Managed Care
Community of Practice
Preparing the I/DD Field for Managed Care

Introduction to Managed Care Community of Practice in I/DD

Managed Care Basics: An Introduction and/or Refresher

August 30, 2018

NEW YORK ALLIANCE FOR INCLUSION & INNOVATION

The Managed Care Community of Practice is a project of the New York Alliance for Inclusion & Innovation in partnership with the following organizations

manatt

McSILVER INSTITUTE FOR POVERTY POLICY AND RESEARCH

NYU SILVER SCHOOL OF SOCIAL WORK

NMR Negri Management Resources, LLC Creating a Partnership for Client Success

VORYS Health Care Advisors

Today's Presenters

Ann Hardiman
President & CEO, New York Alliance for Inclusion & Innovation

Michael Seereiter
Executive Vice President & COO, New York Alliance for Inclusion & Innovation

Maureen Corcoran
President
VORYS Health Care Advisors

Marisa Weisel
Senior Advisor
VORYS Health Care Advisors

Who is the New York Alliance for Inclusion and Innovation?

- One of the state's largest associations of non-profit providers advancing the interest of provider organizations and people with disabilities
- Created through merger of New York State Association of Community and Residential Services (NYSACRA) and New York State Rehabilitation Association (NYSRA)

NYSACRA STRONGER TOGETHER NYSRA

- Comprised of 175 provider organizations throughout NYS including some of the largest, multi-service agencies to the smallest, specialty I/DD service providers in NYS

What is the Managed Care Community of Practice?

- A project of the New York Alliance for Inclusion & Innovation (NY Alliance)
- **Designed to bring technical assistance and resources to the field of I/DD providers to prepare for the transition to managed care**
- The education, training, technical assistance and resources coming from the Managed Care Community of Practice are **free to ALL providers of I/DD in NYS (not only NY Alliance members)**
- MC COP is funded through funds secured in the 2018-19 NYS Budget

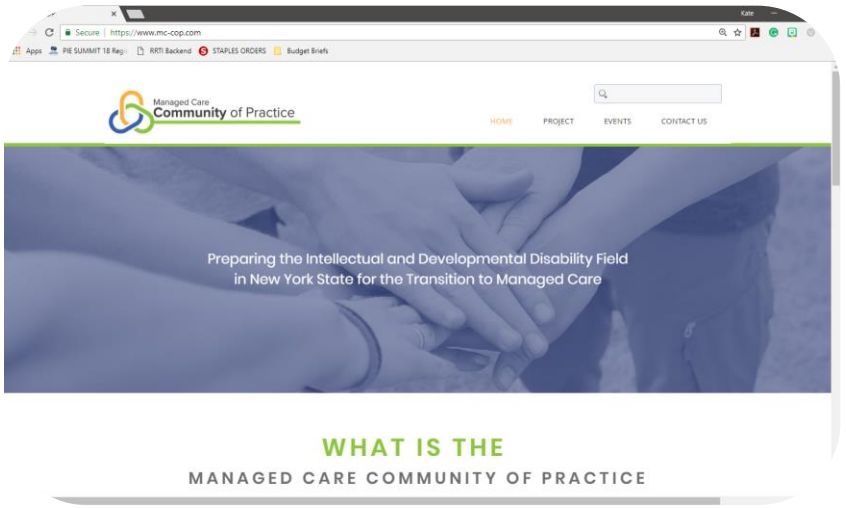
What's Coming Up?

- Initial webinars (Aug 27th, Today, September 6th)
- Provider Readiness Assessment, with introductory webinar (September)
- Results from the assessment (November-December)
- Announcements on future webinars and in-person regional learning collaborative events

How to Get Information/Stay Informed?

Website: mc-cop.com is now live!

