



Medicare Advantage – Tactics

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DEVELOPING CARE MANAGEMENT CAPABILITIES

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Care Management

- Not all Payors are created equal.
 - You need to know your payor sources and what they cover and how they pay to determine if your organization can afford (from a financial and resource perspective) to accept a patient with that payor source.

Care Management

- Developing and Adjusting Care Plan
 - Starts at Intake
 - Acceptance criteria
 - Begin with the end in mind
 - Episode vs visit considerations
 - Streamlined and intentionally focused process
 - Focus on hospitalization prevention
 - HHVBP impact
 - Value Based Programs/Shared Risk

Intake Excellence is Key!

- Right up front
 - Correct payer/plan
 - Authorization
 - Payment evaluation – coverage of care
 - Care plan development alignment
 - Leverage services of the MA plan
 - Coordination costs only

Care Management

- Intake Scenarios to Consider
 - What type of patient is this and what will my financial responsibilities and resource utilization entail?
 - Ex: Wound Care Patient
 - Traditional Medicare: PDGM Payer w/ Supplies Covered
 - MA FFS: Pay Per Visit Model & Supplies outsourced to a third party vendor for coverage

Care Management

- Example: Wound Care Patient Financials
 - 3x a week wound care patient with costly supplies
 - We assume it's a 4 week month for a total of 12 SNV's & a HHA to keep the pressure ulcer clean and dry at 2x per week
 - Traditional Medicare
 - PDGM Payment: \$2400 for 30-day episode
 - Wound Supplies \$185
 - \$2215 left after supply cost to cover direct/indirect cost.
 - MA FFS
 - SNV Per Visit Rate: \$146 equals \$1752 (12 SNV)
 - HHA Per Visit Rate: \$65 equals \$520
 - \$2272 revenue to cover direct/indirect cost since supplies aren't covered by HHA
 - Wound Supplies outsourced and covered by Third Party Supply Vendor

Care Management

- Other Considerations:
 - How much (unreimbursed d/t PPV contract) will this patient require. When you are paid per visit by an MA plan, how are you compensated for care management?
 - What is the family/caregiver support on this patient?
 - Does this patient have a history of compliance?

MA QAPI

- Hospitalized patient retrospective
 - Identify trends
 - Drive future care plan interventions and goals
- Outcomes
 - By payer
 - By Diagnosis
- Denial Reviews

MEDICARE ADVANTAGE CONTRACTING

At Risk Contracts

- Fully understand what is required for you to be successful
 - Front end and total profitability
 - Soft costs
 - Patient demographics
 - Payor reputation
- Resist the urge to contract with every opportunity
 - Not every structure matches your agency's strengths
 - Not all structures are profitable
- Know when to walk away
 - Be objective about the opportunity
 - The drag of an unsuccessful relationship is extreme

Define Your Value

- Know what you bring to the table:
 - Geographic capabilities: What states/Counties do you serve? Are you staffed well if you grow rapidly?
 - Does your mission align with their mission?
 - Capitalize on your specialties: Do you have any specialty programs? Wound Care, IV Infusion, Ostomy, Diabetic Coordinator, Hospital at Home?
 - Do you have any references from local MD's/Hospitals/Facilities on your work and quality metrics (what is your rehospitalization rate?)
 - Include your STAR Ratings/Care Compare/VBP Metrics to tell the quality story of why you are a good partner.
 - HHCAHPS Patient Rating

Negotiate Well

- Know your direct cost per visit and indirect cost per visit
- Know your billable medical supply cost - Who is the MA plan contracted with for this?
- Know the stats on the MA organization you are trying to contract with:
 - Number of members, including average and range of ages
 - Member benefits/services covered and not covered;
 - Authorization policy: Will it require auth? Do you have the staffing to request auth or will you have to hire or outsource this?
 - How soon will the pay (according to the contract) ?

