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ADMINISTRATOR'S SUMMIT

MAY 8–10, 2023



How to Make Medicare Advantage Benefit Your Agency

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COO

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Presented By



- **Beau Sorensen** is chief operations officer at First Choice Home Health and Hospice in Orem, Utah. He has over 25 years of experience in home health and hospice and has extensive knowledge of healthcare systems and processes. Sorensen has worked with organizations across the U.S. to help them better use their EMRs and the data that is in their systems. As part of his work with Allscripts, he has tested and developed major new features in their home care application, including integrations that allow for a fully electronic medical record. These efforts led to his agency being one of the first in the nation to have a fully electronic medical record. Sorensen is actively involved in the home care and hospice community and is currently a member of the HHFMA Advisory Board and the NAHC Finance Committee and Advocacy Councils.

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Learning Outcomes

- At the completion of this educational activity, the learner will be able to:
 - Identify key metrics that insurance companies are looking for when contracting
 - Analyze company's data to determine if Medicare Advantage contracting is right for them
 - Discover new ways to work with insurance providers that provide an edge to their organization

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The Medicare Advantage Landscape

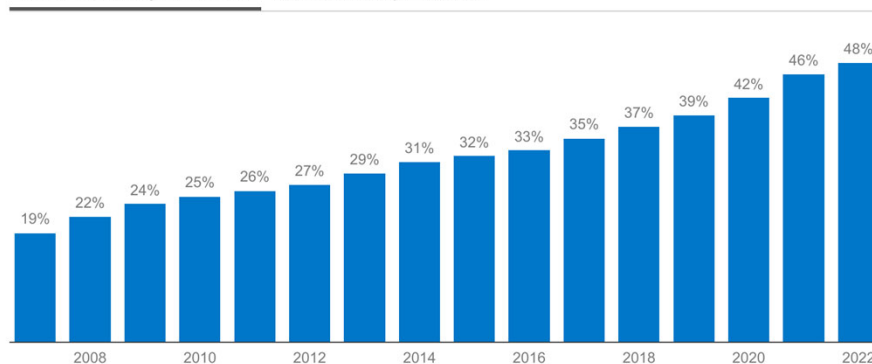
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MA Plans Continue To Grow

Figure 1

Total Medicare Advantage Enrollment, 2007-2022

Medicare Advantage Penetration Medicare Advantage Enrollment



NOTE: Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 58.6 million people are enrolled in Medicare Parts A and B in 2022.

SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2022; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2017; CCW data from 20 percent of beneficiaries, 2018-2020; and Medicare Enrollment Dashboard 2021-2022.

KFF

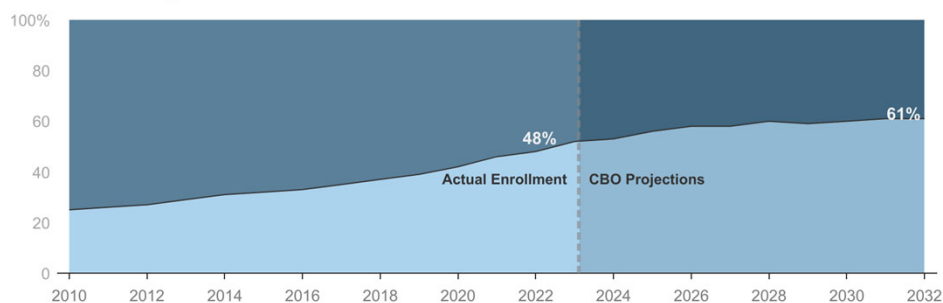
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Figure 2

Medicare Advantage and Traditional Medicare Enrollment, Past and Projected

Medicare Advantage Enrollment Traditional Medicare Enrollment



NOTE: Medicare enrollment is based on individuals who are enrolled in Part B, according to the CBO baseline. This is designed to include only individuals who are eligible for Medicare Advantage and exclude those who only have Part A only (~5 million people in 2023) and cannot enroll in Medicare Advantage. However, it may include some individuals who have Part B only and also are not eligible for Medicare Advantage.

