must include the social determinants of health to be comprehensive and effective.
- ***That is our wheelhouse***.

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Value Added: LTSS Care Management

- ***Care Management is NOT a commodity.***
  - In order to ensure these ends are met, the AAA CM ***must integrate the role of the informal support system*** (family, neighbors, etc.) into the overall care plan
  - They must actually ***see and acquaint themselves with the Member's living environment***, and match services to the specific barriers (or advantages) that their environment creates
  - The AAA CM becomes a trusted friend and problem solver for the member.

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Value Added: LTSS Care Management

- ***Care Management is NOT a commodity***
  - AAA CM outcomes are enhanced by ***personal relationships*** with members
  - AAA CM is ***face-to-face***. We see all members in their homes at least quarterly (more if hospitalizations ED visits, or other incidents occur)
  - AAA CM bring the entire ***range of service in the community*** (beyond waiver services) to the LTSS care plan of the member.

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Value Added: LTSS Care Management

- ***Care Management is NOT a commodity***
  - Long Term Care Management is different than other CM because a member has ***DAILY needs that must be ensured,*** regardless of known or unforeseen changes in circumstance on the part of the member, the caregiver, or the provider. For example:
    - Members must have meals every day
    - Members must dress every day
    - Members must toilet and attend to personal hygiene needs every day.

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Establish Mutually Accepted Contract Standards Up Front

- Definition of ***Member Acuity Level***.
- ***Optimal Caseload size*** by Acuity Level.
- ***Supervisory spans of control***.
- ***Performance standards*** that the Health Plan is rewarded/penalized for in their upstream contracts.

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Understanding your true All-in-Costs

- ***Volume*** (higher volume spreads fixed costs over more units of service, thereby lowering PMPM)
- ***Direct Costs***
- ***Indirect Costs***
- ***Profit*** (yes you can and must make a profit)
- ***Contingency*** (risk premium)

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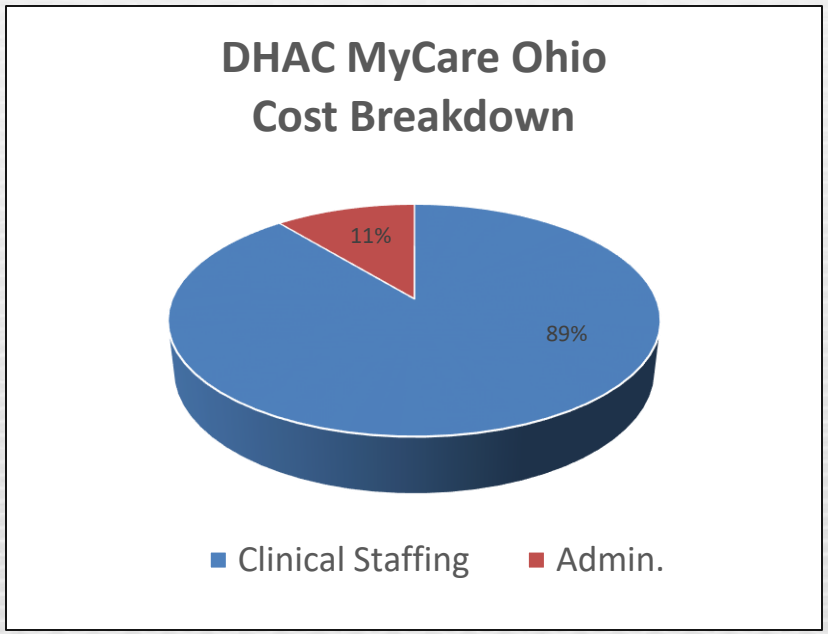
CM salaries are the biggest driver

- The direct service component is the most important to quality and customer service. In fact, the cost our **case management staff represents 89% of our total costs**.



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CM salaries are the biggest driver

- You must ensure that case management salaries are ***set at fair market levels*** to avoid costly turnover.
- We ***target 50th percentile of the regional market compensation levels*** as determined by regular evaluations by an independent salary consultant.
- Caseload sizes always feel too high
  - Important to have your licensed staff work to the top of their license
  - Finding efficiencies becomes critical.