Negotiate Well (continued)

- Which of your referral sources are in network? How many of your competitors are in network?
- Know what is in the contract. You cannot afford to sign a contract you haven't read, and understand, from front to back.
- How easy can you get out of a contract if the MA plan proves to be a poor partner? (Not paying, not paying correctly, over utilization of ADR's, etc.)

UNDERSTAND COSTS AND INVESTMENTS

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Understand Costs

- Direct Costs
- Indirect Costs
- Fixed Costs
- Variable Costs

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Understand Costs

Perform a gross margin review for FFS

- Cost per discipline
- Revenue/Rate per discipline
- Gross margin per discipline
- Visit utilization per plan
- Weighted average revenue/visit per plan

Understand Costs

Perform a gross margin review for PDGM

- Distribution of periods by Clinical Group
- Reimbursement per period
- Visit utilization per period
- Cost per period
- Gross margin per period

Investments Needed

Conduct a staffing impact analysis

- Insurance → referral volumes and monthly verification
- Authorization → initial admissions and census
- Billing & Collections → yearly revenue

Investments Needed *Staffing Example*

Medicare



Billing: 1 FTE/\$25M



Insurance: 100 verifications
/day



Authorization: 0 FTEs

Medicare Advantage



Billing: 1 FTE/\$5-7M



Insurance: 45 verifications
/day



Authorization: 20
referrals/day (initial), 1/250
census (ongoing)

Investments Needed

Consider a Medicare Advantage Specialist or build upon Business Analyst roles

- Intentional focus and expertise
 - Know the details of the plans
 - Start with your local market
- Engage from the beginning
 - Case Manager liaison
 - Collaborate on the care plan

Investments Needed

MA Specialist Roles & Responsibilities

- | | |
|---|--|
| <ul style="list-style-type: none"> • Expertise on plans <ul style="list-style-type: none"> – Similar yet different • Liaison between payer and agency <ul style="list-style-type: none"> – Program development – Outcomes data and communication | <ul style="list-style-type: none"> • Liaison with Case Managers and field staff • Reporting and Analysis <ul style="list-style-type: none"> – By plan – Admission – Outcomes <ul style="list-style-type: none"> • Clinical and Financial |
|---|--|

ORIENT YOUR ORGANIZATION

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Orient Your Organization

- Considerations Steps:
 1. Research the Landscape
 2. Research the Plans (auth, medical review, involvement)
 3. Research the Payment Structure
 4. Research their Billing and Payment Practices
 5. Planning your New Process
 6. Changing Your Orientation
 7. Communication and Administrative Execution
 8. Process Execution
 9. Payment Execution

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Orient Your Organization

Use CMS MA enrollment public use data

- MA Service Area Determination

County	State	Contract ID	Organization	Plan Type	SSA Code	FIPS Code	Enrolled
Autauga	AL	90091	UNITED MHCPP - 18	HCPP - 18	1000	1001	.
Autauga	AL	H0104	BLUE CRC Local CCF	Local PPC	1000	1001	849
Autauga	AL	H0107	HEALTH C Local CCF	Local PPC	1000	1001	.
Autauga	AL	H0154	VIVA HEA Local CCF	HMO/HMC	1000	1001	1451
Autauga	AL	H0432	UNITEDHE Local CCF	HMO/HMC	1000	1001	653
Autauga	AL	H0504	CALIFORNI Local CCF	HMO/HMC	1000	1001	.
Autauga	AL	H0523	AETNA HE Local CCF	HMO/HMC	1000	1001	.
Autauga	AL	H0524	KAISER F Local CCF	HMO/HMC	1000	1001	.
Autauga	AL	H0628	AETNA HE Local CCF	HMO/HMC	1000	1001	.
Autauga	AL	H0710	SIERRA H Local CCF	Local PPC	1000	1001	12
Autauga	AL	H0885	HEALTHIE Local CCF	Local PPC	1000	1001	.
Autauga	AL	H1016	AVMED, II Local CCF	HMO/HMC	1000	1001	.
Autauga	AL	H1036	HUMANA I Local CCF	HMO/HMC	1000	1001	.