SOURCE: KFF analysis Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2017; CCW data from 20 percent of beneficiaries, 2018; and Medicare Enrollment Dashboard 2019-2022. Enrollment numbers from March of the respective year. Projections for 2023 to 2030 are from the May Congressional Budget Office (CBO) Medicare Baseline for 2022.

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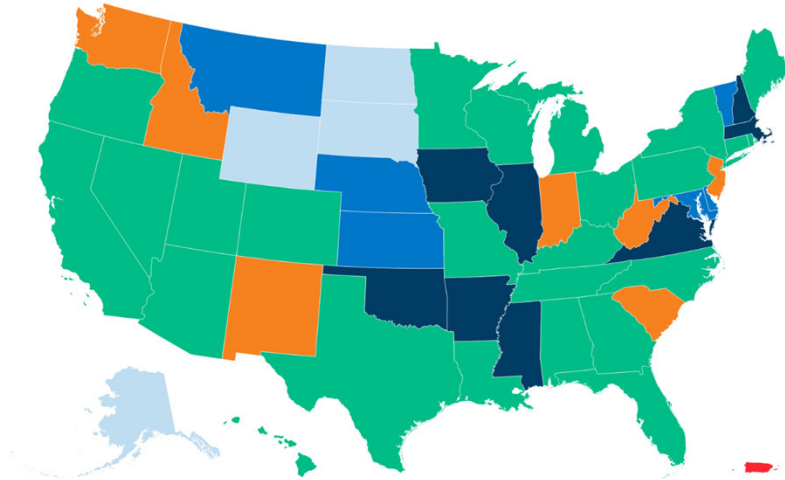
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Figure 6

Share of Beneficiaries Enrolled in Medicare Advantage in 2022, by State

■ < 20%
 ■ 20%–30%
 ■ 30%–40%
 ■ 40%–50%
 ■ 50%–60%
 ■ ≥ 60%



NOTE: Includes only Medicare beneficiaries with Part A and B coverage.

SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2022 and March Medicare Enrollment Dashboard, 2022.

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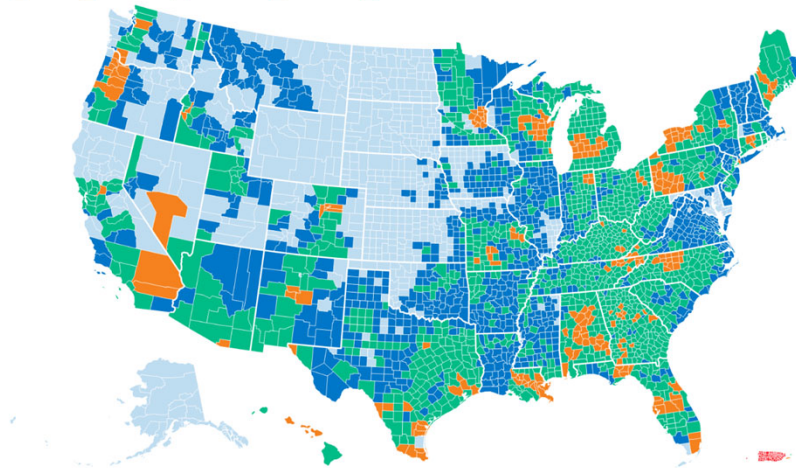
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Figure 7