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CM salaries are the biggest driver

- It is important during negotiations to ***communicate the relative impact of your direct vs. administrative costs***.
- If this is understood, and if the Health Plan accepts that your salaries are at fair market levels, ***the only way for them to propose lower PMPM is to increase case load size***.
- This presents the Health Plan (and the AAA) with quality and member outcome problems.

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❖ Pay for Performance Incentives

Advantages and Benefits

- ***Strategically aligning pay systems*** with the accomplishment of high-priority work activities that produce financial and other value-added benefits.
- ***Reinforcing a culture*** in which people are committed to the organization's measurable level of production and effectiveness, and which emphasizes the achievement of concrete financial and value-added results.
- ***Directing and focusing employee work activities*** and performance toward established organizational goals and priorities.

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❖ Pay for Performance Incentives

Advantages and Benefits

- ***Motivating employees*** to achieve high levels of performance through financial rewards while enhancing coordination, communication, and collaboration among employees in the achievement of desired organizational results.
- ***Enhancing differentiation and accountability***. Systems which utilize explicit performance metrics and incentives demonstrate concrete performance. As such, individuals that do not perform are easily identifiable as not achieving desired results and corrective action may be taken. Such feedback leads to a self correcting system.

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❖ Pay for Performance (P4P)

- It is essential to ***negotiate an acceptable base Per-Member/Per Month rate*** (PMPM).
- We were able to ***negotiate a P4P band (on top of our base PMPM)*** to share incentive payments received by the Health Plan.
- You ***MUST be confident of your ability to perform*** and understand that there is RISK that must be assumed.

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❖ Data availability and integrity

- Your ***primary source of data will be from the Health Plan***.
- ***Not all Health Plans will share data*** once submitted (even if it is your data).
- It is ***imperative that you seek to gain access to your data.***
- ***DON'T ASSUME THAT THE DATA FROM THE HEALTH PLAN IS ACCURATE.***

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❖ Data availability and integrity

- ***DHAC worked directly with the Health Plan data team*** for several months to ensure that all data and reports were consistent and accurate.
- Built into the agreement was a rollout timeline that ***did not allow implementation of P4P variables until both parties agreed to their accuracy.***
- Until such time, ***a higher PMPM remained in place.***

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Measurement and Reporting

- You must have the ability to analyze data; therefore, you ***must have appropriate analytical software and staff capabilities.***
- ***We use BI 360 to produce reports from a comprehensive data warehouse.***

