NWX-HHS-AOA-1

Moderator: Lauren Solkowski
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2:00 pm CT

Coordinator: Welcome and thank you for standing by. At this time all participants are on a listen only mode until the question and answer session of today's conference. At that time to ask a question please press Star 1 and record your name at the prompt.

This call is being recorded. If you have any objections please disconnect at this time. I would now like to turn the call over to your host Lauren Solkowski. You may begin.

Lauren Solkowski: Great. Thank you so much and good afternoon everyone and thank you for joining us today for the Administration for Community Livings Business Acumen Webinar.

Today's Webinar will be focused on rate determination and actually if everyone could mute your phones. I just heard a little bit of feedback. And I believe that operator correct me if I'm wrong, is that Star 6 to mute and un-mute?

Coordinator: Yes that's correct. But only the three speaker lines are open.

Lauren Solkowski: Oh yes, you're right. Okay sorry about that everyone. So maybe that was one of us, my apologies. Okay moving forward so again this is Lauren Solkowski with ACL. And I will be facilitating our Webinar today.

So we've invited Health Management Associates to they will be discussing the Medicare and Medicaid rate-setting for providers and plans and also the dual demo rate methodology as well as payment to providers and a few other emerging issues.

We've also invited Partners in Care Foundation to present the community-based organization perspective in terms of reaching rate agreements with contracted healthcare entities.

So before we start with those presentations I have a few housekeeping announcements to go through. To start with if you have not done so yet please use the link that was included in your calendar appointment to get onto the WebEx so that you can follow along with the slides but also so that you're able to ask your questions when you have them through the chat function.

If you do not have access to the WebEx link you can also go to www.webex.com. That's www.WebEx.com. Click on the Attend a Meeting button that's located at the top of the page and then enter the meeting number.

And today's meeting number is 664198367. Again that's 664197367.

If you have any problems getting into WebEx please call the technical support number. That is 1-866-569-3239. Again that's 1-866-569-3239.

As I've forgotten earlier all of our participants are in a listen-only mode. However we do welcome your questions throughout the Webinar and there are two ways that you can ask your questions.

The first is through the Web using the chat function in WebEx. You can enter your questions and we will sort through them after the presenters have presented and answer your questions.

In addition to asking questions through chat again once the speakers have wrapped up with their presentations we will offer you a chance to ask your questions through the audio line.

And when that time comes our operator will give instructions as to how to queue up to ask your questions. If there are any questions that we don't get to during the Webinar we will follow-up to be sure that we get them answered.

So if you do think of any questions after the Webinar please feel free to email them to me. And I have entered in my email address in the chat box located there on the right-hand side of the screen.

Also listed there in the chat I have listed the ACL Web site as well as the learning collaborative Web site. This is where we will be posting the slides, the recording and transcript of the Webinar after we finish today.

Okay so I think that's all of my announcements. So with that I would like to introduce our first speaker is Lisa Shugarman.

Lisa is a Senior Consultant in the Southern California Office of Health Management Associates. Lisa is an experienced health policy researcher with extensive expertise in both quantitative and qualitative research methods.

She has a keen interest in the integration of medical and supportive services and much of her work has focused on older adults, especially dual eligibles who have long-term service and support needs.

She also has experience working on mental health outcomes for veteran's public health preparedness and a broad range of disability issues.

Lisa I will turn it over to you.

Lisa Shugarman: Thank you good afternoon everybody, happy to be here to talk through issues around rate setting -- a fascinating topic. I'm hope you guys will come out the other side of this presentation thinking the same thing.

Next slide please Lauren. Thank you.

So just a quick overview of what we're going to cover today. And we have a short amount of time to do this. So I'm going to - it's going to go through fairly quickly. I had - I'm assuming that these slides will be made available to you after today's Webinar. And if they're not I'll make sure that you get them if you want them.

We're going to start our conversation today with a quick summary overview of Medicare and Medicaid.

Most of you probably already know a lot about Medicare and Medicaid but, you know, we think this is a good way to sort of get a level set for everybody.

It can get complicated, you know, when you're thinking about rate setting and how it works for Medicare and Medicaid. So it's important to just have a

quick overview of what we're talking about here before we get into the rate setting methodology approaches.

We're going to talk a little bit about the financial alignment models where - or the "dual demonstrations" and then move into the rate setting process for the duals capitated model.

We'll talk about all the different steps involved in getting the rates, developing the rates and getting to the place where your - where payments are flowing to providers.

And we'll talk a little bit about some of the implementation challenges and what's the impact of the rate on those challenges as well.