- E-List Sign-Up Link
- Calendar of Events
- Archive of All Webinars
- Resource Library
- **Coming soon:** Acronym/Glossary Lists



Email: mccop.info@nyu.edu

Webinars Overview

Webinar 1:

What is the Managed Care Community of Practice in I/DD, Why TA is Needed

- Care Coordination Organization (CCO) Status Update
- Timelines for CCO and Managed Care Implementation
- Developing a common, basic understanding of care management concepts
- Intro to Value & Quality

Webinar 2:

Managed Care Basics – An Introduction and/or Refresher

- Basic understanding of managed care principles & how they connect to current CCO work
- Key business capabilities required to work with CCOs and managed care entities
- Talk about the "value" provided by an I/DD agency and its services/supports

Webinar 3:

Talking to Not-for-Profit Board of Directors About CCOs and Managed Care

- Key policy issues Boards need to understand about the changing environment
- Common questions asked by Boards, and potential answers
- Resources for Executive Directors talk to their Boards
- Driving ongoing involvement of Board through the transition

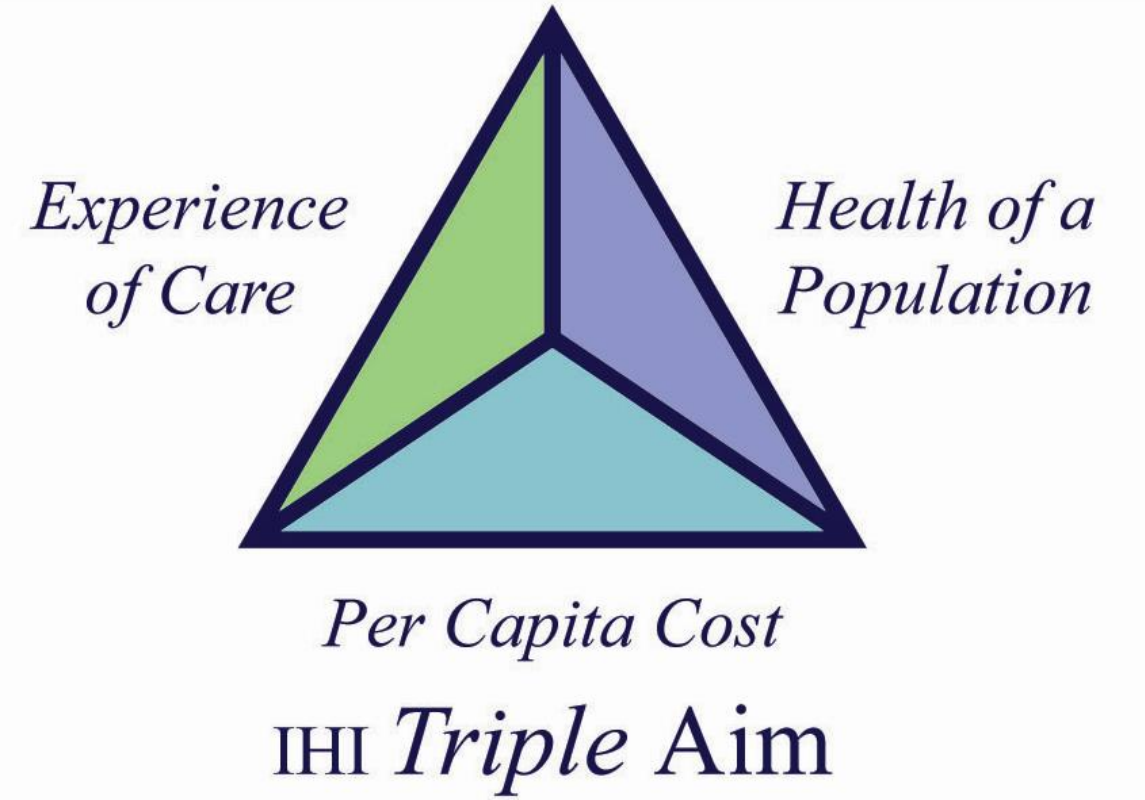
Managed Care
Community of Practice
Preparing the I/DD Field for Managed Care

Managed Care Principles

Managed Care Organization (MCO) refers to:

- FIDA-IDD: MCO currently serving dually-eligible (Medicare-Medicaid) individuals with I/DD
- New specialized I/DD MCOs beginning to offer services to I/DD population in January 2019 or later in 2019
- Mainstream MCOs that will generally enroll I/DD population in later 2019 & beyond

NY MRT: The Triple Aim



MANAGED CARE PLAN

CCO/HH

Case Management & Disease Mgt

MCP NETWORK

REIMBURSEMENT ARRANGEMENT/ RISK

New York State HH Model w/Managed Care

Specialized I/DD MCO

Mainstream MCO

Phase 2

Phase 1

CCO / Health Home

Administrative Services, Network Management, HIT data support/data exchange – 6 HH services

CCO Care Mgr.

