Managing Illinois Medicaid Reform at Your Practice

May 2015
Outline For Discussion

1. Overview of the marketplace today and “transformational” forces in the industry
2. Review of new Medicaid managed care plans and provider contracts
3. Detailed Payor-by-Payor review of Contract Administrative requirements, and other supporting resources
4. Payor Contracting Workshop (“Contracting 101”)
5. Open Discussion/Q&A

1. Illinois has mandated Medicaid enrollees move to Managed Care Organizations by 1/1/15 (HMOs or ACEs); this is happening rapidly.

2. The State has contracted with many new plans to coordinate care for these enrollees (creating short term confusion among patients and a need for a robust contracting strategy for providers).

3. As a result, physicians must secure direct contracts with the new plans to retain their existing patients or participate via other IPA/PHOs.

4. Medicaid clients will no longer be able to “go anywhere that accepts Medicaid”, meaning Patients, Primary Care Physicians, and other care givers will need to ensure referrals to in-network providers. That has significant implications.
Patient Populations Affected in Medicaid Reform

- **MMAI**: Medicare – Medicaid Alignment Initiative:
  - The “Dual Eligible” population
  - 261,000 eligible individuals in Illinois

- **ICP**: Integrated Care Program:
  - FKA: ABD population (Aged, Blind & Disabled)
  - Persons >19 years with disabilities who are not Medicare eligible
  - 159,000 eligible individuals

- **FHP/ACA**: Family Health Plan:
  - FKA: TANF population (Temporary Assistance for Needy Families) and newly eligible patients under ACA
  - 2.9 Million eligible
ACE: Accountable Care Entity

- ACE plans are available to children and their parents/caregivers with the option to accept the ACA adult population.

- ACEs are accountable for the quality, cost, and overall care of Medicaid ACE enrollees.

Original State ACE Model:
- For the first 18 months, it is a Fee-For-Service model with claims submitted directly to and paid by Illinois Public Aid.
- After 18 months: All ACEs must move to a partial risk and then a global risk, and acquire HMO or MCCN status in 3rd year of agreement with the state of Illinois.

New State ACE Model:
- In February 2015, the State proposed that ACEs may have an accelerated timeline to move to risk.
## Payor Enrollment Data as of 4/1/15

<table>
<thead>
<tr>
<th>Health Plan</th>
<th>FHP/ACA</th>
<th>ICP</th>
<th>MMAI</th>
<th>Total</th>
<th>% of Total</th>
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<tbody>
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<td>Aetna Better Health</td>
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<td>Harmony Health Plan</td>
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<tr>
<td>Humana Health Plan</td>
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<td>Meridian Health Plan</td>
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<td><strong>Health Plan Totals</strong></td>
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HFS Illinois - Medicaid Expansion - Greater Chicago Region
Care Coordination Enrollment by Plan
February 2015
## Payor Enrollment Data as of 4/1/15

<table>
<thead>
<tr>
<th>ACE or CCE</th>
<th>FHP/ACA</th>
<th>ICP</th>
<th>MMAI</th>
<th>Total</th>
<th>% of Total</th>
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<tr>
<td>Advocate Accountable Care (ACE)</td>
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<tr>
<td>Better Health Network (ACE)</td>
<td>11,860</td>
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<tr>
<td>Community Care Partners (ACE)</td>
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<td>HealthCura (ACE)</td>
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<tr>
<td>Loyola Family Care (ACE)</td>
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<td>22,060</td>
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<tr>
<td>MyCare Chicago (ACE)</td>
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<td>30,628</td>
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<td>SmartPlan Choice (ACE)</td>
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<td>UI Health Plus (ACE)</td>
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<td>LaRabida Coordinated Care (CCE)</td>
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<td>595</td>
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<td>Lurie Children's Health Partners (CCE)</td>
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<td>Be Well (CCE)</td>
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<td>1,380</td>
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<td>Next Level (CCE)</td>
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<td><strong>Health Plan Totals</strong></td>
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HFS Illinois - Medicaid Expansion - Greater Chicago Region
Care Coordination Enrollment by ACEs & CCEs
February 2015
The Marketplace Today: Transition & Transformation

- Physician Hospital Silos
  - Physician Hospital Integration

- Employer Based or Gov’t Sponsored Healthcare Coverage
  - Individual Plan Selection

- Fee-For-Service “production” mentality in care delivery
  - Value Based Purchasing (VBP) and Population Health Management
Moving from Volume to Value

Supporting Better Performance
Pay for Reporting
- RHQDAPU
- PQRI
- Stage 1 Meaningful Use
Payment for Coordination
- Medical Home
- Patient-Centered Medical Homes (PPACA Section 3502)
Pay for Performance
- Future Stages of Meaningful Use
- Never Events
- Hospital-Acquired Conditions (Section 3008)
Episode-Based Payments
- Bundled Payments (PPACA Section 3025)
- Readmissions Reduction Program (PPACA Section 3025)
Shared Savings with Quality Improvement
- One- or Two-Sided ACO Risk Model
- Accountable Care Organizations (PPACA Section 3022)
Partial or Full Capitation with Quality Improvement
- ACO with partial capitation
- Global payment

