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How Will Medicaid Managed Care Reforms Affect DD Provider Programs and Services?

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The Transition to Managed Care and Working Within a DISCO Network

Please Note

- This presentation was prepared prior to the release of the final RFA by OPWDD.
- As a result, certain of the comments and recommendations that follow may be impacted by the terms and conditions specified in the final RFA.
- My objective is to take a “deeper dive” into Managed Care principles and their impact on DD providers.

Method to Achieve My Objective

- Providing you with a Top 10 List of Managed Care facts you should know and communicate to Management and Board at your organization.
- The transition to Medicaid Managed Care will affect each and every employee of your organization, either directly or indirectly.

Top 10 Things You Need To Know

1. Be aware and knowledgeable regarding the role and responsibilities of Fiscal Intermediaries.

- MCOs = Managed Care Organization
- MSOs = Management Service Organization
- DISCOs = Developmental Disability Individual Service Care Organization
- BHOs = Behavioral Health Organization / Utilization Management
- MLTCs = Managed Long-Term Care Plan / MCO
- IPAs = Independent Provider Association / Contracting Organization
- Health Homes
- PACE Programs – for all-inclusive care to the elderly
- Insurance Companies – Fidelis, Excellus, ILS/Humana, ElderPlan, etc.
- & More!

Top 10 Things You Need To Know

2. Provider contracting with these Fiscal Intermediaries (who will stand in place of OPWDD / DOH via contract) and related negotiations will become extremely important in whether or not you will have success in a Managed Care model.
 - You will need to designate a multi-disciplinary Provider Contracting Team.
 - Do not sign standard template contracts without reading them first. It will be rare for you to sign a “standard contract”.
 - After reading a template contract, you can be assured that some modifications / addenda will be required.
 - Remember that Managed Care is, at its core, a negotiated rate-based financial risk model – AKA insurance.

Top 10 Things You Need To Know

3. The initial shifting of financial risk for the DD population is expected to be from OPWDD / DOH to the Fiscal Intermediary organizations.
 - Most common in the DD provider arena will be the DISCO and/or IPA structures.
 - However, other Fiscal Intermediaries will require your organization as a “Participating Provider” in their Provider Service Network.
 - Be aware that in the initial contracting process (1-3 years), it is unlikely that individual providers will be subject to assuming any major degree of financial risk related to services provided.

Top 10 Things You Need To Know

4. Therefore, it is unlikely that any shift of financial risk to individual providers will be delayed until 2015 / 2016.
 - In the interim and prospectively, individual providers may be receiving a portion of rate reimbursement based on service quality, efficiency, and outcomes.
 - CQL standards and Personal Outcome Measures are anticipated to be used as the “Bible” for Care Coordinators to determine consumer service eligibility, need, and outcome.
 - There will be various payment models developed by the Fiscal Intermediaries for purposes of paying providers.

Top 10 Things You Need To Know

4. Therefore, it is unlikely that any shift of financial risk to individual providers will be delayed until 2015 / 2016 (Continued).

- However, I believe that individual providers will continue to be reimbursed substantially based on negotiated Fee For Service rates after full implementation is achieved.
- During the pilot phase, it is extremely important for individual providers or provider networks to develop creative / innovative alternatives to traditional service delivery modalities.
- Possible scenario – 80% = fee for service, 20% = performance-based compensation
- In my opinion, the State (OPWDD / DOH) is open to and looking for creative solutions from providers that satisfy the State's Managed Care objectives.

Top 10 Things You Need To Know

5. The transfer of Care Coordination responsibilities from the provider to the Fiscal Intermediary is a monumental structural and operational change for every provider.
 - Care Coordination will impact on each and every program service component for every provider.
 - The fundamental expectation of Medicaid Managed Care is to shift focus from what individuals “Want” to what those services “Cost”.
 - The transition of MSC by providers to Care Coordination by Fiscal Intermediaries will be a major challenge, especially during the transition period.
 - That is, certain consumers being served in the MSC model while Care Coordinators take responsibility for high cost and complex cases.

Top 10 Things You Need To Know

6. As a result, this fundamental change moves the DD Sector from decades of providing individuals with what they “want” to a system that provides an external (Care Coordinator) assessment of what the individual “needs”.
 - Individual choice and self-determination may take a back seat to cost in determining program service needs.
 - State intends to use the Coordinated Assessment System (CAS) for maintaining objectivity in determining service needs.
 - Inevitably, a certain degree of subjectivity will be required.
 - For example, MRI vs. CT Scan vs. PET Scan or who is entitled to joint replacement surgery.

Top 10 Things You Need To Know

7. The fundamental programmatic change for providers will, as the State suggests, require “transformational change” throughout your organization.
 - Providers, over time, will become more focused on cost of service delivery.
 - Managed Care principles will result in inherent conflicts of interest and ethical issues for providers and particularly Program Supervisors.
 - Direct Service Professionals will require extensive re-training and education related to the revised approaches to program service delivery.

