Welcome to TIM TALK’s: Business Acumen
“The Role of Accreditation as a CBO Business Strategy Option”
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The Role of Accreditation as a CBO Business Strategy Option

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Consultant
Managed Medicaid Key Issues

• Increasingly States are adopting Managed Medicaid waivers

• Managed Medicaid and Managed Long-Term Services and Supports (MLTSS) impacts some of the most vulnerable residents

• Medicaid benefits managed by a third party MCO
  – Personal Care
  – Home-delivered meals
  – Transportation
  – Nursing home care
Benefit to the State and MCO

• States
  – Medicaid is the nation’s largest payer of long-term services and supports
  – States seek to leverage capitated financing arrangements to achieve key objectives
    • Improve coordination of care
    • Promote HCBS over institutional care
    • Provide person-centered, high-quality care

• MCO
  – Financial incentive to manage a high-risk population
  – Rewarded with shifting from institution to community
Figure 1

States with Medicaid Section 1115 Capitated MLTSS Waivers, 2016

NOTE: Some states are implementing MLTSS through another authority.
SOURCE: KFF analysis of waiver special terms and conditions.
What’s happening in your State?


**State Medicaid Integration Tracker**

The State Medicaid Integration Tracker is published each month by the National Association of States United for Aging and Disabilities (NASUAD).

The State Medicaid Integration Tracker focuses on the status of the following state actions:

1. Managed Long Term Services and Supports (MLTSS)
2. State Demonstrations to Integrate Care for Dual Eligible Individuals and other Medicare-Medicaid Coordination Initiatives
3. Other LTSS Reform Activities, including:
   - Balancing Incentive Program
   - Medicaid State Plan Amendments under §1915(l)
   - Community First Choice Option under §1915(k)
   - Medicaid Health Homes
Business Opportunities for the CBO

- The MLTSS population poses the most risk for cost increases and lower quality
- Support the movement from Institutional care to HCBS
- Person-centered care
- Reducing unnecessary admissions and readmissions
- Addressing Social Determinants of Health
- Coordination of community resources to achieve Healthy Aging in Place
Factors Impacting MCO success

- Dual-Eligible and the MLTSS plan
  - *Limited ability to manage Medicare funded utilization that impacts Medicaid spending
  - *Limited capacity to coordinate Medicare/Medicaid & community-based social services

- Impact of Poverty
  - Healthy Lifestyles
  - Medication Adherence (Co-pays, coverage limits)
  - Access to care

- Limited disease self-management capacity
  - Health Literacy
  - Access and utilization of preventive health services
ACCREDITATION & HEALTH PLAN QUALITY REQUIREMENTS
• Medicare Advantage plans must have an internal quality assurance program
  – Many States have similar requirements for Medicaid plans
• Medicare Advantage plans are deemed to have satisfied the Medicare quality assurance requirements by receiving accreditation and having a periodic review and re-accreditation, from a private organization approved by CMS
  – NCQA
  – URAC
  – Joint Commission
Select List of Accreditation Options that CBOs Can Consider

• NCQA
  – http://www.ncqa.org

• URAC
  – https://www.urac.org

• Joint Commission
  – https://www.jointcommission.org

• CARF
  – http://www.carf.org/Accreditation
The Alabama Experience

As the State of Alabama prepares for MLTSS implementation, the State Unit on Aging Director and the AAA Directors began working together to develop a strategy to support ALL of the AAA’s prepare for the change.

Today, we are highlighting the experience of the AL AAAs as they are one of the first States that developed a Statewide strategy that focuses on supporting all AAAs in the State in seeking accreditation.
Do I Need Accreditation for Contracting?

- We know of AAAs and other CBOs that have secured contracts with and without accreditation
  - If your business development strategy is limited to working directly with physicians and hospitals, and doesn’t include managed care contracting, their may be limited benefit in accreditation
  - If you plan to contract with MCOs, now or in the future, you may want to consider accreditation

- Accreditation, is only one of many things that should be considered as part of an overall business development strategy
  - There are no single magic bullets in this business
What should be part of the consideration for choosing an accreditation model?

- Do the plans in your area maintain NCQA accreditation?  
  - [http://healthinsuranceratings.ncqa.org](http://healthinsuranceratings.ncqa.org)
- For NCQA accredited health plans, an accredited MLTSS plan is required to provide all core services of LTSS case management
- For NCQA accredited health plans, if any element is delegated to another entity, the accredited entity is responsible for providing oversight of the services provided by the third-party  
  - Failure of third-party delegated organization, to adhere to NCQA standards, can negatively impact the accreditation status of the accredited entity
When Could I Consider NCQA Accreditation?