LIFE PLAN

Phase 1 → 2 Care Coordination (CC) options ???

1. CCO becomes Specialized IDD/MCO & does CC
2. MCO contracts with CCO to do CC
3. MCO performs all CC

Life Plan AUTHORIZES Services & Supports

Res. Hab	Day Hab	Employment	Respite	Physical Health
Other OPWDD Supports		Substance Use		Mental Health

Managed Care Premise

New York State contracts with MCP to help meet triple aim, and MCO provides:

- **Quality management**
  - Management of network of providers – credentialing and contracting
  - Work with members: refer to providers, call the nurse hot line to avoid unnecessary ER trips, provide transportation and extra benefits
  - Work with providers: avoid hospital readmissions, follow-up post-discharge, review concurrent Rx use, increase kid wellness checks, etc.
- **Cost management**
  - Reduce services that are not "medically necessary"
  - Improve information sharing and coordination across providers of services, settings
  - Promote prevention activities – to increase health and avoid future costly services
  - Share financial risk with providers (value-based payment)

Over time, ultimate goal is to improve population health

Managed Care Principles: Covered Benefits and Services

- States are required to cover certain "mandatory benefits" and can choose to provide other "optional benefits" through the Medicaid program.
- MCOs can offer additional benefits beyond those required by the state.
  - Extra transportation, pest extermination, air conditioners
- Note where financial risk exists: which services are "Carved in" vs. "Carved out"
  - Ex) Specialized I/DD MCOs will begin taking risk for non-HCBS services in January 2019, HCBS services will be "carved-in" at later date.

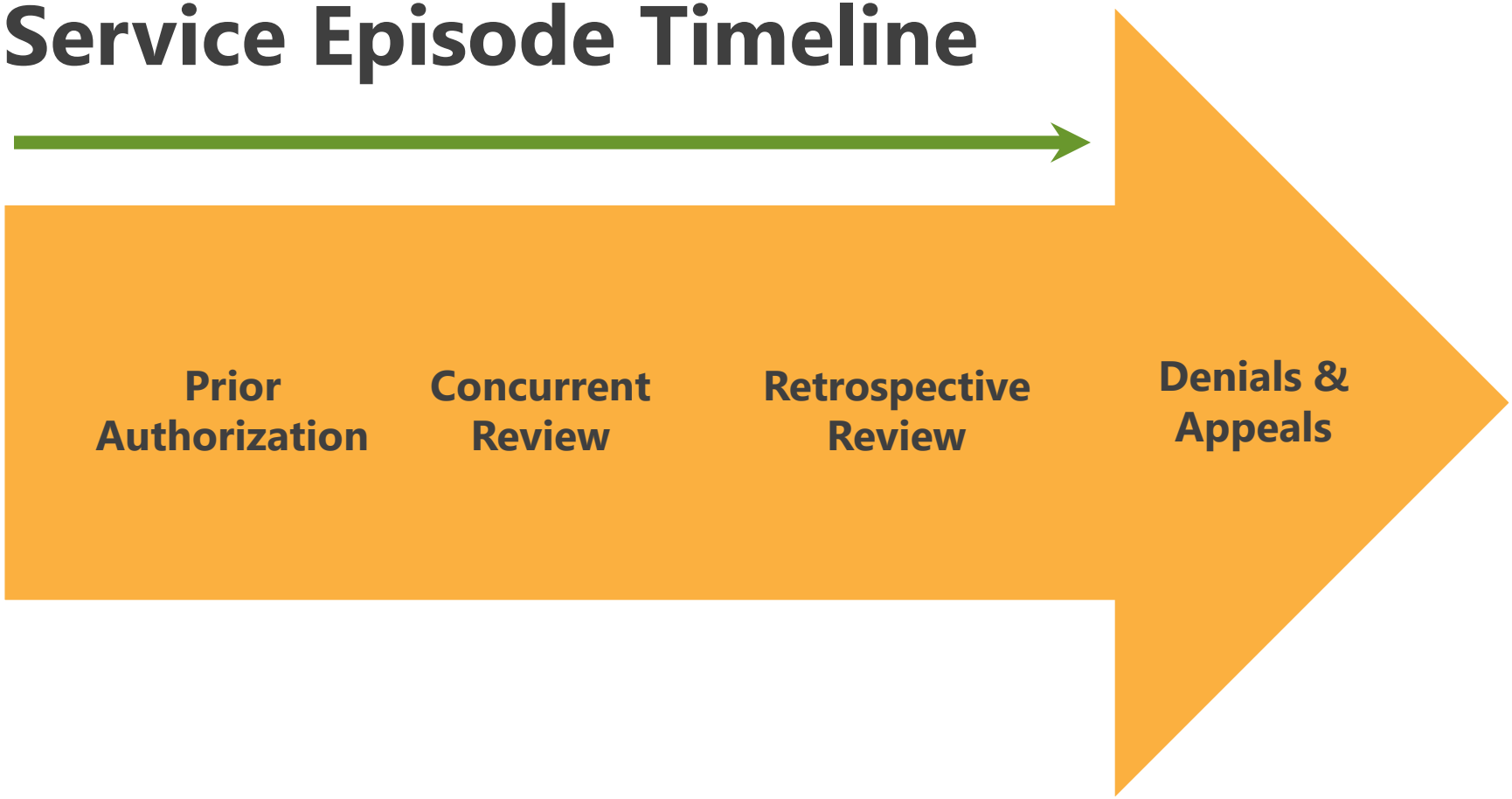
Managed Care Principles: Utilization Management