Next slide, so Medicare comes in sort of two flavors. There's the traditional or fee for service Medicare that's administered by CMS. And that covers Part A which is inpatient and Part B outpatient services and Part D which is put the prescription drug plan.

The government pays providers through intermediate - fiscal intermediaries for the services they provide.

Medicare Advantage which is also Part C of Medicare have been growing in its presence within the Medicare program. It's a voluntary program. And about nationally a little over 1/3 of all Medicare beneficiaries are enrolled in a Medicare Advantage plan.

In Medicare Advantage CMS contracts with private insurance companies to deliver services. And the plans are paid a capitated amount per member

enrolled. And then the plans then develop contracts with providers and pay the providers.

Sometimes Medicare Advantage plans will provide Part D drug coverage, sometimes they don't.

What's really important to know about Medicare Advantage is how it really is distinguished from the traditional flavor of Medicare is that in Medicare Advantage one way that those plans develop a competitive edge is that they can provide other benefits such as dental or vision or both Silver Sneakers programs and other kinds of benefits that can make them attractive to the Medicare population and that those are benefits that are not covered under the traditional or fee for service Medicare.

Next slide, so when we talk about state Medicaid rate setting states are - it's the state's responsibility to set Medicaid rates. They have to get CMS approval for it but they determine the rates.

These are traditionally set on a - they're traditionally set for state plan benefits using a fee schedule. But more and more Medicaid is being delivered through managed care.

Close to 3/4 of the population eligible for Medicaid are enrolled in some sort of managed care plan for at least part of their benefits.

And more and more states are including seniors and people with disabilities. They're carving them into their managed care programs.

Each states method for paying for services is unique. It reflects the policy objectives of the state. For example some states may encourage quality improvement with incentives such as pay for performance initiatives and such.

The Balanced Budget Act of 1997 established that Medicaid rates had to meet a standard of reasonableness with sufficient documentation. The rates need to be actuarially sound and they need to be appropriate for the populations covered and services provided.

And there's actually been further elaboration of this requirement in the Medicaid managed care rule which was released earlier this year. It was released in the end of May 2015. And that's going to have important impact on managed - Medicaid managed care going forward -- a topic for another time.

And so then there's capitated rate development for plans that the states will either develop a blended rate which provides a single rate for all Medicaid services that are covered under the plan or have separate capitation rates for each category of service.

Next slide, so I'm sure you're very familiar with the dual demonstrations. You know, just briefly the goal of the Financial Alignment Initiative or the duals demonstrations to increase access to a seamless high quality program that integrates primary acute behavioral prescription drugs and long-term services and supports for the beneficiary.

Next slide, there are two main models for the financial alignment demonstration. You've got the capitated model where the - a state CMS and a health plan enter into a three-way contract and the plan receives the perspective blended payment to provide comprehensive coordinated care.

And of the 13 states that have approved, demonstrations to date ten of them follow the capitated model for their demonstration. Then there's also managed fee for service. There are two of 13 states that have a managed fee-for-service model for their demonstration.

And the Minnesota is kind of the odd duck here in some ways. And I don't mean that in any. If there's anyone from Minnesota on the call I don't mean that in any way negatively.

But Minnesota's doing things their own way and really focusing on administrative alignment. We're going to focus in this conversation on the states that are operating the capitated model for the duals demo. Next slide, so this summarizes the main principles of the managed-care rate setting for the duals demonstration.

States have discretion regarding the structure of capitation for Medicaid services. And I mentioned earlier either a blended or an individual rate cell methodology.

The duals demonstration rate setting principles include that the rates are risk-adjusted, rates are designed to provide incentives for using common community-based services to reduce institutionalization. That's going to be key.

The rates - there should be rules established for assigning beneficiaries to various plans for within the program. The rates must be budget neutral in total for both Medicare and Medicaid dollars paid.

The plans must have a Medicare Advantage planned with at least a three star rating. And the rates must be actuarially sound. We already talked about that a little bit and the rates must reflect geographic variations.

Next slide, this is the big picture view of the methodology for rate setting. And we're going to go through each of these four steps in more detail. But briefly we'll talk about determining a baseline. That's the first step in the rate setting process.

Second is applying savings to those estimates. Third is making adjustments such as for quality incentives and then finally making the payments to plans.

Let's go to the next slide and we'll start with the first element of this, the rate setting process. So baseline spending is - it's important to first establish what's the baseline spending in order to be able to develop the rates.