Top 10 Things You Need To Know

8. Individual providers should never accept capitation rates without at least 2-3 years of reliable historical cost information.

- In the final analysis, rates / amounts paid by OPWDD / DOH will determine the amount of “pain or pleasure” that providers will experience from a financial perspective.
- Adjudicated claims should not be either the State’s or the provider’s reference point.
- We know that rates currently being paid may bear no relationship to the actual cost of the service being delivered.

Top 10 Things You Need To Know

8. Individual providers should never accept capitation rates without at least 2-3 years of reliable historical cost information (Continued).

- Smaller individual providers (less than \$10 million in annual revenue) will have little to no leverage in negotiating provider contracts with Fiscal Intermediaries.
- Smaller providers should consider formation of a network (i.e., either an IPA or a joint contracting LLC).
- As a provider, your primary goals should be to achieve a strategic position that:
 - Makes you too big to ignore
 - Makes you too big to exclude from provider networks

Top 10 Things You Need To Know

8. Individual providers should never accept capitation rates without at least 2-3 years of reliable historical cost information (Continued).
 - During initial implementation, an individual provider may not want or need to sign a participating provider agreement with every fiscal intermediary that offers a provider contract.
 - It is imperative to have knowledgeable advisors in contract negotiations.
 - Whenever considering some degree of financial risk for a program or certain population of individuals, make sure you speak with a qualified, experienced actuary.

Top 10 Things You Need To Know

9. The State's "Triple Aim" anticipates cost efficiencies together with improved health and service outcomes. This expectation will require each provider to assess its strategic positioning with respect to future service delivery.
 - As a result of the foregoing, major structural and operational changes will be required.
 - Contracting decisions regarding network participation and payment rates will be of paramount importance.

Top 10 Things You Need To Know

9. The State's "Triple Aim" anticipates cost efficiencies together with improved health and service outcomes. This expectation will require each provider to assess its strategic positioning with respect to future service delivery (Continued).
 - Those areas of highest priority are:
 - Cost accounting systems for individual high-cost consumers. These software applications do not yet exist.
 - Electronic Health Records for all program components, not just clinic.
 - Restructuring your billing and accounts receivable systems to accommodate revised contract payment methodologies (e.g., incentive payments for achieving performance goals, P4P).

Top 10 Things You Need To Know

9. The State's "Triple Aim" anticipates cost efficiencies together with improved health and service outcomes. This expectation will require each provider to assess its strategic positioning with respect to future service delivery (Continued).
 - Those areas of highest priority are (Continued):
 - Sophisticated IT applications for purposes of communicating / processing claims and service with the contracted Fiscal Intermediaries while at the same time continuing traditional Medicaid billing through Computer Sciences.
 - Regulatory compliance will be a challenge during the transition period, with certain consumers under the old model and high-cost consumers subject to different approval processes and documentation requirements.

Top 10 Things You Need To Know

9. The State's "Triple Aim" anticipates cost efficiencies together with improved health and service outcomes. This expectation will require each provider to assess its strategic positioning with respect to future service delivery (Continued).
 - Those areas of highest priority are (Continued):
 - Regulatory compliance will be a challenge during the transition period, with certain consumers under the old model and high-cost consumers subject to different approval processes and documentation requirements.

Top 10 Things You Need To Know

9. The State's "Triple Aim" anticipates cost efficiencies together with improved health and service outcomes. This expectation will require each provider to assess its strategic positioning with respect to future service delivery (Continued).
 - If you haven't already done so, your Board and Management must discuss and evaluate the strategies, incremental costs, and people resources necessary to ensure future success and autonomy, if desired.
 - Your decisions regarding strategic positioning in a Managed Care environment are critical components of Managed Care success.

Top 10 Things You Need To Know

9. The State's "Triple Aim" anticipates cost efficiencies together with improved health and service outcomes. This expectation will require each provider to assess its strategic positioning with respect to future service delivery (Continued).
 - If autonomy is not an option, begin the process of evaluating affiliation and merger options with other providers.

Top 10 Things You Need To Know

10. Based on my 30+ years of experience in working with Managed Care models, insurance companies, and being certified as a Managed Care Professional, every provider must be aware of “The Five Rs” developed by this presenter:

- Restricted Access, AKA Challenges to Service Eligibility
- Relocation of Service Delivery Sites, searching for lowest cost of care
- Rationing of Services Through Care Coordination – consumer needs vs. wants
- Redistribution of the Health and Human Services Fiscal Budget (\$\$\$)
- Reduced End of Life Care and aging demographic will result in more Palliative vs. Curative service delivery (e.g., reduced Emergency Room Utilization)

Questions and Answers

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Thank you for listening to and participating in this discussion!