Utilization Management (UM): a set of techniques to conduct case-by-case assessments of the appropriateness of patient care.

- **Prospective review:** reduce provision of medically unnecessary services before they're provided by denying cases that do not meet certain criteria, or by directing patients to more appropriate care settings before a service is provided.
  - Ex: Elective surgeries, specialty care, inpatient hospital stays, prescription drugs
- **Retrospective review:** done *after* care is delivered to determine if an appropriate level of care applied was given. May also be used to decide if and how ongoing patient care should be continued.
  - Ex: Ongoing review of inpatient hospitalization

Utilization Management Activities

Service Episode Timeline



Key Concept: Medical Necessity

New York law defines "medically necessary medical, dental, and remedial care, services, and supplies" in the Medicaid program as those

> **"necessary to prevent, diagnose, correct, or cure conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, or threaten some significant handicap and which are furnished an eligible person in accordance with state law." (N.Y. Soc. Serv. Law, § 365-a).**

Applies to both the fee-for-service and MCO services.

Key Concept: Medical Necessity For Children Through Age 21

Federal Medicaid Law defines early and periodic screening, diagnostic, and treatment (EPSDT) as:

> **"Such necessary health care, diagnostic services, treatment and other measures classified as medical assistance to correct or ameliorate defects and physical and mental health conditions discovered by screening services, whether or not such services are covered under the state medical assistance plan." (42 U.S.C. 1396d(r)(5))**

Note: EPSDT does not include HCBS waiver services

Managed Care Principles: Network Management

- **Network adequacy:** NY state requirements to meet needs of population
  - Distance/travel time standards
  - Number or percentage of certain provider type (even 100%)
  - Member-to-provider ratios (max 1,500 enrollees : primary care physicians)
  - Some different standards for adults and pediatric providers
- **Credentialing:** formal process on periodic basis to assure "program integrity" of providers of services and supports
  - Note: for Behavioral Health (BH) HCBS providers, MCO must accept state designation in place of credentialing individual staff
  - Re-credentialing at least ever 3 years
- **Other:**
  - Assure providers' adequate hours of operations
  - Inform members about changes in network status of primary care provider, others involved in ongoing treatment
  - Require providers to complete continuing education
  - MCO has latitude to tailor network to maximize efficiency

Managed Care Payment

MCO Payment
Via contract with NY State

- **Fixed payment for defined benefit package** usually per-member-per-month (PMPM)
  - Lose $ when payment for services $ > capitation $
  - "Medical loss ratio" requirements – must use certain % for services
- **Pay for value and/or performance**
  - Gain or lose $ if don't meet state metrics

Provider Payment
Via contract with MCOs

- **Negotiated rates for each service** often based on FFS Medicaid rate
- **Per-diem** rates – inpatient hospitals, nursing homes
- **Bundled & episodic payment** payment for all relevant services over set period of time
- **Capitation** with or without downside risk (ACOs)

Managing Risk and Delivering Value

MCO Tools	Provider Tools
• Care Coordination • Utilization management • Network management • Quality management	• Business readiness • Care coordination • Relationships with people served & other providers • Data and information to manage outcomes