Medicare Advantage Penetration, by County, 2022

■ < 20%
 ■ 20%–40%
 ■ 40%–60%
 ■ 60%–80%
 ■ ≥ 80%



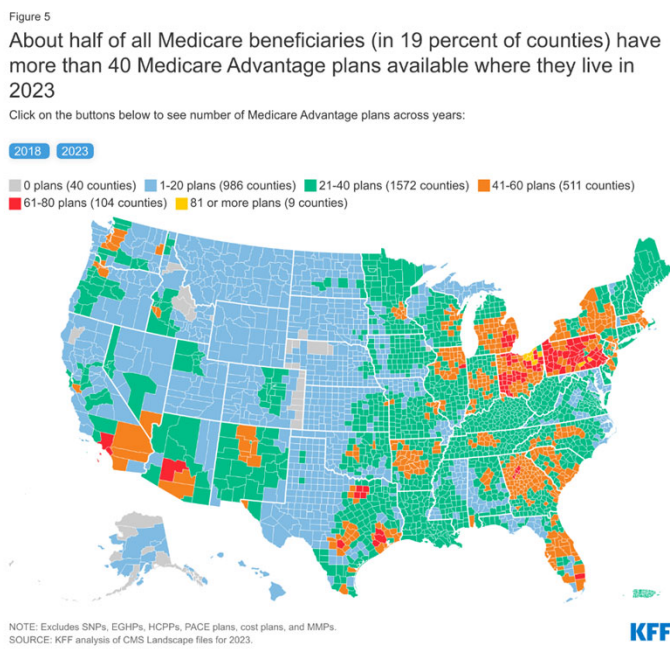
NOTE: Includes only Medicare beneficiaries with Part A and B coverage.

SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2022 and March Medicare Enrollment Dashboard, 2022.

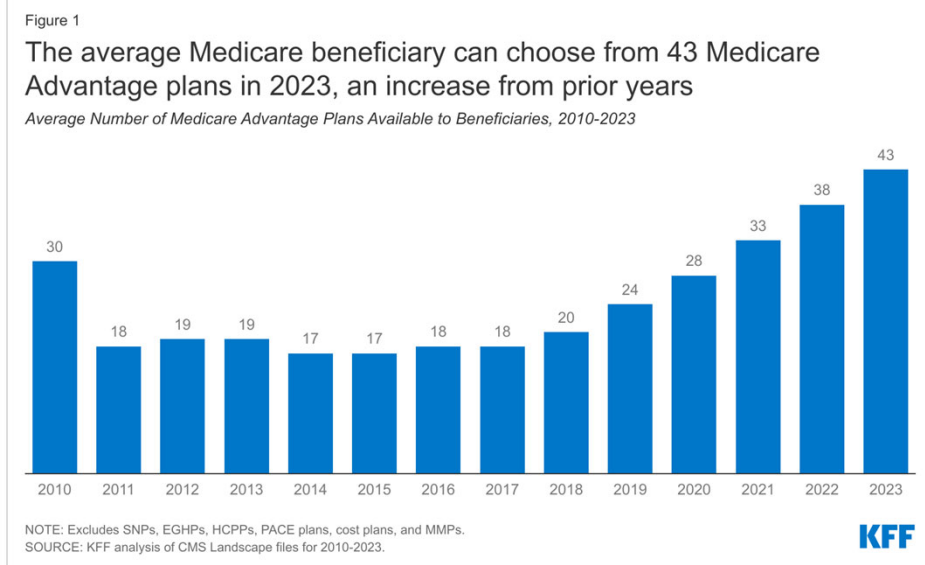
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So Many Choices

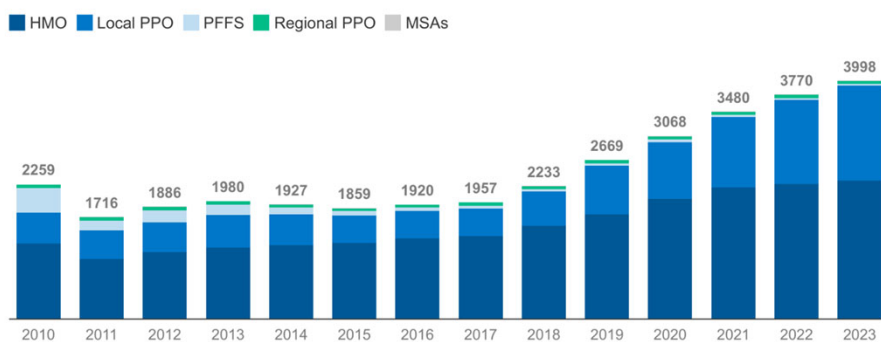


So Many Choices (cont.)