• Do I wish to seek contracts, with an NCQA accredited MCO, to provide any service that is part of the required core care accreditation standards?
  – If Yes, then you should consider obtaining accreditation

• How does accreditation improve my ability to secure contracts?
  – Measure of quality of services
  – Assurance that the service provided meets established standards
  – MCO will receive credits towards their accreditation, when they contract with another accredited entity
Resources to Help Prepare for NCQA Accreditation

- [http://pages.ncqa.org/ltssroadmap/](http://pages.ncqa.org/ltssroadmap/)

**Download: Roadmap to Success in LTSS**

A compilation of resources to guide organizations through meeting Case Management and Health Plan Standards for LTSS

States and managed care organizations need assurance that their partners can coordinate care effectively across medical, behavioral and social services and help keep people in their preferred setting—often, their home and community. NCQA has released Roadmap to Success in LTSS, a compilation of resources to guide organizations through standards for Long Term Services and Supports (LTSS). NCQA's LTSS programs provide a framework for organizations to deliver efficient, effective person-centered care that meets people's needs, helps keep people in their preferred setting and aligns with state and MCO requirements.

**Roadmap to Success in LTSS:**

- Helps you understand the accreditation process and standards
- Guides you through the steps of preparing for the accreditation review process
- Provides examples, tools and resources you can use to prepare your organization for the accreditation journey
NCQA Accreditation Programs

- Health Plan Accreditation
- Disease Management
- Case Management
- Case Management for LTSS
- Wellness & Health Promotion
- Accountable Care Organizations
- Managed Behavioral Healthcare Organizations
NCQA Case Management for LTSS Standards

1. Program Description
2. Assessment Process
3. Person-Centered Care Planning and Monitoring
4. Care Transitions
5. Measurement and Quality Improvement
6. Staffing, Training and Verification
7. Rights and Responsibilities
8. Delegations of LTSS
33 States Require or Recognize NCQA Health Plan Accreditation for Medicaid Managed Care (July 2016)
NCQA Quality Measures

- **HEDIS**
  - Health Effectiveness Data and Information Set
  - HEDIS is the Registered trademark of the National Committee for Quality Assurance (NCQA)

- Tool Used to measure performance of health plans
- 90% of all health insurance plans use HEDIS to measure performance

- **LTSS Quality Measures**
  - NCQA is working with Mathematica to develop LTSS standards
  - MLTSS Quality Measures will closely align with NCQA accreditation requirements
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<tr>
<th>Guest Panelist</th>
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<th>Dana G Eidson, CPA</th>
<th>Neal Morrison Former Commissioner, Alabama Department of Senior Services</th>
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PANEL GUEST QUESTIONS
TORSHIRA MOFFETT, NCQA, MPH
PANEL GUEST QUESTIONS
DANA EIDSON, SARCOA, CPA
PANEL GUEST QUESTIONS

NEAL MORRISON
Expressing Your Value Proposition

• Improving quality and reducing costs
  – Capturing clinical quality measures
  – Drive member engagement

• ROI greater than 1 (>1): greater than expected savings
• ROI less than 0 (<0): less than expected savings
• Track and continually reinforce your ROI to the customer
Leading MCOs in the MLTSS Market

- Centene
- United Healthcare
- Amerigroup
- Molina
- Cigna Healthspring
- AmeriHealth
Risks DRIVE the MCO

• It is CRITICAL that you determine the risks to the MCO
• Risks will drive the decision making for the MCO
  – What their risks are
  – What population presents the most risk
  – Their ability to manage these risks
  – Your access to the population that presents the most risk
  – Your ability to mitigate risks for the MCO
MLTSS Risks

• Changing utilization patterns
  – Overall reduction in Long-term care facility admissions over time
  – Shift towards HCBS expansion

• Many States are requiring that Medicaid MCOs adopt Value-Based Payment Models that align with Medicare VBP models
  – ACOs
  – Bundled Payment
Skilled Nursing Facility coverage

- Medicare covers the cost of care for SNF care as follows
  - *Avg length of stay in a SNF is 20 days
  - SNF Readmissions likely occur between day 20 - 39

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<th>For Days</th>
<th>Medicare Pays for Covered Services</th>
<th>Beneficiary is responsible for the following</th>
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<td>1 – 20</td>
<td>Full Cost</td>
<td>Nothing</td>
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<tr>
<td>21 – 100</td>
<td>All but a daily copayment</td>
<td>Daily copayment (2014 = $152/day)</td>
</tr>
<tr>
<td>Beyond 100</td>
<td>Nothing</td>
<td>Full Cost</td>
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How Payment Alignment is impacted by MLTSS

- Alignment of MLTSS and Medicare VBP models
  - Some States are now requiring MCOs to establish Medicaid and MLTSS Value-Based Payment models that align with Medicare VBP
  - This will require greater adoption of the following contract types:
    - Bundled Payment
    - ACOs
    - The possibility exists for LTSS ACO Networks that align with Medicare ACOs and Bundled Payment Programs
Alignment of Payment Incentives

- Incentives to reduce Medicare and Medicaid directly impacts providers that serve duals
- Reductions in Medicare costs and Medicaid costs can have a dramatic impact on the overall cost of care
- Medicare
- Medicaid (Medicare Supplemental Coverage)
- Managed Long-Term Services and Supports
  - Medicaid Waiver
Challenge for CBOs

• Understanding how your business brings value to the system
• Determine if Accreditation aligns with your contracting strategy
• Define your value proposition and outline the return on investment (ROI)
• Implement the required culture change to realize the opportunity
• Implement systems to drive change and document your impact
Guest Panelist

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