



Welcome to
**“Positioning Your HCBS Program in the
Healthcare Market**
Part 3: Network Collaboration – The Need for Collaboration”

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The webinar will begin at 3:30 p.m. Eastern Standard Time

Webinar #1 Review



- Medicare Basics
- Medigap and Medicaid coverage
- Medicare coverage of hospital care
- Skilled Nursing Facility Care
- Policy and Practical Implications of each

Webinar #2 Review



- Return on Investment
 - **Meal Delivery Service vs Comprehensive Nutrition Program**
- Readmission Penalties
- Value-Based Purchasing and Medicare
- Medicare Advantage Requirements/Opportunities

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Key Concept Recap



- Medicare Eligibility
 - People 65 or older
 - People under 65 with certain disabilities
 - SSI
 - People of any age with End-Stage Renal Disease
- Duals are included in the Medicare Eligible category (Medicare + Medicaid)

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Key Concept Recap (cont.)



- Four Parts of Medicare
 - Part A
 - Inpatient hospital, SNF, Home Health, Hospice
 - Part B
 - Doctor services, office visits, emergency care, ambulance services
 - Part C
 - Medicare Advantage
 - Part D
 - Prescription Benefit

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Return on Investment



- Which of the two programs demonstrate a greater return on investment for the MLTSS plan?
 - Meal delivery service
 - Delivers meals to plan members and can report how many meals were delivered
 - Comprehensive Nutrition Program
 - Nutrition assessment provided quarterly
 - Program delivers appropriate meals and **assesses intake of meals**
 - Conducts quarterly wellness assessments and environmental safety checks – transmits data to health plan
 - Reports risks and deterioration in clinical status to the health plan on a weekly basis

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- 1 Medicaid Waiver/Reform
- 2 Managed Long Term Services and Supports
- 3 Accountable Care Organizations
- 4 Review of Webinar #4 Topics

Managed Long Term Services and Supports



- The delivery of long term services and supports through capitated Medicaid managed care programs
- States that elect to adopt MLTSS often use this as a strategy to expand HCBS to eligible beneficiaries

State Adoption of MLTSS



- 2004 – 8 States participated
- 2012 – 16 with many more States in the process of adopting some form of MLTSS initiatives
- States have wide discretion as to the implementation of MLTSS
 - **Target Population**
 - **MCO participation**
 - **Incentive and risk models for participating MCOs**

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MLTSS Implementation



- State Division of Medicaid meets with applicable Stakeholders to design a proposed MLTSS model
- Medicaid MLTSS programs can be operated under multiple Medicaid Managed Care authorities
 - **1915a**
 - **1915b**
 - **1115**
- State approves Medicaid Director to submit a State Plan Amendment (SPA) to CMS

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MLTSS Implementation (cont.)



- State Division of Medicaid and CMS work together to develop an acceptable MLTSS program that is acceptable to both parties
- SPA accepted along with an implementation timeline
- If MCOs are participating, CMS requires two or more plans to allow for consumer choice
- MCOs selected through open bid process

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MCO Selection Process



- CMS requires that States that implement MLTSS provide consumers with a choice in MCO providers
- State Division of Medicaid issues a RFP
- Most States have a bidders conference to explain the proposal submission requirements
- Two or more MCOs provide consumers with a choice in each MLTSS approved market
- State selects MCOs based on an objective proposal evaluation methodology

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Waiver Recap



- Medicaid Program authorized under Title XIX of the Social Security Act – July 30, 1965
 - **Enacted to provide health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities**
- 1972: Medicaid eligibility extended for elderly, blind, and disabled residents under the newly enacted Federal Supplemental Security Income Program (SSI)
- 1981: Freedom of choice waivers (1915b) and home and community-based care waivers (1915c) were established in Medicaid

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Populations served by Medicaid MLTSS



- It is important to note that persons in a Medicaid MLTSS plan must first qualify for Medicaid
 - **Medicaid Waiver participants DO have Medicaid or else they would not qualify as a Medicaid Waiver participant**
 - **This is separate and distinct from the State option to expand Medicaid**
 - ***Common misconception – “My State is not accepting Medicaid expansion or Obamacare so we don’t have adults on Medicaid”**

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MLTSS Population Selection



- States have flexible discretion to propose mandatory and voluntary populations to participate in MLTSS reforms
- Many States propose both mandatory and voluntary participants in MLTSS
- Mandatory vs Voluntary Populations
 - **Mandatory Populations must select a MCO plan or accept an auto-assignment if they do not select within a defined time period**
 - **Voluntary Populations are not required to participate and have the option of not participating in MLTSS**

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Sample Mandatory and Voluntary Populations



- Common Mandatory Populations
 - Medicaid recipients currently receiving services under 1 or more Medicaid Waiver Programs
 - Any Medicaid recipient residing in a long-term care facility
- Common Voluntary Populations
 - Dual Eligible beneficiaries currently receiving services under 1 or more Medicaid Waivers