<https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrollData/Monthly-MA-Enrollment-by-State-County-Contract>

Orient Your Organization

Use CMS MA enrollment public use data

- MA Specific Payers/Plans

Contract ID	Payer	Organization Type	Plan Type	Enrolled
H5521	Aetna	Local CCP	Local PPO	16 1%
H4909	Anthem	Local CCP	Local PPO	150 6%
H9572	BCBS	Local CCP	Local PPO	11 0%
H0271	Care Improvement Plus	Local CCP	Local PPO	796 50%
H2228	Care Improvement Plus	Local CCP	Local PPO	282
R3444	Care Improvement Plus	Regional CCP	Regional PPO	250
H3447	Healthkeepers	Local CCP	HMO/HMOPOS	214 8%
H2944	Humana	PFFS	PFFS	55 10%
H5216	Humana	Local CCP	Local PPO	175
R1532	Humana	Regional CCP	Regional PPO	45
H2001	Sierra Health	Local CCP	Local PPO	158 6%
H0169	UHC	Local CCP	HMO/HMOPOS	279 20%
H2802	UHC	Local CCP	HMO/HMOPOS	243

Medicare Advantage Compare

MedicareAdvantage.com
A trusted, non-government resource

Speak with a licensed insurance agent
1-855-235-5181 | TTY 711, 24/7

Plan Options Learn About Medicare About Us Compare Plans

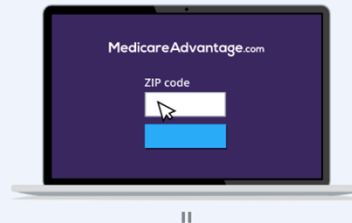
Find a Medicare Advantage plan in 3 simple steps.

1. Compare local plans side by side.
2. Enroll in the right plan for you online or by phone.¹
3. Sit back, relax and enjoy your new plan!

Enter ZIP code

Compare plans →

Hablamos Español



<https://www.medicareadvantage.com/>

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MedicareAdvantage.com

Speak with a licensed insurance agent
1-844-753-7408

Great news! We found **26 Medicare Advantage plans** for you in Stone, Missouri. [Change ZIP](#)

ADD LOCATION COMPARE PLANS ENROLL ONLINE DONE

Print results

+ Add doctor

+ Add drugs

Sort by:

Low to high

Monthly premium

Out-of-pocket max

Estimated total cost

Medicare star rating

Filter by:

Coverage Type

Medicare Advantage plan

Humana

Humana Community (HMO-POS)

Plan ID: H4623-002-000

\$0.00/
monthly premium

Why \$0?

Enroll now →

Speak with a licensed insurance agent
1-844-753-7408 | TTY 711, 24/7

NOT ADDED	NOT ADDED	✓	✓	✓
Doctor In-network	Drug(s) Covered	Vision	Dental	Hearing

Show more plan features

Add to comparison



Every 60 seconds, we help someone enroll in a Medicare Advantage plan.¹

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MedicareAdvantage.com
A trusted, non-government resource

Speak with a licensed insurance agent
[1-844-753-7408](tel:1-844-753-7408) | TTY 711, 24/7

Great news! We found 26 Medicare Advantage plans for you in Stone, Missouri. [Change ZIP](#)

ADD LOCATION COMPARE PLANS ENROLL ONLINE DONE

[Print results](#)

[+ Add doctor](#)

[+ Add drugs](#)

Sort by:
Low to high ▾

☐ Monthly premium
 ☐ Out-of-pocket max
 ☐ Estimated total cost
 ☒ Medicare star rating

Filter by:
Coverage Type
☒ Medicare

wellcare™

Wellcare No Premium Open (PPO)

Plan ID: H7518-001-000

\$0.00,
monthly premium

[Why \\$0?](#)

[Enroll now →](#)

Speak with a licensed insurance agent
[1-844-753-7408](tel:1-844-753-7408) | TTY 711, 24/7

☐ Add to comparison

NOT ADDED
Doctor In-network

NOT ADDED
Drug(s) Covered

☒ Vision

☒ Dental

☒ Hearing

[Show more plan features ▾](#)