At Risk: Capitation Rate

At Risk: Business Model

Value Based Payment

Final Note: Each MCO is Different

Each MCO manages state requirements, processes, timelines in different way

- Each will have a separate billing system
- Each will credential providers through unique processes
- Each will use different utilization management methods – some heavier on prior authorization, others heavier on concurrent or post-payment review
- Each will interpret medical necessity with unique lens

Managed Care
Community of Practice
Preparing the I/DD Field for Managed Care

Key Business Capabilities

Preparing your organization for managed care & value-based payment

POLL QUESTIONS

From Webinar 1 Homework

Call someone who is doing care coordination for the HARP, ask them what they wish they had known before the HARP began.

POLL 1: Did you talk to someone?

A: Yes
B: Not yet, but I plan to

PLEASE TELL US: What did you learn?

Type it in the chat box – we promise we'll put the info we collect back in front of you during next webinar!

What do you want to be in 5 years?

- **A 'specialty' service provider ? Individuals with IDD? Mental illness? Substance use disorders?**
  - Service provider
  - Employment provider
  - Housing provider

Services?
Which?
For Who?

- **Comprehensive, integrated care provider ?**
- **Care coordinator / CCO ?**

System role?

- **ACO ?**
- **Managed care entity ?**

Risk bearing entity?

Business Architecture: Past and Future

Past

- Medicaid simple & low risk business
- Virtually all claims paid.
- No need for strong authorization/UM processes
- Dated accounting, IT systems
- Lots of paper-based processes
- No productivity measures
- Little attention to collections
- No articulated business reason to do better
- Management and Boards are long-term
- Not very disciplined, high tolerance for inefficiency

Future

- Build effective contracting & billing processes w/ multiple payers
- Improve accounting processes & software
- Implement UM processes
- Deploy electronic health record, person centered data
- Increase demand for staff performance, productivity, and service quality
- Implement continuous quality and cost improvement processes
- Work with increasingly sophisticated Boards of Directors
- Ongoing change to org. culture

Dimensions of New Business Model

- **Customer Value Proposition**
  - what are you doing for whom-- that they cannot do for themselves for less-- and why you?
- **Financial Model**
  - how will you ensure profitable revenue?
- **Key Business Processes**
  - what is your "special sauce" in terms of how you do things?
- **Key Resources**
  - what are your unique assets, technology, and who are your key people?

Revenue Cycle Management

CREDENTIALING
verify credentials for services & payers- initial & ongoing

INTAKE PROCESS FOR NEW PATIENT

REPORTING & MONITORING
agency wide & by MCO, program, practitioner, etc.

CHECK IN-VISIT
registration, financial counseling, co-pays etc.

CODING & COMPLIANCE
practitioner credentials, service codes, etc.

SCHEDULING & VERIFICATION
eligib & insurance; MCO enrollment; appt. reminders, maintaining calendars

CONTRACT MANAGEMENT
monitor & verifying applicable requirements

CLINICAL AUTHORIZATION & UM
benefit limits, PA, SUD LOC determination & monitoring

AR FOLLOW-UP
adjustments, re-bills, write-offs, collections

SERVICES PROVIDED
documentation, coding & charge capture

PAYMENT REJECTION & DENIAL MANAGEMENT
reconcile, rework, resubmit

BILLING & CLAIMS PROCESSING
COB, M'care X-over, contractual adj, patient statements. posting payments.

READINESS FOR DISCHARGE
Ongoing assessment

Revenue Cycle Management

- **Revenue Cycle** is the process that begins with service point of entry and ends with payment receipt/resolution
- **Revenue Cycle Management (RCM)** includes the administrative and clinical functions, processes, and software applications that contribute and manage the registration, charging, billing, payment and collections tasks associated with the individual's services.