So the baseline spending what that is it's an estimate of what both the federal and state governments would have paid in a payment year for both Medicare and Medicaid in the absence of the demonstration. So this is established going forward prospectively on an annual basis.

The Medicare methodology to determine the baseline is consistent across all states participating in the duals demos. There's no difference across states.

The Medicaid methodology will naturally vary from state to state because each state Medicaid program has different rules, has different eligibility criteria, has different ways of paying for services and such which will impact the development of that baseline.

Next slide, so for the Medicare piece CMS develops the baseline cost estimates for Part A and Part B at the county level.

They make spending - they calculate based on spending assumptions for Medicare Advantage and for fee for service Medicare and then they develop a weighted average based on expected enrollment to establish that baseline spending.

For beneficiaries that are coming from fee for service Medicare the baseline is based on the standardized fee for service county rates. That actually reflects historical fee for service expenditures.

Those - that baseline is adjusted at the county level by wage and practice cost indices.

And then for the beneficiaries coming from Medicare Advantage the baseline is based on the estimated amounts that would have been paid to those MA plans including Part C rebates in the absence of the demonstration.

The baseline also include plan specific assumptions about bids, quality bonus payment adjustments - adjusted benchmarks and rebate amounts for each county.

Next slide, the Medicare Part D baseline is projected - it - the projected baseline rather it is set as the Part D national average monthly bid amount for the payment year. So that’s set every August.

CMS also estimates the average monthly payment for the low income subsidy or LIS cost sharing and federal reinsurance subsidy amounts. And these payments are reconciled after the payment year has ended.

Next slide, so on the Medicaid side the - as I mentioned earlier the Medicaid baseline methodology varies from state to state. All states must provide data to support their baseline projections to CMS actuators who are going to validate those data and the projected baseline cost.

The Medicaid baseline takes into account historic costs and must consider both fee for service, Medicaid and Medicaid managed care plan payment where they already serve dual eligibles through Medicaid managed care.

Historic spending is used to reflect cost for services to be included in capitation rates for the target population that's incorporating data for the most recent years available.

Next slide, so now we're moving on to step two. So we've talked about now how the baseline is determined for getting to those rates. And now we're going to talk about the next step in the process which is applying savings.

So CMS determines an aggregate savings percentage based on modeling of their - what they expect will be changes in utilization.

So for example they may assume that with implementation of the dual demo in a particular state or rather for the demonstration that they're going to be rejections in nursing facilities admissions and there will be reductions in hospitalization by better integrating Medicare and Medicaid and aligning incentives to keep people in the community.

So they'll make an assumption about what the savings would be based on their expectations for that change in utilization. And those savings percentages

will vary from state to state and they'll vary from year to year of the demonstration.

The savings are prospectively applied to those baseline amounts that were already calculated to determine the rates paid to plan. So they're taking those dollars off the top essentially.

The savings percent is then applied to both the Medicare and Medicaid components of the rate and both payers both Medicare and Medicaid proportionately share in the savings regardless of underlying utilization patterns.

So they're going to regardless of whether the savings that are - that might be attributed to the demonstration is more in terms of reducing hospitalizations which is something that traditionally Medicare is the primary payer for or long stay nursing facility emissions with Medicaid pays for it doesn't matter where the savings accrue from. The actual savings state and federal government get is evenly shared based on their relative contributions to the program.

So in California based on what was in the Memorandum of Understanding between the state of California and CMS the minimum savings percentages were 1% for the first year of the demonstration, 2% for the second year and 4% for the third year.

The savings that we just talked about are not applied to the Part D component.

Next slide, this is just a graphical presentation of how the blended - how they blend the payment rates for savings.

So on the left side you see the pink box. The total box there is the total CMS spending. That's the baseline spending. And then the pink portion of that box is the part that is contributed into the capitated rate.

The white part of that box is what the savings that are estimated and taken off the top of that baseline. Similarly on the right side of that slide the total box, the box there at the top that as part blue and white that's a total space spending absent the demonstration.

The blue portion of that box is what's contributed to the rate setting process, the next step in the rate setting process.

So let's move on to the next slide. And now we're at the third step in the rate setting process. So here is where rates are being risk-adjusted by both Medicare and Medicaid.

This is where the rates account for differences in expected costs based on characteristics of the individual. So differences in health status, differences in different demographics of the population.

On the Medicare Advantage side CMS risk adjusts county Medicare Advantage rates at the enrollee level. Rates are also adjusted for coding intensity.

There's also a quality incentive withhold. So this is where CMS and the state withhold a percent of the capitated payment they would pay a plan for a member. But the plan can earn back if they meet quality targets.