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Plan features:

- ✓ Prescription drugs
- ✓ Hospital & Medical
- ✓ Dental
- ✓ Vision
- ✓ Hearing
- ✓ Mental Health Care
- ✓ Chiropractic Care

Prescription drugs:

—

Cost estimates:

N/A out-of-pocket maximum

\$0 primary care physician copay

\$30 specialist copay

Medicare Star Rating:

☆☆☆☆☆ 4 out of 5 stars (2023 plan year)

[View full plan details](#)

[Enroll now →](#)

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IMPORTANT INFORMATION:

2023 Medicare Star Ratings



Aetna Medicare - H2663

For 2023, Aetna Medicare - H2663 received the following Star Ratings from Medicare:

Overall Star Rating: ★★★★★
 Health Services Rating: ★★★★★
 Drug Services Rating: ★★★★★

Every year, Medicare evaluates plans based on a 5 star rating system

Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

More stars mean a better plan – for example, members may get better care and better, faster customer service.

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

The number of stars show how well a plan performs.

★★★★★ EXCELLENT
 ★★★★★ ABOVE AVERAGE
 ★★★★★ AVERAGE
 ★★★★★ BELOW AVERAGE
 ★★★★★ POOR

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2023 Summary of Benefits

Aetna Medicare Premier Plus (HMO-POS)
H2663-023

aetna
 medicare solutions

Here's a summary of the services we cover from January 1, 2023 through December 31, 2023. Keep in mind: This is just a summary. Need a complete list of what we cover and any limitations? Just visit [Aetna.com](https://www.aetna.com) where you'll find the plan's Evidence of Coverage (EOC) or you may call us to request a copy.

We're here to help

You may have questions as you read through this information. And that's OK — we're here to help.

Not a member yet?

Call 1-833-859-6031 (TTY: 711)

October 1–March 31: 8 AM–8 PM local time, 7 days a week

Already a member?

Call 1-833-570-6670 (TTY: 711)

8 AM–8 PM, 7 days a week.

Other benefits	Your costs for in-network care	Your costs for out-of-network care
Equipment, prosthetics, & supplies*		
Diabetic supplies	0%–20%	0%–20%
	We only cover OneTouch/Lifescan supplies, including test strips, glucose monitors, solutions, lancets and lancing devices for \$0. Note: In case of an approved prior authorization, other brands or types of devices may be covered at 20%.	
Durable medical equipment (e.g., wheelchair, oxygen, continuous positive airway pressure (CPAP))	20%	50%
Prosthetics (e.g., braces, artificial limbs)	20%	50%
Substance abuse*		
Outpatient substance abuse (individual therapy)	\$35	50%

* Prior authorization may be required for these benefits. See the EOC for details.

Additional benefits and services provided by Aetna Medicare Premier Plus (HMO-POS)	Benefit information	
	Your costs for in-network care	Your costs for out-of-network care
24-Hour Nurse Line	Speak with a registered nurse 24 hours a day, 7 days a week to discuss medical issues or wellness topics.	
Aetna Medicare Payment Card	You will receive a preloaded debit card in the mail to be used towards the following:	

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MA Operational Challenges

- Common MA issues
 - Poor “negotiation” process
 - Plans tend to push contracted providers to a (low) per-visit payment rather than a PDGM payment
 - High out-of-network patient copays or deductibles
 - Control utilization through prior authorization process
 - Intensive pre- or post-pay medical review
 - Regionality issues, even with national payers

Orient Your Organization

Conduct a review of current contracts and evaluate potential plans

CURRENT CONTRACTS

- Evaluation
 - Contracts in place
 - Last negotiated/Effective Date
- Credentialing
 - When is recredentialing due?
- Contracting
 - Rates & Patient Copays/deductibles
 - Performance
 - Third-party/conveners
- Monitoring
 - EMR set-up

