Opportunities in Managed Care

Healthy Students, Promising Futures
Learning Collaborative
Unconference

• General instructions:
  • People who turn in topics to the conference staff will be asked to make a 5 minute mini-presentation on their topic to people who choose to attend during the unconference immediately following the panel. After the 5 minute presentation, attendees will have Q and A and discussion with the presenter. This is similar to a table top conversation.

• Managed care: What do you have to share from your experience about how to form win-win partnerships with managed care organizations?
Medicaid Managed Care
101
Ashley A. H. Gray, MPP
Health Research Associate
Institute for Medicaid Innovation
## A Closer Look at Fee-for-Service and Managed Care

<table>
<thead>
<tr>
<th>Fee-for-Service (FFS)</th>
<th>Managed Care Organizations (MCOs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care coordination is not provided by the state.</td>
<td>Care coordination is provided by the managed care organization (MCO).</td>
</tr>
<tr>
<td>Payments to providers are based on volume of patients seen and services received – <strong>not</strong> quality or outcomes.</td>
<td>MCOs are paid an established capitation rate for each member within a specified group (e.g., pregnant women, children with intellectual disabilities) from the state.</td>
</tr>
<tr>
<td>▪ Payments are set in the physician fee schedule, identified by the state Medicaid agency.</td>
<td>▪ MCOs must operate within the rates provided by the state, managing risk and the health of their members to improve health outcomes and quality of care.</td>
</tr>
<tr>
<td>▪ It is very unlikely that a provider would receive reduced payment due to:</td>
<td>▪ Payments are also tied to quality and value. Health plans face financial consequences for:</td>
</tr>
<tr>
<td>○ Patient non-compliance</td>
<td>○ Patient non-compliance</td>
</tr>
<tr>
<td>○ Poor quality outcomes</td>
<td>○ Poor quality outcomes</td>
</tr>
<tr>
<td>○ Unnecessary utilization</td>
<td>○ Unnecessary utilization</td>
</tr>
<tr>
<td>○ Poor patient satisfaction</td>
<td>○ Poor patient satisfaction</td>
</tr>
<tr>
<td>Claims are submitted by providers directly to the state. The state then pays providers, per the physician fee schedule.</td>
<td>Claims are submitted by providers directly to the MCO. The MCO then pays providers, per the negotiated contracts with providers.</td>
</tr>
</tbody>
</table>
Enrollment in Medicaid MCOs has Grown to 73 percent of all Medicaid Enrollees in 2016

Source: Avalere analysis of CMS Medicaid Managed Care Enrollment Reports, 1997-2011.
What are the goals of MCOs?

MCOs function and operate very similarly to commercial insurers, or those offering employer-sponsored insurance.

• Prevention
  ▪ Shift services from treatment to prevention focus, keeping members out of emergency rooms, and reduce/eliminate in-patient stays and urgent care visits.
  ▪ Focus on targeted case management of chronic conditions.
  ▪ Integration of behavioral health with medical care.

• Quality Providers
  ▪ Providers deliver high-quality care and are incentivized to manage utilization.
  ▪ Strengthening primary care providers and centralizing care in a medical home model.
  ▪ Receive accurate and detailed billing information from providers and facilities.

• Appropriate Services and Facilities
  ▪ Care must be medically necessary and appropriate for each patient’s condition.
  ▪ Care must be provided by the right provider, in the most appropriate setting. (*Meet beneficiaries where they are. For example, school based health centers.*)
What factors do MCOs consider when contracting with providers?

- MCO contract requirement to devise and implement a performance improvement project.
- Gaps in service delivery and service delivery coordination.
- Innovative and creative alternatives to enrich traditional services.
- Integration of member/family voice in planning, evaluation, and delivery of service.
What do MCOs need from their network participants?

• High quality services that are also compliant with state and federal regulatory requirements.

• Services that achieve positive, **measurable** results that improve quality of care and health outcomes and reduce gaps in care.
  - Examples of measurable results include increased completed health risk assessments, increased preventive screenings, increased medication adherence, reduced emergency department use.