And the quality metrics, there are certain number of quality metrics that are consistent across all the demonstrations and then each state has the opportunity to develop state specific quality metrics as well.

So the aim is to ensure that the cost savings are not at the expense of quality.

So with the demonstration the capitated rates that plans receive has 1% taken off the top in year one and then in years two and 2% and 3% respectively. That's the amount that the quality withhold.

In the first year of the demonstration the quality withhold is the measures are based on encounter reporting and process measures. So it's really making sure that the plans are reporting the right information and doing so consistently.

In the second and third years of the demonstration the way those quality withholds our structured is to reward plans based on their actual performance.

Next slide, so the Medicaid risk adjustment parameters, the Medicaid component of the rate is adjusted according to methodologies that are proposed by the state. So again this is another place where the rate setting process will vary state to state.

On the Medicare side it's the same process regardless of which state is participating in the demonstration. On the Medicaid side it will vary.

The approach that the state takes has to be approved by CMS. And what CMS is looking for in when they review the state's methods they want to make sure that the risk adjustment approach is incentivizing community alternatives to institutional placement that has clear operational roles and processes for assigning beneficiaries into a rate category that are compatible with an

individual's risk level or profile and are budget neutral across the whole program.

Next slide, so now we're at this stage of making the actual payment so how payment rates vary by plan.

For the Medicare component of the payment the base rates are developed at a county level using a standardized approach fee-for-service county rates and Medicare Advantage benchmarks.

Those rates don't vary from plan to plan. The same county baseline applies to all plans operating in a particular county.

Where the Medicare rates will vary is going to be based on the risk adjustment by enrollee. So the payment the CMS will pay on the Medicare side will vary from enrollee to enrollee based on their characteristics but not based on any kind of - there's no negotiation with the plan which would result in variation in the payments from plan to plan.

States have discretion again subject to CMS approval to develop the Medicaid component of the payment. And they could choose to develop rates on a county basis, a regional basis or a statewide basis and customize those risk adjustment methodologies.

Next slide, so when the payment is being made to the plan the Medicare and Medicaid funds are not co-mingled. So Medicare - CMS pays the Medicare piece in one flow of dollars actually for part A&B and then for part D is a separate flow of dollars. And then on the Medicaid side the state makes the payment to participating health plans for the Medicaid component of the rate.

Medicare and Medicaid do coordinate in rate setting and they like I said before they are going to share in the achievable demonstration savings.

So and I also mentioned earlier unlike with Medicare Advantage the plans that are participating in the dual demonstration are not submitting bids.

They basically take the rates that are being offered to them. There's very little negotiation once those - once the rates are set there's no negotiation in the process.

Next slide, I'm not going to go through all the details of the slide but basically what this slide describes is the ways the plans negotiate provider rates generally speaking.

So this is about once the plans have the per member per month payment for each enrollee how do they pay the providers?

On the Medicare side rates are usually negotiated as fee for service although there is more and more risk delegation happening across the states.

Where I am in California this is a dominant model where we see physician groups in particular are accepting risk on a capitated basis for a set of services for a given population.

We see that both on the Medicare and the Medicaid side in California.

On the community-based side it's important to understand how the plans want to pay for certain services that AAAs or other CBOs might make - might provide rather.

Knowing that there's a high opt out rate for the duals demo may change a provider's perspective on assuming risk in getting capitated payments.

The challenge here is because of the high opt out rate someone might be enrolled one month and opt out the next and you could lose a revenue stream if you're accepting risk.

So as a provider you really have to look at how the policies within the dual demo program will work and decide whether you want to be operating on a fee for service based approach where you provide the service you get paid versus a capitation based payment.

Next slide, so this is a list of the services, of the long-term services and supports. There are examples of where plans are going to be looking for support, for vendors or for providers. You know these services. You provide many if not all of these services already.

You know, it's really about identifying amongst the types of traditional services that plans are going to be looking to contract for which are the ones that you really want to be providing that you're going to do best at.

The key here is to understand the policies of the dual demo in your state because there will be additional reporting requirements and costs associated with the way the program is structured.

There's a real question about how many members might be assigned to you. As a provider there's no guarantee that you'll have a certain number of members to serve.

You'll want to know what level of service you'll be providing. You may have to be able to demonstrate providing services within negotiated time frames and you'll need to consider what staffing would look like to meet those requirements. These are all important questions to be asking as you think through participation in programs such as this.

