THE "NEW" WORLD OF MANAGED CARE

• Our Changing Healthcare World - The "Great Shift" - Why?
• National/State Legislation & Initiatives forcing the "Great Shift" – How?
• "Best Practices" - Facility Systems to manage Managed Care
  • Case Manager
  • Internal Communication
  • External Communication
• Captain of the Ship – Who is this in our "NEW" world
• A Look into Michigan

THE "NEW" WORLD OF MANAGED CARE

The "Great Shift" - Skilled Mix

O UR PAST:
For Fee-For-Service (FFS)

O UR PRESENT/ FUTURE:
Managed Care

Medicare
+ Federal Payer
Medicaid
+ State Payer
Health Plan/MCO
+ Payor

OUR PAST:
2003 SNF Payer Mix
For Fee-For-Service (FFS)

THE "NEW" WORLD OF MANAGED CARE

2013 Future SNF Payer Mix
Managed Care

Medicare + Federal Payer
Medicaid + State Payer
Health Plan/MCO + Payor
THE "NEW" WORLD OF MANAGED CARE

Many changes are taking place in regards to Medicare and Medicaid from quality of care, coordination of care to payer of healthcare provided services.

- Affordable Care Act
- Financial Alignment Demonstration
- Medicare Advantage Plans
- ACO's
- Health Benefit Exchanges

A big change in regards to dual Medicare and Medicaid beneficiaries (medi-medis/duals). As a result, we see the "Great Shift"

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Affordable Care Act

Medicaid changing to Managed Care
1. Doesn't need 3 day qualifying stay
2. Need to obtain authorization
3. Part B authorization hard to get
4. Vendor usage can be an issue

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Financial Alignment Demonstration/ Medicare Advantage/ACO's (18 states)

Medicare/Medicaid (Duals) changing to Managed Care
1. Shorter time with patients
2. More traffic in facility
3. New Doctors/NP's/PA's directing care
4. New steps/systems to get patients things they need
5. Admissions 24/7
THE "NEW" WORLD OF MANAGED CARE

Health Benefit Exchange
Uninsured get insurance
1. Younger population
2. Additional line of business
3. Intro of new following Doctors

THE "NEW" WORLD OF MANAGED CARE
Federal/State and CMS pay a managed care organization a blended payment to provide Medicare and Medicaid services

THE "NEW" WORLD OF MANAGED CARE
The "Great Shift" - Healthcare Payment Delivery Model

WHY IS MY ADMIN SO CRANKY?
Financial Implications of changing payer:
1. Potential level rates vs RUG rates
2. Length of stay
3. Copay - Cross over
4. Reimbursement timelines

<table>
<thead>
<tr>
<th></th>
<th>Medicare Patient FFS</th>
<th>Managed Care Patient</th>
<th>HMO Patient w/100% of RUGS</th>
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<tr>
<td>Reimbursement per day</td>
<td>$900</td>
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<td>Maximum Payment</td>
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<td>Length of Stay</td>
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<td>Payment Received</td>
<td>$15,000</td>
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The GOAL in Managed Care is to financially THRIVE not just survive!
THE “NEW” WORLD OF MANAGED CARE

The “Great Shift” – Managing the “Managed” stay

<table>
<thead>
<tr>
<th></th>
<th>Managed Care</th>
<th>Medicare</th>
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<tbody>
<tr>
<td>Authorization upon admission</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Extended Authorization</td>
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<td>No</td>
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<tr>
<td>Change in levels/authed</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Minimum once a week update on progress</td>
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<td>No</td>
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<td>Electronic billing options</td>
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<td>Billing options</td>
<td>3 day qualifying stay</td>
<td>No</td>
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<tr>
<td>Change of pace</td>
<td>Yes</td>
<td>No</td>
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</tbody>
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MANAGED CARE VS MEDICARE

Levels/authed
Minimum once a week updates on progress
Electronic billing options
Billing options 3 day qualifying stay
Change of pace

The “Great Shift” = GAME CHANGER

THE “NEW” WORLD OF MANAGED CARE

NO MORE STATUS QUO

“BEST PRACTICES” Facility Systems to manage Managed Care

Case Manager
- Important role in the New Managed Care World
- Single contact for provider case manager for consistent communication
- Builds good rapport and relationships with health plans to cultivate trust
- Verifies eligibility and pays on admission
- Ensures correct level of initial authorization and the levels of care are being authorized throughout the resident's stay
- Obtains extended authorizations for additional skilled days
THE "NEW" WORLD OF MANAGED CARE

"BEST PRACTICES" Facility Systems to Manage Managed Care

Case Manager

- Negotiate a Letter of Agreement (LOA) with health plans with which you are not contracted
- Brings together the Interdisciplinary Team for the safety and management of the resident
- Captures exclusions and communicates with the Business Office Manager (BOM) to ensure appropriate billing
- Coordinates ancillary services that are contracted with the provider to avoid having to pay for these services
- Advocates for highest level of care, best care for the resident, and facility payment for care provided