Understand & Optimize Revenue Cycle Management

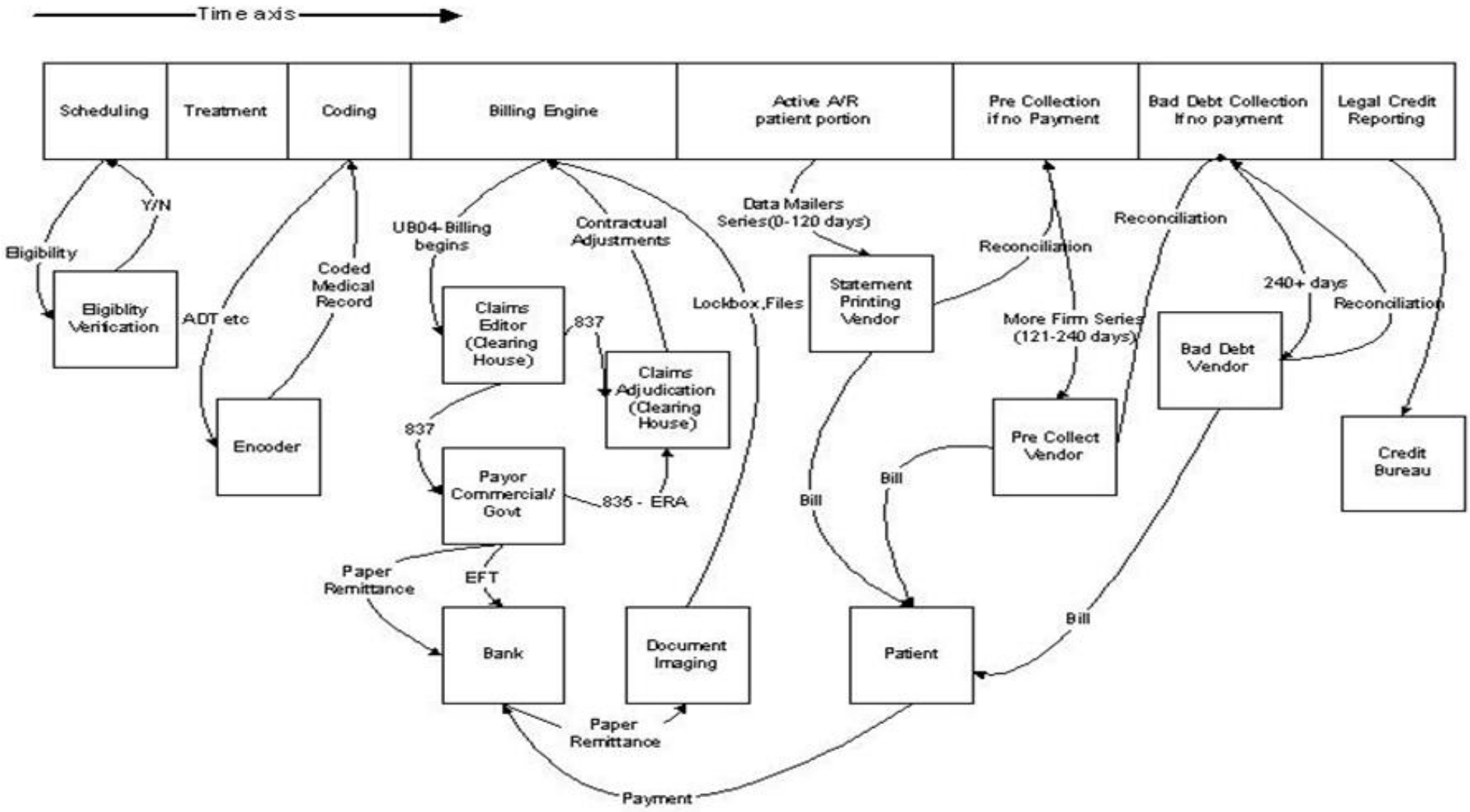
Begin Now:

- Map every element of the revenue cycle
- Design more efficient and effective processes
- Look at staff "productivity" and relationship to billing

For Managed Care…Plan to:

- Collect every dollar as efficiently as possible
  - Don't sit on denied claims – work them immediately
  - Nationally, 10-15% of revenue comes from denied claims that later get approved
- Work with others to decrease administrative burden (NY State? MCOs?)

RCM Process Flow



RCM IT Systems Touchpoints

Intake	Initial Delivery of Services & Supports	Ongoing Delivery of Services & Supports	Discharge
Verify Insurance(s) eligibility	Record clinical & non-clinical information	Conduct and record ongoing assessment	Complete documentation
Screen for services & supports	Translate clinical data to coding	Submit information for ongoing UM	Record follow-up on experience & outcomes
Determine if PA is needed	Send claims to clearinghouse	Communicate with other providers	
Submit PA documentation	Submit claims	Receive electronic payment	
	Receive remittance	Reconcile Accounts	
	Work denials & appeals	Audit documentation, billing, and payment	

POLL QUESTION

POLL 2: For which of the following do you currently have IT capabilities?