Figure 2

More Medicare Advantage plans are available in 2023 than in any other year going back to 2010

Number of Medicare Advantage plans generally available by plan type, 2010-2023



NOTE: Excludes SNPs, EGHPs, HCPPs, PACE plans, cost plans and MMPs. Numbers may differ from previous publications in cases where the Landscape File for the year was updated after initial publication.
SOURCE: KFF analysis of CMS Landscape files for 2010-2023.

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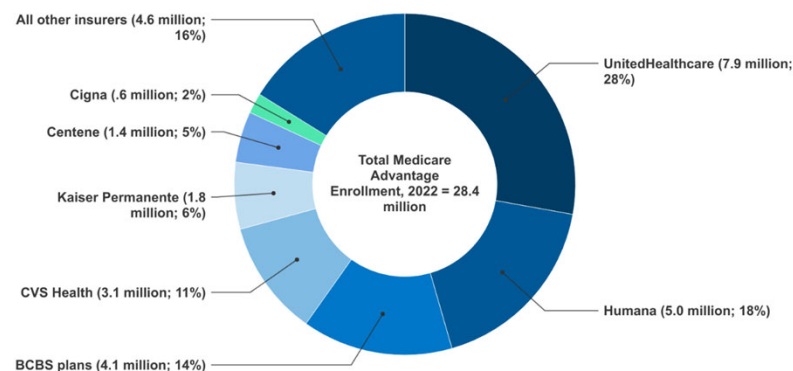
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There Are 2 Big Plans... and Everyone Else

Figure 8

Medicare Advantage Enrollment by Firm or Affiliate, 2022



NOTE: All other insurers includes firms with less than 2% of total enrollment. BCBS are BlueCross and BlueShield affiliates and includes Anthem BCBS plans. Anthem non-BCBS plans are about 2% of total enrollment.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2022.

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What Are the Biggest Plans in Your Area?

- <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDENrolData/Monthly-Enrollment-by-Contract-Plan-State-County>
- This is a great resource to see growth in your area by plan

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So, you've decided to jump into Medicare Advantage...



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Plan

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Identify Your Objective

- Why are you getting (deeper) into Medicare Advantage?
- What is your value proposition to your plans?
- Identify your win.

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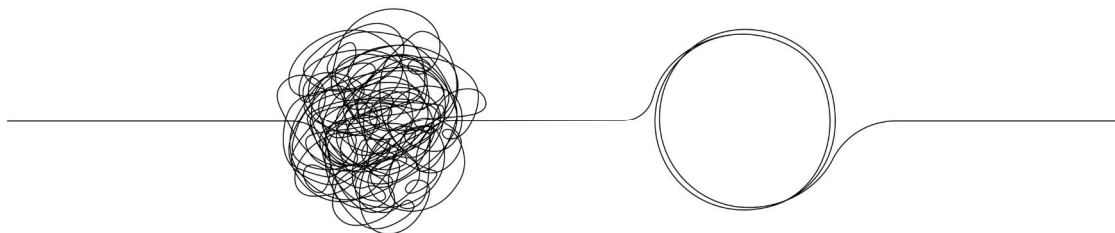
Identify Your Constraints

- What are your current costs?
- What will be your additional costs for a new payor?
- What will be your opportunity costs?
- Is your EMR set up for these new payors? Do you know what you need to do to get it set up for them?

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Do you have the capacity for complexity?



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Complexity Added by Medicare Advantage Plans

- Multiple payors, even amongst a single payor
- Some payors lease out their networks, so you may get a Cigna referral, but it's actually a small company called HMDE that leases the Cigna network.
- Institutional vs. Professional claims
- Authorizations
- Medical review
- “We follow Medicare guidelines” – until they don’t.