Internal Communication

WHAT NEEDS TO HAPPEN WITHIN THE FACILITY TO PROPERLY MANAGE THE RESIDENTS STAY

1. Educating staff on changes, new systems, pace
2. Communication with new doctors in the building
3. Nursing active in admission process (High cost meds/ medical equipment/ care ordered)
4. CM and nursing communication
**The “New” World of Managed Care**

**“Best Practices” Facility Systems to Manage Managed Care**

**Internal Communication**

**What Needs to Happen Within the Facility to Properly Manage the Residents’ Stay**

1. Managed care weekly meetings:
   - Resident goals
   - Barriers
   - Discharge plans
   - Items to review

2. Daily communication between admissions, BOM, CH, SSD, Nursing and DOR must be done verbally as well as written.

3. Teamwork = successful stay and well-managed resident. (HAPPY, HAPPy, HAPPy)

**Internal Communication**

**“Best Practices” Facility Systems to Manage Managed Care**

**Items to Review**

- Functional Status (PT/OT)
- Diet (KD/Dietary)
- Wounds (Treatment/Stage)
- Medications (IV’s, Injections, Diabetic Management)
- High Cost Meds (Exclusions)
- Psych (Behavioral Concerns/ Cognitive Status)
- New Appointments
- Specialty DME
- Authorizations (Lab/Radiology)

**Weekly meetings**

**Teamwork**

**Daily Communication**

*When this triad comes together, the physicians, medical groups and hospitals will want to refer their whole case mix to your building!*
THE "NEW" WORLD OF MANAGED CARE

"BEST PRACTICES" Facility Systems to manage Managed Care

External Communication

**COMPLETING WEEKLY CLINICAL UPDATES**

- Request the MCO template/form to complete weekly updates.
- Specific Form Given for Updates
  - Case Manager to Complete for Clinical and Functional Status.
- No Specific Form Provided for Updates
  1. Case Manager to Complete for Clinical and Functional Status.
  2. Skilled Diagnosis (Reason for Admission)
  3. Skilled Services Provided
  4. Current Level of Function
  5. Prior Level of Function and Living Arrangements
  6. Plan of Care (Functional Level and Duration Meet Goals)

WHAT HAPPENS WITH A WEAK OR NONEXISTENT CLINICAL UPDATE

- Shorter Length of Stay
- No pay to the Skilled Nursing Facility
- Upset the health plan
- Limited business from health plan

Managed Care is HERE – Captain of the ship!

We are not steering the ship anymore!

We Must be a Co-Captain Leading The Way! Not a First Mate or a Deckhand.
1. The health plan wants:
   a. 24/7 admission
   b. Admissions from ER/Admissions from home
   c. Shorter length of stay
   d. A discharge plan within 24-48 hrs of admission
   e. A single contact - communication
   f. Low percentage of hospital readmissions
   g. Track key variables and data (RTA, LOS)
   h. Patient transferred to lower level of care as soon as possible

2. The health plan has a job to do

3. Familiarize yourself with specific request of each health plan

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**THE "NEW" WORLD OF MANAGED CARE**

**MICHIGAN**

**FINANCIAL ALIGNMENT DEMONSTRATION**

Regions/Health Plans

- **Region 1**: Upper Peninsula
  - AmeriHealth, Coventry Cares and Meridian

- **Region 4**: Coventry Cares and Meridian
  - Secure Care, Midwest Health Plan, Molina and United

- **Region 9**: AmeriHealth, Coventry Cares, Fidelis
  - Secure Care, Midwest Health Plan, Molina and United

**TOTAL LIVES**: 105,000 lives affected
**MICHIGAN – FINANCIAL ALIGNMENT DEMONSTRATION**

Dual Eligibles will be passively enrolled into the Care Bridge system unless they choose to opt out of the program.

**Phase 1:**
- Region 1 & 4
- Voluntary Enrollment:
  - Enrollment period starts no earlier than 10/1/14
  - Services start no earlier than 1/1/15
- Automatic Enrollment:
  - Includes a 60-day and 30-day notification letter
  - Services start no earlier than 4/1/15

**Phase 2:**
- Region 7 & 9
- Voluntary Enrollment:
  - Enrollment starts no earlier than 3/1/15
  - Services start no earlier than 5/1/15
- Automatic Enrollment:
  - Includes a 60-day and 30-day notification letter
  - Services start no earlier than 7/1/15

As of August 2014

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**MICHIGAN MEDICAID EXPANSION**

In September of 2013, the Michigan House approved a bill expanding the state’s Medicaid program. The expansion was slated to begin in April 2014.

- Aims to have 320,000 individuals in Michigan covered within the first year
- Aims to have 470,000 by 2021

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**MICHIGAN HEALTH BENEFIT EXCHANGE**

There are 13 health plans available in the marketplace for the state of Michigan:

- McLaren Health Plan
- Meridian Health Plan
- Molina Healthcare
- Upper Peninsula Health Plan
- Priority Health Choice
- United Healthcare
- HealthPlus Partners
- Coventry Cares
- PHP Family Care
- Total Health Care
- Midwest Health Plan
- Blue Cross Complete
- Harbor Health Plan
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Think OPPORTUNITY not OBSTACLE!

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QUESTIONS

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Email: info@mixsolutionsinc.com

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9/30/2014