Payment Reforms Progressively Move Away from FFS & Support Sustainable Health Care Reform
Progressively Requires Greater Risk Management, Data, Analytics
The Marketplace Today: Pillars of the New Era in Healthcare

1. **Value-Based Purchasing:** All payors are moving toward reimbursing providers based on their performance, not based on negotiating leverage or brand name (FKA: P4P). Performance is driven by use of Evidence-Based Medicine (EBM) and best practices. Care delivery is migrating to standardized clinical pathways and guidelines to deliver care, and payors are linking contracts, networks and reimbursement to “quality” and “outcomes” measures.

2. **Integration & Alignment:** Starting with “100,000 Lives” report, the evidence clearly points to fragmentation of care/unaligned incentives as the biggest problem in health care delivery in the U.S. Central to all reform concepts is integration of care, and the processes, people, workflows, and technologies that provide it, including funding and reimbursement.

3. **Technology:** The technology revolution will touch all transactions and workflows (clinical, administrative, business) within the operating platform of the U.S. healthcare system (inter-organizationally, business-to-business, provider-to-patient). It is expensive and time consuming.

4. **Patient/Consumerism** Someone else has always paid for our healthcare (Medicare, employer-sponsored coverage), so we’ve never had to shop for healthcare. With increased cost shift to consumers, and mandated individual insurance purchasing, we can anticipate “retail” shopping behaviors and tools to support it. Expanded coverage means more patients, enrolled in a variety of plan options. Increased focus on “wellness” and “patient engagement” models.

*All this is occurring at a time when there are significant numbers of new patients coming into the U.S. health system under new insurance plans, adding administrative costs, putting more pressure on finances.*
The Increased Importance of Payor Strategy

Demands on payor contracting and practice management increase exponentially.

Patient Segment

Uninsured
- No Coverage, Self-Pay

Public Aid
- Medicaid, Medicaid, Medicaid HMO (ABD, MMAI, TANFF, D-SNP)

Commercial
- HMO, PPO, POS

Medicare
- Medicare, Medicare Advantage

Today’s Benefit & Contract

Tomorrow’s Benefit & Contract

Medicaid, Public Exchange, Medicaid HMO, Co-Ops

Medicaid, HIX Plan, Co-Ops, Medicaid HMO (ABD, MMAI, TANFF, D-SNP)

HMO, PPO, POS, HIX Plan, Co-Ops, Commercial Contracts, HX Contracts, Employer Contracts, Broad and Narrow Networks

Medicare, Medicare Advantage, Broad and Narrow Networks
Current Issues & Concerns with Payors

Top Concerns Being Discussed/Addressed with Payors

1. **Volume**: Many physicians are afraid that they will be overwhelmed with Medicaid patients if they join, especially Specialists.

2. **Lack of Specialists**: For PCPs, they are already concerned that there is not adequate specialist panel to refer to, and, also being on hold literally for an hour trying to work with the HMO to find a Specialist and/or get a Referral/Authorization.

3. **Reimbursement**: The Illinois PA Fee Schedule for Specialists is not good. Additionally, the Federal/State reimbursement enhancement (“Medicare for Medicaid”) for PCPs ended in 2015.

4. **Referral/Pre-Authorization Requirements**: In addition to a variety of different requirements to manage, practices are facing long phone hold times, and it is not practical for some practices to utilize online tools.

5. **Confirming Eligibility & Benefits**: Best practice is to confirm Eligibility and Benefits for every patient visit. There have been problems with outdated Eligibility information being distributed.
Review of Chicago–area Payor Contracts

Tips & Observations

- Credentialing with the new plans can take 2–3 months
- Transactions can be done telephonically or online; phone hold times can be high, so you are encouraged to set up online capability if practical
- Reimbursement is typically 100% of Medicaid Fee Schedule, however, Provider Incentive Programs exist in many plans/products:
  - Care Coordination Fees
  - HEDIS Bonuses (patient level, population level)
  - Annual Patient Care Exams
  - Annual Health Assessment
- Establish and maintain a relationship with your Provider Relations representative; if they are not responsive call management
- Keep each plan’s “Quick Reference Guide” at your fingertips
- No referrals required for routine referrals, HOWEVER:
  - Referrals to Out of Network physicians require referrals
  - All plans have separate “Prior Authorization” requirements for certain services
  - All plans have OP Lab and Mental Health requirements
Review of Chicago–area Payor Contracts

See Payor Contract Summary handouts for detailed summaries of all payor contract requirements:

- Key Contacts:
  - Primary Contacts for physician practices
  - 800#s, Websites, Links, Supporting Tools (QRGs, Manuals, etc.)