• Support health care affordability principles and result in a cost effective approach to services.
  - Consider return-on-investment. Can partnering with your organization result in reduced costs and increased health outcomes/positive results?
AmeriHealth Caritas District of Columbia

Healthy Students, Promising Futures Learning
Collaborative Managed Care Session

August 3, 2017

Karen M. Dale
Market President/CEO
At AmeriHealth Caritas, our mission is to help people get care, stay well and build healthy communities.
• Approximately 57% of our enrollees are females
• Over 52% of our enrollees are children, aged 0-20
The contract with the Department of Health Care Finance requires that the MCO:

✓ Furnish diagnostic and treatment services to Enrollees through age twenty (20), the need for which is indicated by an EPSDT periodic or inter-periodic screening.

✓ Cover all Medically Necessary services, for children through age twenty (20), regardless of whether the service in question is also identified as a —Related Service under a child’s education-related treatment plan.

✓ Cover all transportation to and from Medically Necessary services, for children through age twenty (20), regardless of whether the medical or health care service in question is also identified as a —Related Service under a child’s education-related treatment plan.
The contract with the Department of Health Care Finance DOES NOT require that the MCO:

- Be responsible for otherwise Covered Services (including targeted and routine case management services) when the service is furnished in a school setting by the District of Columbia Public Schools (DCPS) employees or contractors.

- Be responsible for transportation services to or from Covered Services furnished in other than educational settings, when the transportation is furnished by DCPS or by a DCPS Contractor.

- Be responsible for coverage or payment of screening, diagnostic, and treatment services when such services are furnished to an Enrollee in a school setting by a school program.
Plan's Priorities – EPSDT Participation Ratio 80%

**Goal:** 80% of Total Eligible Enrollees Receive at least One Initial or Periodic Screen

**Barriers:**
- Incorrect contact information for enrollees.
- Enrollees use pediatric specialty providers as PCPs.
- Use of the emergency room in lieu of PCP.
- Parents have difficulty scheduling appointments for multiple children in the household.
- Opportunity missed by providers to code appropriately if check up is performed during a sick visit.
We need valued partners

**PROVIDER**

- Know EPSDT periodicity schedule
- Conduct outreach and appointment reminders
- Offer flexible scheduling
- Use Proper ICD-10 and CPT codes for EPSDT billing
Intervention: Partner with DCPS Schools to perform school physicals

• Collaborate with DC Scores to spread the word.

• Partner with schools to have physicals done at school location as part of school’s summer and back to school activities.

• Contract with a nurse practitioner (credentialed with the MCO) to perform physicals in DCPS schools.
We have a provider:

- Who is independently licensed and able to bill (contracted or employed).
- Willing to be contracted/credentialed with your MCO.
- Will communicate back to the child’s PCP.
- Will communicate within two (2) business days with the MCO regarding whether visit was kept and results of EPSDT screening.
Delivering the Next Generation of Health Care
Managed Care Contracts
Managed Care Contracts

- LAUSD School-Based Clinics Staff and Services
- California Child Health and Disability Prevention (CHDP) Program and services
- LAUSD Managed Care Contracts
- Lessons Learned
- Requirements per plan
- Things to Consider
- References
14 LAUSD owned and operated School-Based Health Clinics throughout the district

Staffed by LAUSD employees:
- 4 school physician’s
- 14 Nurse Practitioner’s
- 2 Optometrist’s
- 1 Ophthalmologist
- 1 Nutritionist
- 13 Medical Assistants

*funded by LEA reinvestment for health services
Serving students and their siblings ages 1–18 years old, with and without health insurance.

Services include:

- *Regular check-ups & school entry exams
- *Immunizations and TB testing
- *Sick visits
- *Sports physicals
- Nutrition counseling
- Enrollment in health insurance programs
- Teen health
- *Reimbursement
Child Health and Disability Prevention (CHDP) Contract

California CHDP is a preventive program that delivers periodic health assessments and services to low income children and youth in California. CHDP provides care coordination to assist families with medical appointment scheduling, transportation, and access to diagnostic and treatment services. Health assessments are provided by enrolled private physicians, local health departments, community clinics, managed care plans, and some local school districts.
The CHDP program provides complete health assessments for the early detection and prevention of disease and disabilities for low-income children and youth. A health assessment consists of a health history, physical examination, developmental assessment, nutritional assessment, dental assessment, vision and hearing tests, a tuberculin test, laboratory tests, *immunizations, health education/anticipatory guidance, and referral for any needed diagnosis and treatment.