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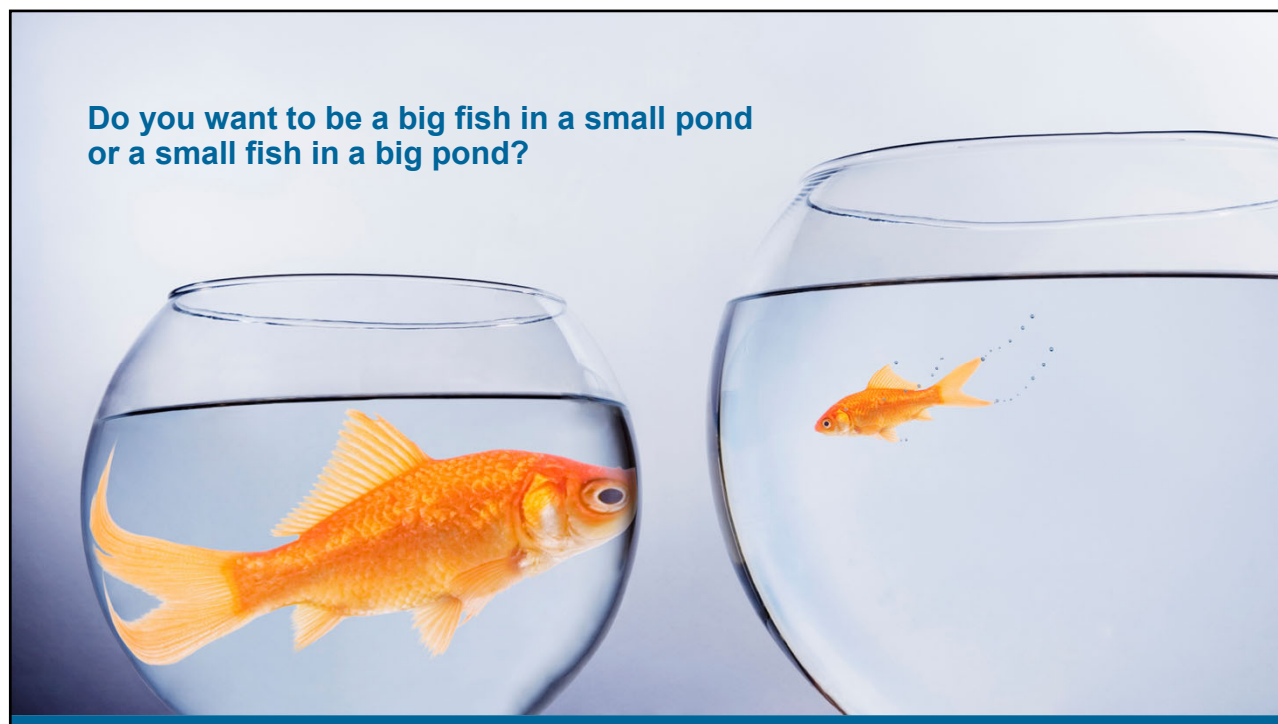
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Identify Your Opportunities

- Will this increase your market penetration somewhere?
- Is there a referral source that wants you to be on a Medicare Advantage network?
- What other providers are on that network in your area?

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A photograph of four business professionals (three men and one woman) smiling and engaged in conversation. They are dressed in professional attire. The image is partially obscured by a purple banner on the left side of the slide.

Negotiate

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OVER 2 MILLION COPIES SOLD

'This book
blew my mind.'
Adam Grant

A former FBI
hostage negotiator's
tools for talking anyone
into (or out of) just
about anything.

NEVER SPLIT THE DIFFERENCE

NEGOTIATING AS IF YOUR
LIFE DEPENDED ON IT

CHRIS VOSS
WITH TAHL RAZ



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Before You Start

- Identify your costs
 - Direct
 - Indirect
- Establish your acceptable reimbursement range
- Remember, it's awfully hard to make up losses on volume!

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Once you're clear on what your bottom line is, you have to be willing to walk away. Never be needy for a deal.



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Scenario 1: Diversification from Medicare to Medicare Advantage

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Example 1: Will This Work?