The dual demo themselves most of them are well through the halfway mark of the demonstration. Some have already - some states have already indicated that they're going to extend the demonstration a little bit longer.

We don't know what will happen on the other side of the demonstration but we anticipate that these models of integration may evolve but will likely not go away. So thinking about the role that you want to play in this space is really important.

Next slide, these are some of the provider negotiation strategies. I'm not going to go through these in great detail. Again this is where, you know, I'm happy to share the slides with you for you to study later.

The key here is that it's important to be familiar with the population you're going to be serving in your own capability to address their - the requirements of the plan of the population that you'll be serving.

Next slide, so here are some of the unique issues to think about. Some of them we've already mentioned, one of them being the high opt out rates currently in the demonstration that creates some real variance in how people are assigned to plans. And it's creating a lot of issues related to beneficiary low enrollment rates.

So most demonstrations are going to - are starting off very slow in terms of enrollment. And it may be really challenging to know as a provider how to ramp up your staffing to serve the population.

So also understanding how that fits into your negotiation strategy is going to be important core adherence to providing health risk assessment.

Plans are really looking for strategies to improve the health risk assessment uptake. So the health risk assessment is a requirement of the demonstration where every new member is assessed to identify where their risk lies. And then they can use that information as part of the care planning process.

But there are some very hard to find members, enrollees and they have certain targets they're trying to hit for completion of their health risk assessment.

And this is an opportunity where you as community based organizations, you know your communities, you know your populations really well and you could be an asset to the plan in helping to find the hard to find members and help the plan in completing those health risk assessments. There's value in that to the plan because that is part of the quality incentives across the state that they are subject to.

They can earn back some of their, the quality withholds by achieving high rates of health risk assessment completion.

There's a lot of beneficiary confusion about their options. And states and plans are looking for ways to educate beneficiaries and show them the positive benefits of the demonstration.

This is another place where you as knowledgeable and trusted advocates of this population can be supportive in giving them information to help them make decisions. I think there's an opportunity there.

There's a lower level of medical risk than anticipated amongst those enrolling in the demonstration.

I think this is an important and complicating feature of what's happening. So people who are at higher risk seem to be opting out. People at lower risk are opting in which means there may not be as much business opportunity depending on the risk profile of the population enrolling.

And then there's star rating issues. So the Medicare Advantage plans that are part of this they're required to have a minimum of three star rating for the previous three years.

I know in California this was a complicating feature because we had one plan in particular that did - that received a low performing icon for a few years in a row. And it brought into question the viability of a demonstration ended in a particular county in California.

Some plans had to delay participation in the program because of these challenges and so something to be mindful of.

It also mentioned that, you know, the star ratings are really important thing for the plans and to the extent that US providers can be helping to support improving their star ratings, improving their quality ratings there is a real opportunity there as well.

Next slide, so just to bring the presentation to a close, you know, I'm certainly aware that the rate setting process was very complicated with regard to the dual demonstration.

And, you know, the intention with this presentation as quick as it is was really to just help bring some sunshine and transparency into the process so you'll understand what goes into the rate setting process. And it can help you in understanding when you're - when you sit down to develop your business strategy, your pricing the way that you want to negotiate a contract with the plan that you have some understanding of what they're up against in terms of how they're getting paid. I think that's really the key here.

And then on the last slide there are some - on the next slide there are - these are some resources. These are a little bit dated but they're actually I think still the most current data resources for thinking through the issues around the rate setting process. And so these are materials that you can refer to after this presentation.

And with that I am going to conclude my comments and I'll be happy to answer question at the end of the Webinar. Thank you.

Lauren Solkowski: Great, thank you so much Lisa. Okay so now I would like to introduce and welcome our second speaker, Sandy Adkins.

Sandy is the Vice President Institute for Change at the Partners in Care Foundation where she is in charge of home meds dissemination, consulting, evaluation and new initiative development.

Prior to joining Partners in Care Sandy served as Executive Director of Hospice of Pasadena at the USC Andrus Gerontology Center.

She directed the Center for Long-term Care Integration. This was a state funded effort to help counties integrate Medicare and Medicaid systems both medical and long-term care services for the age, blind and disabled population.

Thank you Sandy. So you're welcome to begin. And I'm going to switch these controls over to you. And I'll tell you when I've done that.

Sandy Atkins: Hello everybody. And for the big picture that Lisa just gave you I am going to take you way down into the weeds, what our experience is with pricing and a little bit of negotiating contracts with healthcare entities and how we approach it.

And Lauren when the time comes can you queue up the Excel spreadsheet too?