- Billing & Payment Requirements
- Reimbursement Models (Fee Schedules & Incentive Programs)
- How to verify Eligibility & Benefits
- Referral & Pre-Authorization Requirements
- OP Lab and Network Carve-Outs
- Sample ID Cards
- Pharmacy Formulary
Payor Contracting Workshop

I. Strategy Considerations in Contracting
II. Review of Typical Payor Contract
III. Working with PBC to process contracts with the Payors
I. Strategy Considerations in Payor Contracting

*Get in all vs. get in a few:*

- It is important to be contracted with these plans to retain your referral base of physicians and patients.
- Since enrollment is first voluntary and then random assignment, you/we simply don’t know how these patients will enroll in which products/plans, so it’s safer to be in than out, and next year you can revisit which plans make the most sense to stay in and terminate the rest.
- Access/Prioritize your participation in other plans based on your practice position, and alignment with referral base.
I. Strategy Considerations in Payor Contracting

*Prioritizing Payor Contracts:*

- Since you are already likely contracted with the following plans, these make the most sense to get in right away: BCBS, Humana, CIGNA

- The following 4 plans have all 3 products (MMAI, ICP, FHP): BCBS, ABH, Illinicare, Meridian

- The existing large Medicaid HMOs: FHN (Family Health Network), and Harmony Health Plan

- County Care: CountyCare has contracts with all academic medical centers in Chicago (specialist access).
II. Review of a Typical Payor Contract

*Structure: (see Language Guidelines handout)*

- Definitions
- Roles of the Parties
- Term & Termination
- Attachments
- Products
- Reimbursement
- State and/or Federal Required Contract Addendums
II. Review of a Typical Payor Contract

Key Provisions in every contract:

- **Products:** Which products it applies to, ability to limit additional products being added without your consent
- **Billing:** Ensure at least 90 days, but preferably 180–365 days to submit a claim from DOS
- **Reimbursement:** Ensure reimbursement terms as clearly defined, obtain copy of source Fee Schedule, understand/maximize Incentive Programs (where available)
- **Term/Termination:** Understand your ability to get out of an agreement; ideally a 90 day no cause termination clause
- **Amendment:** Ensure the agreement can only be amended via mutual written consent (other than state/federal mandate requirements)
- **Administrative Requirements:** Ensure you understand the administrative requirements, often detailed in a separate Provider Manual.
III. Working with PBC to process your Contracts

*Process/Timeframes*

- PBC can work with your practice to get these contracts together and send/have sent to your office, with a Contract Summary of Key Provisions.
- You and/or your administrative staff will need to complete/submit any applications and credentialing documents. We can work with you/your admin staff but we cannot fill out/submit the applications.
- It does take a while to get "in network" with these plans; if you are already contracted w/a plan you don’t need to be credentialed which will shorten the timeframe, but many of these are new plans where you will need to be credentialed, so it could take 90–120 days.
- PBC Contacts:
  - To set up appointment with one of our Consultants call Christine O'Malley at 630–928–5228 or email Christine_OMalley@pbcgroup.com
  - PBC Project Managers and Contract Consultants:
    - Cathy Johnson (630) 928–5246 or Cathryn_Johnson@pbcgroup.com
    - Chris Claussner (630) 928–5235 or Christina_Claussner@pbcgroup.com
    - Nicole Channell (630) 928–5230 or Nicole_Channell@pbcgroup.com
Summary & Conclusion: Understand and Manage Medicaid Reform

1. Understand the changes and act accordingly now (patients are getting letters and making choices/decisions right now)

2. Assess your need/desire to participate in contracts/networks, while also considering the needs/desires of your referral base and your patient base

3. Be able to explain/articulate to your patients their options, and those plans that you participate in.

4. Work with PBC and your practice management staff to manage this process well:
   - Make good contract/network participation decisions and to get “the paperwork” done
   - Manage your practice “front end” well (eligibility/benefits, referral/pre-auth)
   - Watch your “back end” claims adjudication and denials: You will likely need to appeal and/or re-submit some claims for patients with eligibility errors
   - Stay informed and engaged as these initiatives proceed
Summary & Conclusion: Big Picture: Have A Strategy for Your Practice

- **Strategy:** Understand the world we are entering as partly ACA and partly the Wild West. We understand some of each, and some of it makes no sense. Plan accordingly.

- **Networks:** Participate in payor and provider networks aligned with your referral base. Know that sometimes what is important to you is not important to your referral base, and vice versa (i.e., Medicaid, Exchange patients).

- **Infrastructure:** Invest in the infrastructure to be able to manage a rapidly growing and diverse Payor Contract Portfolio and Patient Base, driven by VBP and Consumerism.

- **Volumes:** Assume an influx of new patients to the system; but utilization of services will likely drop. Assume less payment per service, with a greater portion of revenue will come from patients (not payors).

- **Communication:** Go above and beyond to communicate to referring physicians and your entire patient base. This drives the Patient Satisfaction scores the most.
Discussion…Questions?

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