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MLTSS MCO Perspective



- MCO is at-risk for Long Term Services and Supports
- The services included in LTSS risk models is defined by the State and included in the RFP
- Plan is only responsible for LTSS services defined by the State
 - Examples include HCBS, home delivered meals, personal attendant services, etc.
 - Traditional Medical Services are generally covered under a separate Medicaid program and not the responsibility of the MLTSS plan

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Patient Example



- 70 y/o Female widow, dual eligible, living alone in the community and receiving LTSS from a large MCO
- LTSS services include limited in-home supportive care services -- according to an individual service plan (ISP)
- Consumer is high-risk for falls and has fallen 10 times in the past year with 6 hospitalizations due to injury
- What services would you market to this MCO?
- How would you define the ROI for home delivered meals in this scenario?

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Who is the Payer?



- The MLTSS is often implemented as part of a separate bid process
- A MCO may have a current contract to provide Medicaid Managed Care for medical services and elect not to bid on an open MLTSS RFP
- Consumer may have one Medicaid Managed Care plan for Medical services and a different payer for MLTSS
 - **Consumer may not know the difference**
 - **As the provider, it is important that you understand the terms of your contract and have knowledge of the risk incurred by the payer**

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What happens to Duals in MLTSS



- Duals can participate in MLTSS in multiple ways
- Each State must have CMS approve their implementation plan as it relates to Duals
- Many States allow Duals to voluntarily participate
- Duals often keep their Medicare intact
- A dual **MAY** have a Medicaid Managed Care plan for their Medical Services and a separate Medicaid MCO for MLTSS
 - Medicaid MCO for medical covers all medical services not covered by Medicare
 - MLTSS plan covers all long term services and supports not covered by Medicare

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Example – Who is the Payer??



- 68 y/o male, dual eligible w/Medicaid MCO, voluntarily enrolled in a MLTSS plan at the local congregate meal site
- Receives congregate meals
- Admitted to the hospital for CHF and then readmitted for a fall -- discharged to a SNF post fall
- Discharged from SNF to home after a 30-day stay in the SNF with the following HCBS: skilled nursing, in-home aid services, and home delivered meals
- Consumer has Original Medicare, Centene for Medicaid Managed Care and UHC for MLTSS

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Answer



- Beneficiary has the following coverage
 - **Original Medicare,**
 - **Centene - Medicaid MCO, and**
 - **UHC - MLTSS**
 - Medicare Part A covers the hospital stay
 - Medicare Part B covers ER & physician care 80% / Centene covers the 20% coinsurance and any deductible requirements
 - Medicare Part A covers the full cost of the SNF stay for days 1 – 20. UHC covers the SNF copayment requirement of \$152/day, for days 21 – 30 = \$1,520.00 for the long-term care services
 - Post discharge from the SNF, UHC covers the expanded LTSS services in the home, including skilled nursing care

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Who benefits from Prevention?



- Everyone benefits if we prevented the readmission
 - Beneficiary remains in the community longer
 - Medicare Trust Fund expenditures reduced
 - Hospital readmission penalty averted
 - SNF readmission penalty averted
 - Centene Medicaid MCO averts the coinsurance requirements for ER and physician care related to the hospitalization
 - UHC averts the cost of long term care at the SNF and the post SNF expanded in home supports services

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Capitation



- Medicaid Managed Care Organizations accept a capitated contract with Medicaid
- The MCO receives a Per Member Per Month (PMPM) rate for each enrolled beneficiary
- MCO **MUST** cover all medically required services, for the entire population, with the PMPM collected
 - **MCO cannot deny medically required services if the consumer has exceeded an monthly expenditure amount**

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MCO Risk Pool



- MCO Actuary calculates the risk
 - Risk is distributed across the entire population
 - Some members will exceed the PMPM and some will fall far below the PMPM
 - The plan must have enough well members to make up for the very sick members that will be high users of services
 - It is to the benefit of the plan to distribute their risk across as large a population as possible

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How does an MCO expand their risk pool?



- The MCO Actuary wants to distribute the risk across as large a population as possible
- It is statistically unlikely that the MCO will have all high utilizers in a large population
- The larger the population, the larger the profit potential, so the MCO implements the following:
 - During the RFP process each MCO proposal is scored according to a defined evaluation criteria
 - MCO that scores the highest is often assigned a larger population
 - High scoring MCOs also often get the lion share of auto-assignments which adds to their risk pool
 - Direct marketing to the target population to facilitate a switch

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Medical Necessity



- Medicare, Medicaid Managed Care, and MLTSS all adhere to medical necessity requirements
- Medical Necessity must be established to determine the eligibility for services
- If Medical Necessity cannot be determined then the service may be denied
- It is important to fully understand the requirements for establishing medical necessity