Lauren Solkowski: Yes. Just let me know and I'll pull it up.

Sandy Atkins: Okay.

Lauren Solkowski: And you should have control.

Sandy Atkins: Okay it hasn't done anything on my screen to indicate that.

Lauren Solkowski: Let me see.

Sandy Atkins: It doesn't seem to respond why don't you just keep control and I'll tell you what to do. And maybe when we get to the spreadsheet it would be really great if - that one would be a little hard for me to tell you what to do with.

Lauren Solkowski: Okay the spreadsheet's very simple to switch over but...

Sandy Atkins: Yes.

Lauren Solkowski: ...so I'll go to the next slide for you.

Sandy Atkins: Okay so I think the next slide is going to be just a little introduction to where our path has led us. Have you switched? Maybe my connection has gone dead?

Lauren Solkowski: Yes. I'm - I have gone through a couple of slides. Do not see them changing?

Sandy Atkins: I don't see it.

Lauren Solkowski: Let's see.

Lisa Shugarman: Yes, I'm not seeing the slides advance either on my end.

Sandy Atkins: Okay. So it's not me. Yeah. I'm such a - I have to help with a local county supervisor's office in dealing with - oh there we go. So I'm kind of in transit here. So the next...

Lauren Solkowski: Okay. So now okay so what slide, Slide 2?

Sandy Atkins: Next one. And just a lot of our experience with our contracting has been made possible through funding from John A. Hartford Foundation and the (Arts) Foundation. We just wanted to thank them because we're kind of out there and they let us do that.

Next, there we go.

So just, you know, lest you think we're a little rinky-dink you - we're a small organization about 14 million total but we've got 25 contracts with 13 different healthcare entities.

Now we do have the waiver continuation which was required was six health plans. But we also have a waiver like program for people who are not quite eligible and for the waiting list. And those are discretionary contracts.

We do - you - I'm hoping you're a little familiar with Home Meds. We've named a program Home Meds Plus where we go into the home and do an assessment and some short-term care coordination.

We have contracts with a couple physician groups, Medicaid plan, Medicare Advantage plan, exchange plans.

So when you talk about dual eligibles it's not the only place where we can operate and make a difference and have these the contracting partnerships. So I just don't want you to think it's only about dual plans or only about Medicaid.

Beyond our CMS CCTP where we have three sites still going we have care transition contracts with the Medicaid plan and some Medicare Advantage plans, hospitals , a couple hospitals -- that kind of thing.

And we do evidence-based self-management. And there we've got a fairly significant public contract with a health plan doing their commercial and their public employees which is CalPERS here and also the Medicare Advantage.

And this contracting has so far been good for us because we've gone from sort of a struggling nonprofit breakeven to a kind of positive bottom line of about $1 million. We'll see what happens once CCTP ends because it's been a great teacher there.

Next slide, so here are a couple of let's say lessons learned in our experience. And I'm the one that usually comes up with pricing. So I'm very hands-on in this.

So what their perspective on what they're comparing us to is very often not correct.

For example when it comes to care transitions or in-home, a home safety assessment they think home health. And home health is a model, I call it a hit-and-run model where I've seen it - I've been in a home and somebody visited my relatives in a home health. And they kind of tap on the knee and do the blood pressure and that's about it.

And they do the oasis in one visit and all the rest of them are really, really quick generally.

And so we need to let them know that's not what we're doing. And so it's very important to message what's included in what we do. It's, you know, we're spending a couple hours in the house. We're looking around, we're looking at their meds so that's the kind of thing you need to be able to just describe.

What we've done basically is offer pricing at the high end of what we would consider a reasonable rate. And then they can talk us down a little bit without

breaking the bank or having us be donating as a small nonprofit donating to a big health plan.

If you can, know your return on investments. And I've put together a table of all the different services and programs that has the ROI or, you know, the value in different terms, usually in utilization.

And if you have your own data that's great. If you could CCTP and collect the data and you can talk about what you do that's fabulous.

If you don't, you know, say you want to spread evidence-based programs then you go to take (Lori)'s studies and matter of balance studies but somehow you kind of need to know what's the value that they're likely to get and because the rates are never good enough.

And Lisa did a fabulous job of telling you about them but I don't know of anybody who would say oh yes that's a really great rate for us.

I remember when it was just Medicare, just Medicaid. I've got to put my windows up. There's helicopters - I'm in a car.

And so they - I'm just going to skip that. I'm taking too long.

The competition that we see, actually we have one contract where we have two sources of competition. One is the national take - the large national case management companies. And the other is building it themselves and hiring staff to do these things.