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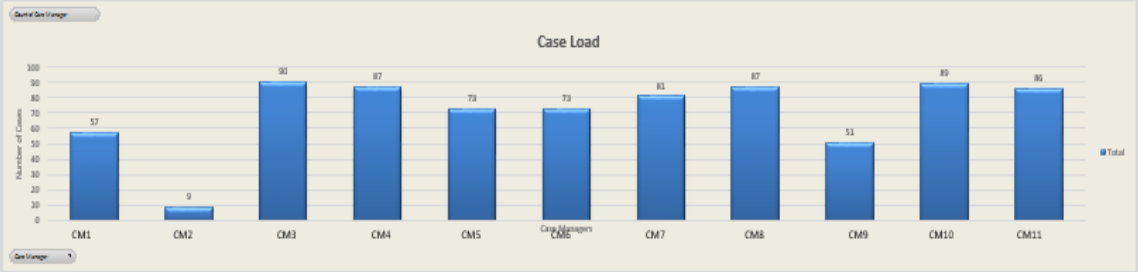
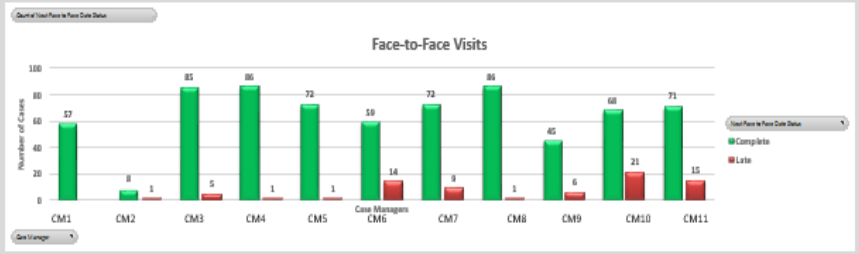
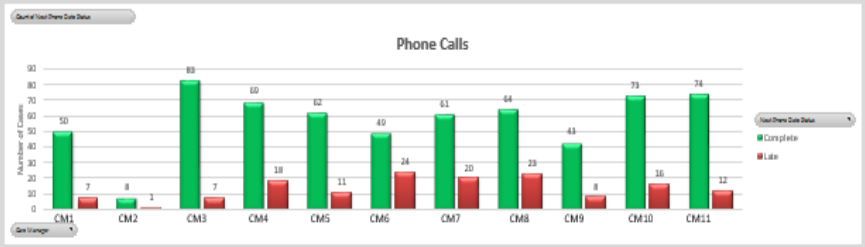
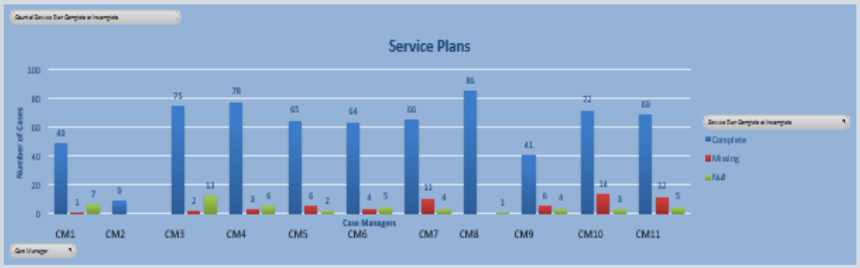
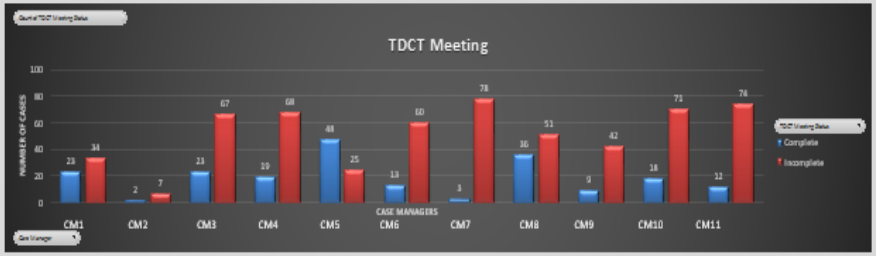
❖ Performance Dashboard