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Application of Medical Necessity



- Consumer admitted to the hospital
- Discharged with prescriptions
- Reports to CVS Pharmacy to fill the prescriptions
- CVS Pharmacy submits to the MCO proof that medical necessity is met based on an approved prescription from a physician
- The MCO pays CVS the contracted rate for dispensing this medication

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Prescriptions vs Meals



- We can all relate to the Medical Necessity example in the previous slide
- Would you expect that Meals would be treated differently?
- The MCO must cover all medically necessary services to include HCBS
- The provider must understand the MCO requirements for establishing Medical Necessity and then advocate for your consumer

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It is Easier to Just get coverage from the AAA for OAA funds



- If a consumer is enrolled in a MCO MLTSS plan, and medical necessity is established, should you just continue to use Older Americans Act or local funding for meals, because it is easier to obtain?
- No, No, No...
- Can I repeat – with Emphasis – No, No, and No Again
- If a consumer is enrolled in a MLTSS plan, then the MCO is required to cover the services
- You are really in violation of OAA requirements by taking Federal/State funds to offset the costs of a multi-million dollar private MCO

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Accountable Care Organizations



- Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high quality care to a defined set of attributed Medicare beneficiaries
- All beneficiaries attributed to an ACO are enrolled in Original Medicare
 - If a consumer elects to participate in a Medicare Advantage plan, then they are removed from the ACO

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ACO Goals



- Goal #1
 - **Reduce the overall Cost of Care for the defined ACO beneficiary population**
- Goal #2
 - Improve the quality of care for the defined ACO beneficiary population
- ACO will earn “Shared Savings” based on their ability to achieve BOTH goals listed above

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Shared Savings



- Medicare Shared Savings Program (MSSP)
ACOs are eligible to earn shared savings according to the following model
 - An overall reduction of costs for the total attributed population from an established baseline for the same population
 - The difference between baseline costs and the total cost of care after the ACO implements their program is the “Total Savings” eligible for sharing
 - The ACO must meet minimum quality standards, in order to be eligible to receive their portion of the shared savings

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Shared Savings (cont.)



- Single Sided, no-risk ACOs are the most prevalent ACOs in the MSSP program
- These ACOs are eligible for up to 50% of the total savings generated.
- The 50% attributed to the ACO is their portion of the shared savings
- If the ACO fails to meet the quality requirements then they are not eligible for the shared savings they created
 - *They Must improve quality AND reduce costs

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Example



- Anywhere USA ACO has a attributed population of 10,000 Original Medicare Beneficiaries
- After a year in the MSSP program, the ACO generates \$10 Million in shared savings
- The ACO is eligible for 50% of the savings generated = \$5 Million
- During the same period, the ACO only meets 50% of the quality improvement requirements
 - The ACO receives only a percentage of the shared savings, **based on their quality performance**
 - The ACO may only obtain 50% of the 50% shared savings = \$2.5 Million actually earned

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How is the ACO paid



- The ACO is Eligible for a portion of the Shared Savings based on their ability to reduce the total cost of care and their performance on defined quality metrics
- MSSP ACOs do not receive a special capitation or enhanced rate for the population
- No additional compensation is provided to the ACO other than what they already receive for delivering direct medical care under the Original Medicare Program

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Why do Physicians participate in an ACO



- Value-Based purchasing and ACOs are here to stay.
- Many private payers are adopting the same ACO shared savings model
- Physicians can achieve economies of scale by working together in an ACO and contracting with multiple payers for shared savings
- Perceived Drawbacks
 - Beneficiaries maintain Original Medicare – Consumer Choice
 - Patient assignment is attributed and not selected
 - Must invest in a population health approach – with no additional funding
 - Shared savings, if achieved, not likely to be seen for at least 18 months

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ACO Attribution Process



- Beneficiaries to not elect to participate in an ACO
- The ACO receives an Attributed list of beneficiaries from CMS
- Since Original Medicare allows consumers maximum choice there is no defined PCP
- The ACO has an attributed list of patients based on a three-year look-back to determine which provider delivered the majority of primary care to the beneficiary over the defined time period
 - The provider with the most claims is attributed the patient

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ACO Opportunity for CBOs



- ACOs must achieve cost savings and improve quality
- Some of the quality improvement and cost savings strategies align with HCBS
- For example, all ACOs receive a quality score based on the number of consumers they assess for fall risk
 - If the consumer screens positive for falls, then the ACO provider is required to find community resources to support the consumer in preventing a fall
 - Duals that are in a MLTSS can also be in an ACO
 - Win-Win for the ACO and MLTSS MCO if you help monitor and prevent falls for a high-risk consumer

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Upcoming Webinars



- Webinar #4
 - Bundled Payment Initiatives
 - Conducting a Market Analysis
 - Strategic planning to expand revenue for community based programs in health care

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Questions



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