The CHDP program oversees the screening and follow-up components of the federally mandated Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for Medi-Cal eligible children and youth.

*Vaccines For Children (VFC) program/reimbursed for administration of vaccines
LAUSD is a contracted CHDP *Health Assessment Only* provider with the California Department of Health Care Service (DHCS) Medi-Cal

- We are not a comprehensive care provider
- All students with outcomes of “problems suspected” must be referred to comprehensive care CHDP providers for follow up
Late 1990’s/early 2000’s DHCS issued a letter of agreement to managed care plans stating they need to work with schools.

Health Net of California, Inc
- Plan reached out to LAUSD for the provision of CHDP services to their members and reimbursement to LAUSD for these school based services.

LA Care Health Plan
- LAUSD Medical Director transitioned to LA Care Health Plan Medical Director and negotiated the contract for the provision of CHDP services to their members and reimbursement to LAUSD for these school based services.
Lessons Learned

- Signed contracts must be implemented between both parties
  - Template has standard MCO language, must read to determine if we can abide by all terms when renewing contracts
  - Reimbursement for Medi-Cal managed care members only
  - Verification of eligibility is done at every visit by clinics
  - CHDP services are reimbursed at prevailing CHDP fee schedule rates, other services are reimbursed at prevailing Medi-Cal fee schedule rates
  - Reimbursement began as “invoice”, transitioned by requirement to standard CMS1500 claim forms with universal procedure and diagnosis codes, then to electronic claiming formats
LAUSD had to cross-reference coding for claims; we use the Preventative Medicine Services codes (99381–99397), ICD–10 DX codes and School (03) as place of service.

LA Care provides no charge clearing house access for electronic claims, we are able to use it for Health Net claims too.

Consistent reconciliation of claims to review for correct payment amounts.

Keep updated on fee schedule changes.

Liaison to facilitate communication between both organizations.

As part of their service to their contracted providers, LA Care provided liaison to assist LAUSD to apply for and receive Medi-Cal Electronic Health Record Incentive for Meaningful Use.
<table>
<thead>
<tr>
<th>Requirements</th>
<th>Health Net</th>
<th>LA Care</th>
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</thead>
<tbody>
<tr>
<td>Practitioner’s must be credentialed with health plan</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Timelines for claims submittals</td>
<td>✓ 60 days</td>
<td>✓ 45 days</td>
</tr>
<tr>
<td>W9 Request for Taxpayer ID# and Certification</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Identify rendering provider on claims</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Submit claims electronically</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Universal CPT codes and ICD–10 diagnosis codes</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Bill other health insurance first when applicable</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Members referred back to PCP/medical home</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Provide health plan with copies of the CHDP exam</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Enter/update immunization status into state registry</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Abide by health plan Operations Manual and Quality Improvement &amp; Utilization Management</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>General and professional liability insurance or other risk program</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
Things To Consider

- Do you employ or contract practitioners providing services that can be billed to managed care plans?
- A school nurse may have a Nurse Practitioner license that may qualify as a managed care provider.
- Contact your local managed care plans for discussion of services.
  - Are you able to assist with health data for their members: Healthcare Effectiveness Data and Information Set (HEDIS)?
  - Without claims/invoices the managed care plans do not know what healthcare services schools are providing to their members.
References

California CHDP Program –

LA Care Health Plan –
https://www.lacare.org/

Health Net –
https://www.healthnet.com/

HEDIS & Performance Measurement –
http://www.ncqa.org/hedis-quality-measurement

Vaccines For Children’s Programs
https://www.cdc.gov/vaccines/programs/vfc/providers/eligibility.html

Margie Bobe, Manager
LAUSD Medi-Cal Reimbursement and Cost Recovery Unit
margarita.bobe@lausd.net
213–241–0558
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