Direct Costs per Visit	\$76
Indirect Costs per Visit	\$63
Visits per period (across all payors)	14
Medicare Margin	\$200/period
Overall Medicare Revenue/period	\$2150
Increased Overhead per Visit (new payor)	\$2 (for new payer only)
Total Medicare periods	1000
Projected increase (decrease) in Medicare periods	-50
Increase in new payor periods	200
Proposed per visit rate (new payor)	\$110

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Example 1: The math

Increase in total direct per visit costs	\$159,600
Increase in total indirect per visit costs	\$132,300
Decrease in total profit margin vis-à-vis Medicare	-\$10,000
Revenue from new payer	\$308,000
Increased Overhead Costs	\$5,600
Original Revenue	\$2,150,000
Original Profit (assuming started at 100% Medicare)	\$200,000
New Revenue	\$2,458,000
Original Expenses	\$1,950,000
New Expenses	\$2,248,100
New Profit	\$209,900

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Scenario 1: Is it worth it?

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Scenario 2: You only get 80% due to authorizations and record denials

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Example 2: 20% breakage

Direct Costs per Visit	\$76
Indirect Costs per Visit	\$63
Visits per period (across all payors)	14
Medicare Margin	\$200/period
Overall Medicare Revenue/period	\$2150
Increased Overhead per Visit (new payor)	\$2 (for new payer only)
Total Medicare periods	1000
Projected increase (decrease) in Medicare periods	-50
Increase in new payor periods	200
Proposed per visit rate (new payor)	\$110
Percent of claims paid (new payor)	80%

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Example 2: The Math

Increase in total direct per visit costs	\$159,600
Increase in total indirect per visit costs	\$132,300
Decrease in total profit margin vis-à-vis Medicare	-\$10,000
Revenue from new payer	\$308,000
Increased Overhead Costs	\$5,600
Original Revenue	\$2,150,000
Original Profit (assuming started at 100% Medicare)	\$200,000
New Revenue	\$2,458,000
Original Expenses	\$1,950,000
New Expenses	\$2,248,100
20% breakage deduction	-\$61,600
New Profit	\$148,300

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Scenario 2: Is it worth it?

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Scenario 3: Diversification with reduced indirect costs per visit due to efficiencies

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Example 3: Efficiencies Gained

Direct Costs per Visit	\$76
Indirect Costs per Visit	\$63
Visits per period (across all payors)	14
Medicare Margin	\$200/period
Overall Medicare Revenue/period	\$2150
Increased Overhead per Visit (new payor)	\$2 (for new payer only)
Total Medicare periods	1000
Projected increase (decrease) in Medicare periods	-50
Increase in new payor periods	200
Proposed per visit rate (new payor)	\$110
Reduction in fixed overhead costs per visit (all payors)	\$5

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35

Example 3: The Math

Increase in total direct per visit costs	\$159,600
Increase in total indirect per visit costs	\$132,300
Decrease in total profit margin vis-à-vis Medicare	-\$10,000
Revenue from new payer	\$308,000
Decreased Overhead Costs	\$74,900
Original Revenue	\$2,150,000
Original Profit (assuming started at 100% Medicare)	\$200,000
New Revenue	\$2,458,000
Original Expenses	\$1,950,000
New Expenses	\$2,173,200
New Profit	\$284,800

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Scenario 3: Is it worth it?

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Negotiation is not an act of battle; it's a
process of discovery.

A handwritten signature in black ink, consisting of a stylized 'Q' followed by a horizontal line.

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What To Bring to the Table

- Know your numbers
- As much as possible, know who you are negotiating with
 - Ask what they care about
 - Better yet already know what they care about before you get to the table – don't assume when you get there that you know their position, so ask what they want. Get to "that's right."

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Negotiate in their world. Persuasion is not about how bright or smooth or forceful you are. It's about the other party convincing themselves that the solution you want is their own idea. So don't beat them with logic or brute force. Ask them questions that open paths to your goals. It's not about you.

A stylized, handwritten signature in black ink, consisting of a large, loopy 'Q' followed by a horizontal line.