And that - the do-it-yourself builder buy versus buy is more often the case so you have to in your pricing you do have to keep yourself below the salaries that they have to be paying internally.

Luckily they usually have labor unions and they have real high scale that's competitive with hospitals and folks like that. So you may be able to continue to do that and still make some money.

And the - our experience is the first - maybe first and second years of a contract are basically a pilot.

It's a lot of work for them and a lot of work for you. But and the volume will almost certainly be low which means if you priced it wrong it's going to be - the pain is going to be short-lived.

You've got to have a board that's going to let you take the risk of offering a service in the absence of a lot of information about how it's going to roll out and so to be wrong about it and then have a short enough contract that you're not going to be too far down the river and digging your grave.

And so the fact that you're learning and building a resume is worth losing money in the short run. So we've taken those risks. We've decided that it's okay and that they know that we don't think we're covering our costs and we're going to renegotiate it at some point.

Next slide, so in a nitty-gritty way I don't know if those of you on the phone have a lot of experience with budgeting and coming up with prices, so this may be too elementary. And if it is I apologize but I just wanted to make sure that we're covering all of the real costs of the interventions when we look at what our price is going to be.

So the first is direct variable cost. So that's essentially anything that changes based on the anticipated number of clients or patients or participants.

To some extent staff could be in this or it could be considered a fixed cost. I consider it a variable cost because it kind of helps me determine what my staffing needs to be, how many FTEs we're going to need to hire. And then you can hire some part-timers and you can hire some short-term people, some salaried people.

Then you have your direct fixed costs which are costs you would not incur if you were not having the program, the project.

And you're going to - but they're generally going to be an allocation of salaried people like managers, supervisors. And then there's also going to be like an IT system that's dedicated to the line of business. And I'll go through that later.

And you also use this for your breakeven analysis approach.

Indirect costs I'm sure you all know that we call overhead or whatever which is essentially what it costs for you to be an organization.

And these are still legitimate costs. If your finance department is in there they're going to have more work. Your HR department is going to have more work so all of those things really should be included.

I've seen other people say don't include your indirect. Certainly you can negotiate on your indirects. And if you don't cover your indirects you probably, you know, if you've done CCTP you know what it means to not be

covering your indirect at least by naming them. You know, we've covered our indirectors by increasing our salaries and things like that.

Margin, you really want to have a margin because that's how you continue to build and hire, you know, hire new people before you have quite enough business to be able to afford them.

And then we're having to build in network management costs. I'm thinking of them as MSO, Management Services Organization which is what the physician group started hiring when they got into the business of contracting with managed care.

Next slide, so what are these variables direct costs? And the first the most important one usually in the kinds of things we do especially in I'm talking about our care management, kind of our waiver in home services here.

We also have a line that's evidence-based programs. And we can talk about that at another time but right now I'm focusing on that.

So the first thing we do is a time study. So we have to know how long it takes us to deliver the services. And now we have a network so I had to involve other organizations and wow was that variable.

We had one network member where their coach was saying they were spending 12 hours doing something that everybody else had took six hours.

So we're obviously not going to budget it at the level of that 12 hour person. We're going to tell them you guys need to figure out what's going on there.

We did tend to budget our salaries on the high side but you need to know what your actual salaries are going to be because it's again you're going to probably have to negotiate at some point.

We needed to consider inefficiencies that were built into our old ways of doing business especially for example writing everything down by hand on a piece of paper in the home and then transcribing it.

When we did a time study our case managers were spending two hours putting all the data in the IT system even though they had a laptop with a mobile connection.

So we're working on getting them to do as much as possible in the home rather than doing everything back at the office so that we can affect some efficiencies.

Because if you've priced at what it's taking you now the only way you're going to make enough money is by decreasing the amount of time it takes.

We have contracts that require an LCSW to sign off on each assessment which means they have to read it. We budgeted 15 minutes. It turns out this person's spending an hour or more participating in all kinds of care case conferences and that.

So philosophically you need to determine what is the role of the network office and the quality of the services delivered by the network members and budget that into either the network member should be doing their own oversight and it's not up to us to do that or it's up to the network office to do that, the MSO and/or both. And then you have to budget it twice which starts to make this kind of expensive.

There are of course program variations in your contracts that will lead to time and cost variations.

So we have for example a service plan where all you do is hand it over to the health plan case managers versus other contracts where we're doing all of the service arrangements.