A: electronic health record

B: electronic billing

C: exchanging health information with other organizations (beyond secure e-mail)

D: at least two of the above

E: none of the above

Reimbursement & Cost Management

Providers are increasingly looking at costs of their own services & the services of others, as well as total cost of care

- Do you know the cost to serve your consumers**?**
  - Average?
  - Outliers?
  - How do you think this compares to others?
- Can you calculate the cost to implement a consumer's entire person centered plan?
  - What portion is your agency, vs. others?
  - Where can efficiency be gained?

Credentialing & Re-Credentialing

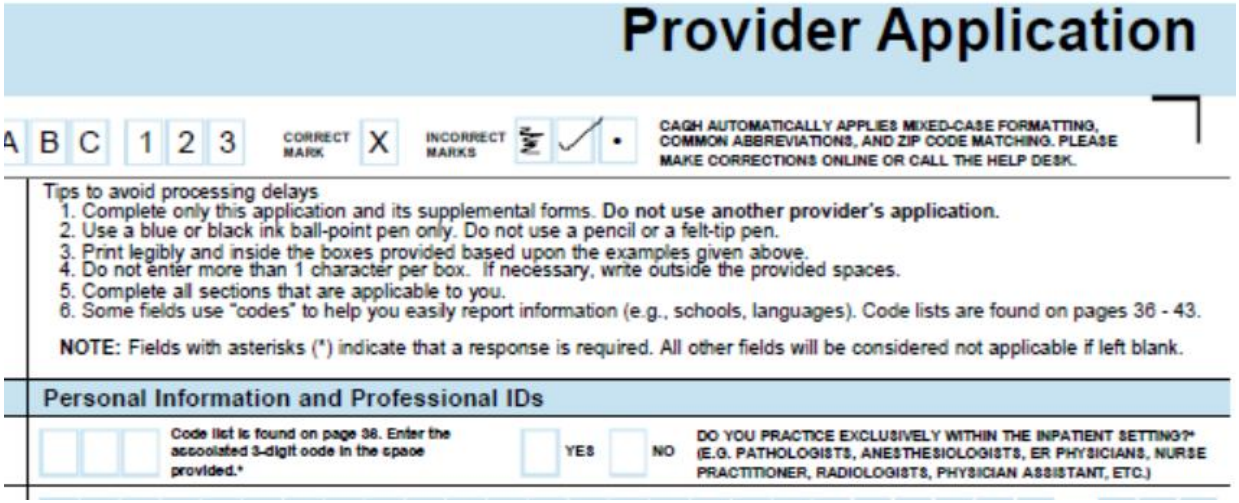
- **Process of review prior to being added to the MCOs panel of allowable providers**
  - It is not "any willing/qualified provider"
  - Cannot contract with anyone on federal prohibited list, anyone who has license suspended by state exclusions (NY State Department of Education, Department of Health, etc.)
- **Process is required of MCO for national accreditation**
- **May sign individual contract**
  - Licensed practitioners. Usually considered "professional services" & billed on CMS 1500
- **May sign facility, Agency or Institutional contract**
  - Not individually credentialed. E.g. PH, IOP. Billed UB04

Tips to Prepare for Contracting & Credentialing

- Visit MCO websites, read:
  - Provider Manuals
  - Level of Care/Medical Necessity Guidelines
  - Provider Newsletters
  - Practice Guidelines
- Each MCO will have different requirements – even if many use CAQH (see next slide) many will require additional information
- The final step is claims testing

Check Out CAQH

- Council for Affordable Quality Healthcare (CAQH)
  - Many insurers use the CAQH application to evaluate providers for credentialing by MCOs
  - 43 page application – see FAQs



Provider Application

A B C 1 2 3 CORRECT MARK X INCORRECT MARKS

CAQH AUTOMATICALLY APPLIES MIXED-CASE FORMATTING, COMMON ABBREVIATIONS, AND ZIP CODE MATCHING. PLEASE MAKE CORRECTIONS ONLINE OR CALL THE HELP DESK.