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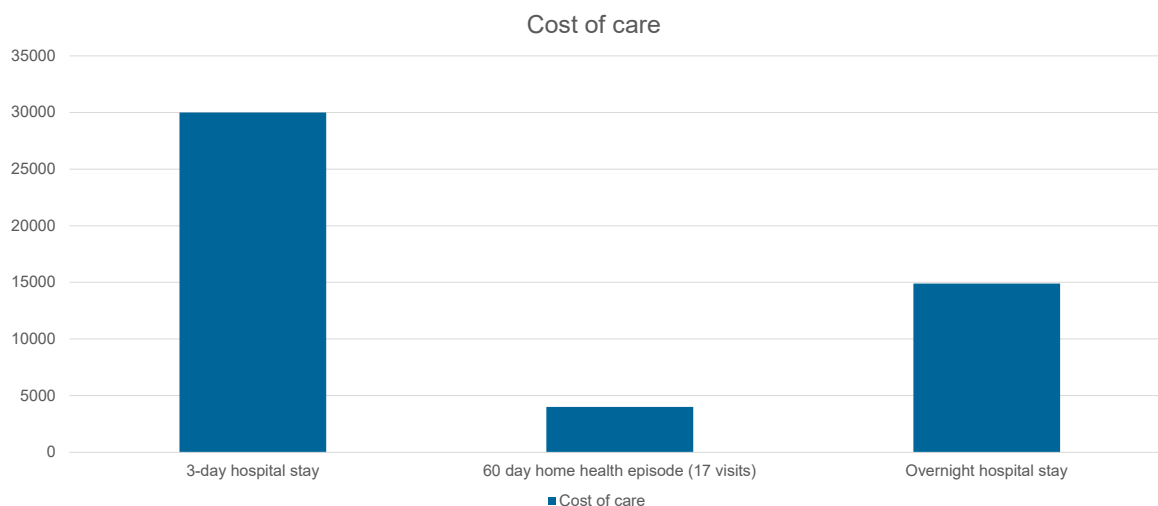
Key Metrics for Insurance Companies

- 30-day rehospitalization rate
- Patient satisfaction rates
 - Use numbers that are in their language. “I asked 50 patients what they thought, and they love us” is not nearly as good as “when asked at discharge, patients give our agency a Net Promoter Score of 82” or “According to Medicare Compare, our patient satisfaction is 93 compared to 87 for our competitors.”
- Coverage area
- Your rates

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Hospitalizations



*Data from Healthcare.gov, CMS.gov, and AHRQ

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What Is a Net Promoter Score?

How likely is it that you would recommend us to a friend or colleague?

Highly
Unlikely 0 1 2 3 4 5 6 7 8 9 10 Highly
Likely



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Coverage Area

- As insurance companies grow, they want to know that they don't have to piece together a patchwork network.
- It's easier to work with one provider instead of 10.



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Rate-Setting

- You are not competing against hospital rates; you are competing against other agencies to reduce their hospitalization rate.
- If your per-visit rates are more than your competitors, you better have data to back that you are worth it.

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Putting It All Together

<u>Cost Analysis</u>	<u>Direct Cost</u>	<u>Indirect Cost</u>	<u>Total Cost</u>
Your per-visit cost for skilled nursing	\$74	\$63	\$137
<i>Utah benchmark (median)</i>	\$72	\$66	\$133
<i>National benchmark (median)</i>	\$76	\$76	\$159
<u>Quality Analysis</u>			
Your CMS quality star rating			4.5
Your rehospitalization rate			8.3%
<i>Utah benchmark (average)</i>			12.8%
<i>National average (average)</i>			14.2%
<u>Patient Experience Analysis</u>			
Your CMS patient experience star rating			4.5
Your overall care rating			93%
<i>Utah benchmark (average)</i>			82%
<i>National benchmark (average)</i>			84%
<u>Spending Analysis</u>			
Your CMS ratio of Medicare spending per episode			0.86
<i>National average</i>			1.00

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Anything you throw out that sounds less rounded – say \$37,263 – feels like a figure that you came to as a result of thoughtful calculation.



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Getting Data

- Your EMR
- Data.medicare.gov
- Trella Health
- SimiTree
- SHP
- etc...