POTENTIAL PLANS

- Evaluation
 - Assessment of payer potential
 - Direct contracting vs. “affiliate” contracting
- Credentialing
 - Payer-specific enrollment process
- Contracting
 - Contract “negotiation”
- Implementation
 - EMR payer set-up & testing
- Monitoring & maintaining

Orient Your Organization

Common MA *billing* challenges

- No authorizations → Authorization practices, visit utilization and monitoring
- Coverage terminated → Insurance verification practices
- Non covered services → Communication of services covered in care planning and plan set-up in EMR
- Untimely NOAs → Initial visit completed and proper identification of payor
- Timely filling → visit completed and orders tracking
- Missing or invalid CPT/HCPCS codes → visit type selection and plan set-up in EMR

Orient Your Organization

Establish clear communication channels between revenue cycle departments, operations & IT

- Authorization escalation plan
- Unbilled reporting and root cause
- Bad debt communication
- Revenue adjustments

Orient Your Organization

Evaluate your payor set-ups

- Payor/Plans
- Payment methodology
 - PDGM, FFS (rate/visit or unit), VBP/shared risk arrangements
- Claim Form
- Timely Filing
- Revenue/HCPCs/ Procedure Codes
- Covered Services and Visit Limits
- Authorization Requirements
- Contract Effective Date

Orient Your Organization

Document payor intelligence and identify who will maintain/communicate changes

- Re-credentialing timelines
- Payor contacts, escalation channels
- Contact information (phone, fax, portals)
- Conveners

Orient Your Organization

Develop MA Scorecard / Value Prop Sample

Cost Analysis	Direct Cost	Indirect Cost	Total Cost
Your per-visit cost for skilled nursing	\$74	\$63	\$137
State specific benchmark (median)	\$97	\$64	\$167
National benchmark (median)	\$77	\$76	\$164
Quality Analysis			
Your CMS quality star rating			4.5
Your rehospitalization rate			8.3%
State specific benchmark (average)			14.6%
National benchmark (average)			14.2%
Patient Experience Analysis			
Your CMS patient experience star rating			4.5
Your overall care rating			93%
State Specific benchmark (average)			87%
National benchmark (average)			84%
Spending Analysis			
Your CMS ratio of Medicare spending per episode			0.86
National benchmark (average)			1.00



Webinar content was developed by the Home Care & Hospice Financial Managers Association (HHFMA), a NAHC affiliate.

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- Networking with peers
- Monthly industry update calls (including benchmarking of key metrics)
- Educational programs
- Access to exclusive HHFMA ListServ addressing industry concerns
- And more...

For more information, visit hhfma.org or call 202-547-7424.



MEDICARE ADVANTAGE PRE-CONFERENCE

Sunday, July 16 | 9:00 AM - 3:00 PM | New Orleans, LA

- ✓ **12 Experts**
- ✓ **Original Data & Trends**
- ✓ **Provider and Payor Insights**

Learn More: NAHC.ORG/FMC2023



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PRECONFERENCE: #803. MEDICARE ADVANTAGE PRE-CONFERENCE



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Lindsay Doak MBA
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Rob Griffith MBA
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UPMC Home Healthcare



David Holmes MBA
Vice President Of Business Development
Liberty Healthcare



Devin Woodley
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VNS Health



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UnitedHealthcare Medicare & Retirement



Glenn Tolchin
VP Financial Planning & Analysis
VNS Health



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Chief Revenue Officer
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Shradha Aiyer MS
Vice President of Product Development
Axxess



Joe Calcutt MBA
CFO
Liberty Home Care, LLC



Jordan Holland MBA
Vice President, Value-Based Care
Compassus



Mike Simone MBA
Director
SimiTree

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FINANCIAL MANAGEMENT CONFERENCE

HIGH-IMPACT SOLUTIONS

- Medicare Advantage (MA) Trends
- Health Plan Perspective on Value
- VBP Contracting and Care Management
- Data-Driven Cost & Margin Analysis
- Lunch (Included!)
- Outcomes Measurement
- Negotiating Strategies and the Importance of Payor Relationships

Learn More: NAHC.ORG/FMC2023