Tips to avoid processing delays
1. Complete only this application and its supplemental forms. **Do not use another provider's application.**
2. Use a blue or black ink ball-point pen only. Do not use a pencil or a felt-tip pen.
3. Print legibly and inside the boxes provided based upon the examples given above.
4. Do not enter more than 1 character per box. If necessary, write outside the provided spaces.
5. Complete all sections that are applicable to you.
6. Some fields use "codes" to help you easily report information (e.g., schools, languages). Code lists are found on pages 36 - 43.

NOTE: Fields with asterisks (*) indicate that a response is required. All other fields will be considered not applicable if left blank.

Personal Information and Professional IDs

Code list is found on page 36. Enter the associated 3-digit code in the space provided.*

YES NO

DO YOU PRACTICE EXCLUSIVELY WITHIN THE INPATIENT SETTING?* (E.G. PATHOLOGISTS, ANESTHESIOLOGISTS, ER PHYSICIANS, NURSE PRACTITIONER, RADIOLOGISTS, PHYSICIAN ASSISTANT, ETC.)

Re-Credentialing

Each plan will have their own processes & criteria

- Re-check credentials (licensure and insurance up-to-date, exclusions lists, legal or disciplinary actions)
- Patient satisfaction rating, complaints
- Outcomes
- Administrative performance
- Access
- Peer review and appeals decisions

Measuring and Delivering Value

VALUE-based payment will rely on
OUTCOMES and COST EFFECTIVENESS

Measuring, improving, demonstrating
outcomes & cost effectiveness relies on **DATA**

WHAT DO YOU KNOW NOW
about your & others' outcomes and costs?

What kind of **DATA** do you need to demonstrate
your **VALUE** for individuals with I/DD?

How can you leverage **INFORMATION SYSTEMS** to help?

POLL QUESTION

From Webinar 1 Homework

Use your IT system (not individual paper charts) to see if you can identify some of the following kinds of information:

- How many client have diabetes?
- Do all clients have current vaccinations?
- Which of your clients' BMI puts them in the morbidly obese category?

POLL 3: If you tried, were you able to easily extract this kind of data from your IT system?

A: Yes

B: No, it can't be done

C: No, it's not easy to do, but we can work on it

Consumer Experience

- **There will be metrics**
  - Consumers input on experience with MCOs
  - Consumers input on experience with their providers
- **MCOs can help you improve consumer outcomes**
  - Referrals to providers – dentists, psychiatrists
  - Cover things that FFS won't cover (extra eye glasses, early Rx fill)
- **Consumers will benefit from your sincere engagement with MCOs**

Achieving benefits & promises of managed care = <u>as much up to you & your agency as it is to the MCO</u>

Business Relationships with MCOs

Particularly for Mainstream MCOs…

- **Get to know them**
- **Understand how they look at you**
  - You are not a doctor, not a hospital, more like a home health agency
- **Invite them to make presentations at regional/state meetings**
- **It's all about the contract and the product line they are purchasing from you**
  - State Medicaid, SNP, HIE, Commercial

Things MCOs Want You to Know…

- **MCOs are incentivized to help members get the right care in the right setting at the right time. They drive toward efficiency, not just cutting costs.**
  - Increasing efficiencies will best position you for the future
- **MCOs look at an individual's care across providers – this can be really helpful.**
  - Ex) medication management
- **MCOs can work with you to ensure continuity of care.**
  - Even if you don't want to contract with an MCO for all people, consider single-case agreements

Things MCOs Want You to Know…

- **Working with MCOs may require you to implement new processes & work with new providers.**
  - May have to order durable medical equipment (DME) from different suppliers, go to different pharmacies, etc.
  - Work with your key partners as you join networks.
- **MCOs can help you with billing…you need to work the claims**
  - Ask the plans you contract with to sit down with your billing offices, assist in submitting claims.
  - Reach out immediately if something is denied – don't wait.
  - Request peer-reviews of denials from MCOs.

Homework

Please answer the following questions in preparation for Webinar 3, which will take place on September 6 from 4-5 PM. REGISTER HERE!

1. Do you have Directors & Officers Insurance for your Board of Directors?
2. Identify three materials you use when orienting new board members.
3. Have any of your board members participated in OPWDD-sponsored events about CCOs & managed care?
4. How many times has managed care been discussed at board meetings in the last 12 months?