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Finalizing the Contract

- When rates are set, the negotiation is not over. You still have other details to sort out
 - Length of the deal
 - Carry-forward clauses
 - Timely filing deadlines
 - Clean claims requirements
 - Force majeure clauses
 - Code sets
 - Records requirements
 - Authorization requirements

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Finalizing the Contract (cont.)

- Do you want to do anything other than your core services? Many insurances have ancillary benefits that are natural extensions of what we do already. If you might want to include those, it is easier upfront than to add in down the line.

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Splitting the difference is wearing one
black and one brown shoe, so don't
compromise...
No deal is better than a bad deal.



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You're in...Now What?

Your Responsibilities

- Insurance plans are extraordinarily bad at communicating with you if there is a change in requirements, representative, etc.
- Keep channels open; follow up with them regularly, as they probably won't follow up with you.
- This makes rate increases easier as you will have a rapport with someone already there (and you'll know they still work for the insurance company).

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Your Responsibilities (cont.)

- Determine what the relationship is
 - Some insurance companies have very close relationships, to the point that they communicate directly via secure instant messaging with providers
 - Some insurance companies are very arms' length and barely want to see you
- Provide requested data
 - Insurance companies are asking for more information to save money on their enrollees.
- Don't let recredentialing pass you by.
 - Make sure that you keep insurances current on who is your insurance person

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Unique Opportunities



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Partnerships

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Humana

- Move 75% of patients to Humana-driven ACOs
- Working on programs to improve the cost of their health populations inside these ACOs by providing services like meals on wheels at no cost to beneficiaries

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Optum

- UnitedHealthCare purchased the nation's largest provider, LHC Group
- In areas where UHC doesn't own an agency, they are winnowing provider groups and restricting access to plans
- For providers who are with UHC's Optum plans, there is an extraordinary level of data-sharing, going beyond what any other insurance company has done

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Three Weaknesses of the Current System:

1. The fee-for-service payments that reward providers for the volume and intensity of services delivered irrespective of quality or efficiency
2. A fragmented delivery system that inhibits care coordination across providers and care settings
3. Innovative approaches to care that rely on new lower-cost sites of treatment or wireless services that are not compensated in traditional payment systems.



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The most promising payment reforms dampen the financial incentives for providers to deliver more care and reward providers when they focus on the efficient delivery of services that improve patient health.



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How Do We Break Down Silos?

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Collaborative Approach

- Tandem365 is a joint venture between multiple SNFs, ALFs, EMS services, and home health care providers to improve members' health and decrease overall healthcare costs.
- There is no homebound requirement.
- They provide the full gamut of services provided by their member organizations as well as a healthcare navigator, telehealth, and meal services

TANDEM365
CARE IS BETTER TOGETHER

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Affiliate Programs

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Affiliate Programs

- Utilize the leverage of a health system to negotiate rates on your behalf
 - The health system has significantly higher leverage than you do as an independent agency

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What Is Your Value Proposition

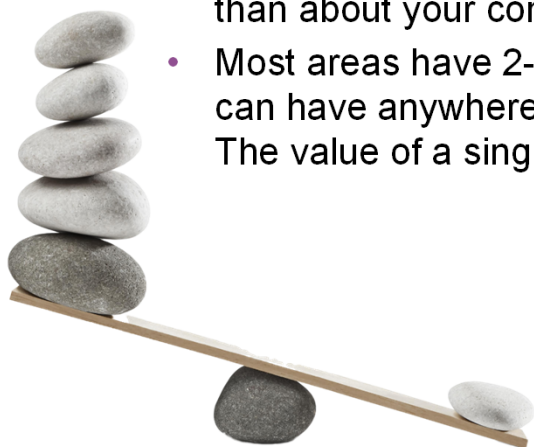
- Instead of selling to the insurance, you would sell to the health system
- They care about outcomes – they want to know what the value proposition and solution is for the system. Why do they want to work with you?

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Why This Works

- Insurance carriers care more about the hospital contract than about your contract.
- Most areas have 2-3 major hospital chains, while they can have anywhere from 20-100 home health agencies. The value of a single hospital contract is far, far greater.



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Thank you. Questions?

beau@visionbound.com

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