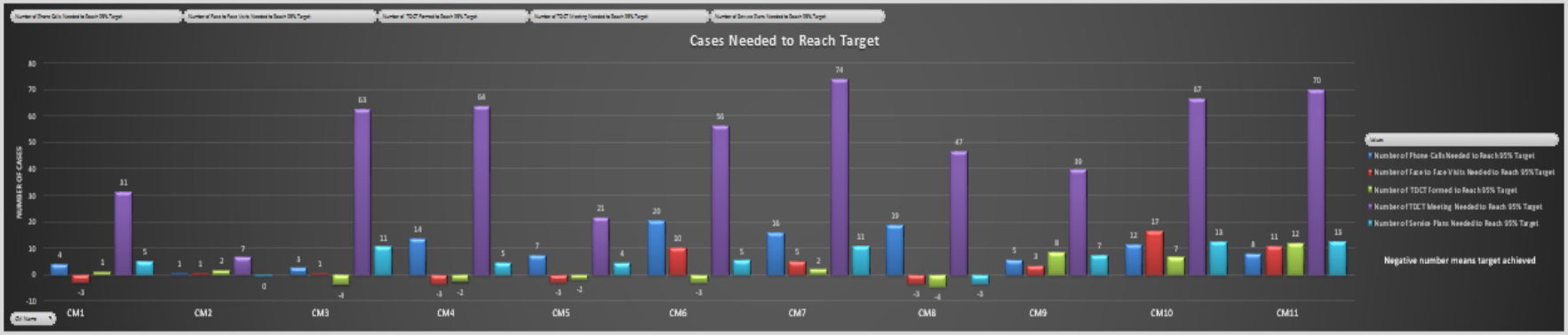




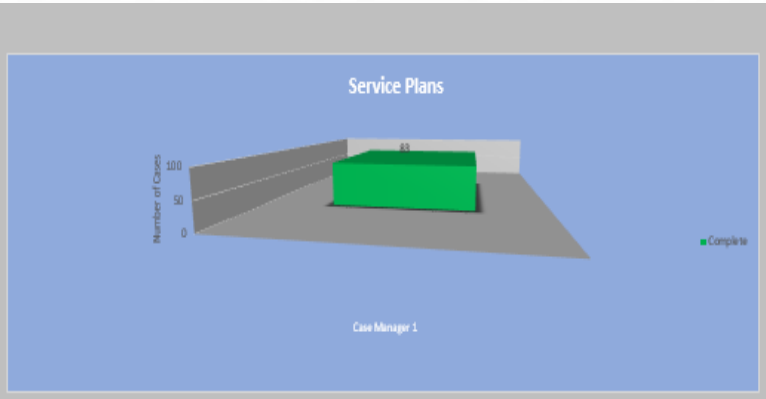


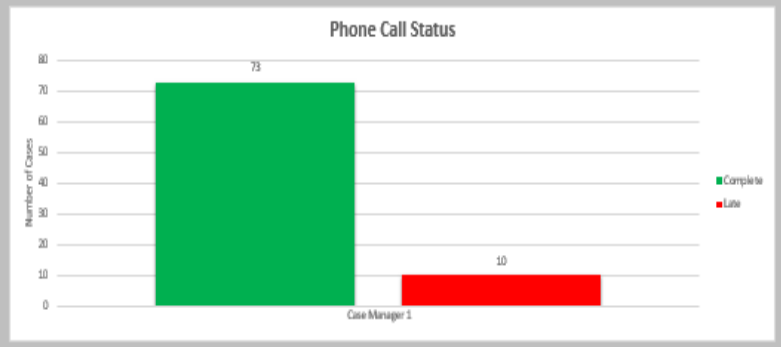


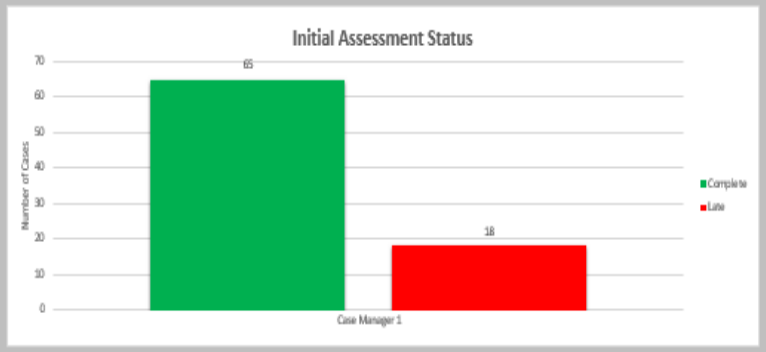


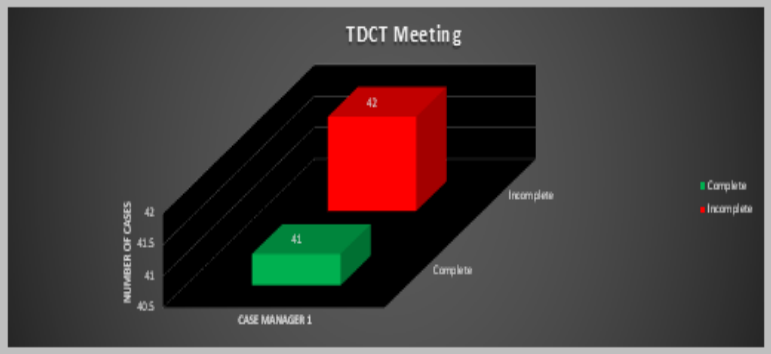


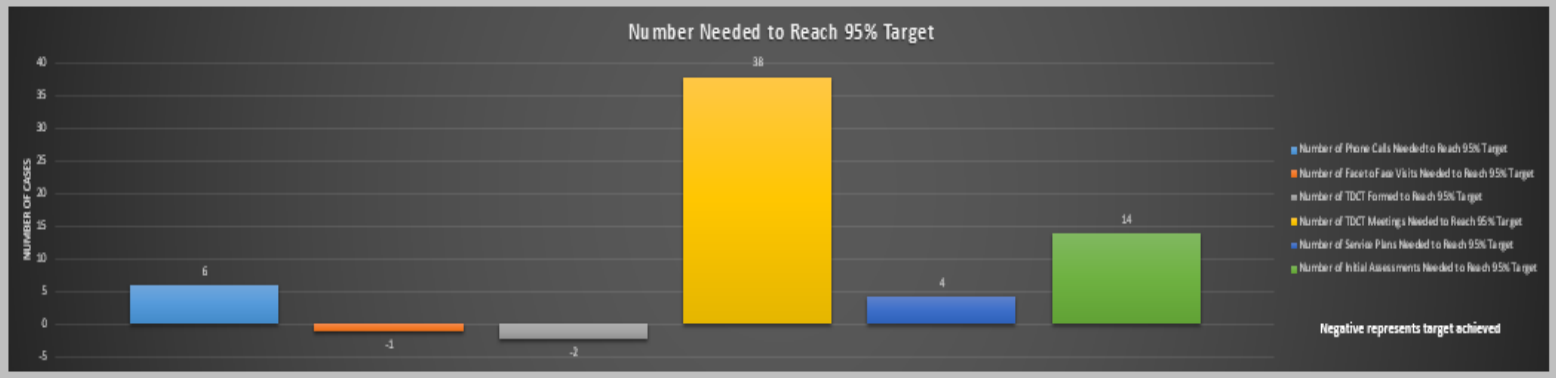
Performance Dashboard











❖ Inflation Escalators

- Seek annual escalated Per Member/Per Month
  - Strive to obtain an ***escalator on PMPM*** payments.
  - This essential for ***inflation protection in multi-year contracts.***
  - This can be ***difficult concession*** to get from the Health Plan because in some cases they may not have escalators in their upstream capitated rates.
  - Health Plans are NOT known for increasing rates, rather they tend to ***seek to REDUCE rates*** over time.

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❖ Cash Flow

- ***Accounts Receivable management*** becomes paramount.
- ***Health Plan payment timeliness*** may be significantly slower than that to which you have been accustomed.
- Make sure that the ***timing of P4P payments are explicitly defined*** within acceptable ranges.

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Related Sessions, DHAC

- ***Big Data: Improving Performance Forecasting to Support Operational Decisions*** – Monday 2:30-3:45, Chris Fagerstrom, Corey Mullins and Denese Schneckenburger
- ***A Consolidated Business Services Model: Sharing Backroom Services Among AAAs to Gain Efficiencies*** –Tuesday 1:00-2:15, Barbara Kallenbach and Cory Mullins
- ***Know Your Worth: Negotiating LTSS Rates with Health Plans***– Tuesday 3:15 – 4:30, Gary Cook and Susan Sigmon
- ***Business Strategy, Quality Improvement and Innovation- A State and AAA Perspective*** – Tuesday 4:45-6:00, Abigail Morgan, Matthew Reed, Donell Doering and Christa Merritt
- ***Don't Be Left Behind: Evolve Your Aging Services Business***- Wednesday 4:00-5:15, Rachel Cohen and Gary Cook

Questions?

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Contact

Gary Cook, MA, MBA, Chief Operating Officer

gcook@directionhomeakroncanton.org

Susan Sigmon, Vice President, Long Term Services & Supports

ssigmon@directionhomeakroncanton.org

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