And then we have mostly short-term contracts. Even with the dual plans they don't seem to want to pay us except under the waiver to do long-term case management. They want to do that themselves which just it's a very interesting phenomena for us because we're used to being the case manager.

And now we're an extension of somebody else who's the case manager we're just we call eyes and ears in the home which is a totally different relationship with clients and that kind of leads us to some cultural expectations in our own staff just FYI an experience thing there.

And then they often because they want it short term that means there's a lot of frontloading of costs. If you've done the waiver, you know, the reason that the waiver may give you enough money to continue is because I call it till death do us part case management.

And what you spend in the first three months you make up in the next three years. Whereas if they only want you to do something for one to three months you've got to make sure you're capturing all those costs in those three months. So you have to know what the contract provisions are about.

And of course population makes a difference. We're used to frail Medicaid eligible nursing home eligible people. And all of a sudden we're dealing with

people in their 40s, 50s and 60s with chronic diseases that are not poor. They're at home and there is no such thing as a home delivered meal that they don't have to pay for.

So these things make differences also in how you price things and what your staff has to do and that sort of thing.

We of course in our direct variable cost we include mileage and parking. We picked a high average distance for the commute, especially in California because miles don't make as much difference as time. So we just built that into the price and we don't charge mileage separately.

We do - we build everything on our home meds and our pharmacist reviews so that has to be included, materials and handouts so we - we're doing advanced directives with people. So we need to have the cost of an advance directive and the brochure on how to do that. And there will be many unanticipated expenses.

Next slide, this is just a list of the kinds of things we included in the time study. I'm not going to belabor it but basically you just break down everything into tiny little steps.

I took a class once in how do you train a cognitively intellectually disabled person to do something? You have to break it down into micro-steps. And that's where - what we did here.

Next slide, okay our fixed direct costs are program related but they don't particularly vary by the number of clients or patients except, you know, when you reach a breaking point threshold.

So we included in that our - actually the first time we did it we modeled it based on the program that we had allocated costs most realistically to.

You know, as nonprofits, you know, a foundation's going to tell you can only put 10% in indirect which means you never have programs that have a good allocation of your actual cost.

So we tried to find the program that had the best allocation of everything from rents to insurance to all of those things because we really didn't have very much experience with this.

You may have to start from ground zero and my little pricing model has a lot of those in it. And I think we're free to share that.

Of course you want oversight and supervision because you're not going to just say oh go do this and not have any relationship especially since this is a new business line and we have to really shine here.

So but on the other hand we can't afford a full-time project manager when we're getting five cases a month. It just doesn't pencil out that way.

We include admin staff, making copies, making appointments -- things like that. We put some students stipends in there. If there's an IP system specific to the program so for CCTP we used look back so we would put that in the budget, program supplies, copying and things like cell phone mobile hotspot where you have a subscription per person. It's not per a patient.

Next slide, indirect costs I pretty much covered this. You know, they're real costs. You can negotiate them down because obviously you have a budget that

has more than just these pilots paying the bills but those you might just as well start with this included in your pricing.

Next slide, and the new thing for us is wow how much it costs to set up these contracts.

So our biggest contract literally the legal $40,000. We've had to do sales. We've figured we spent 2000 hours in sales, marketing, contract negotiations and all of that kind of stuff as our executive staff time.

Credentialing the network members we've got to collect all the insurance information. We're actually supposed to do network security audits so that's a real cost for us as the network office.

We also have - we have to sign off on all the assessments so we've had to include our LTSW. She has found quality to be an issue so she's spending more time than anticipated as I said.

We had to add insurance. And a lot of the network members especially for evidence-based programs. They don't have the kind of insurance that's required by the health plans which means essentially we are absorbing the uncovered insurance of our network partners if we allow them to become part of the network without having like $5 million umbrella policies. So we have bolstered our own insurance against that risk.

Of course it really costs us to do the billing and then receive the invoices from our network members. But we've had to become accredited so that we could do the contracting. So that was about 33,000 NCQA plus another 33 for consultant to get us there.

We had to get a Medicare and Medicaid billing. We had the Medicaid but we had to get a Medicare billing number. We're getting the software. We had to set up a contact center. And we've had a lot of customer relations -- weekly meetings and all that kind of stuff.

So there's a lot of real costs beyond the delivery of services to operating as a network.

Next slide, so maybe it's a good time to look at the Excel spreadsheet.

Lauren Solkowski: All right Sandy I'm going to pull that up. Hold on I've got to clear my screen. And then let me make you the controller.

Sandy Atkins: Okay.

Lauren Solkowski: Oh and now...

Sandy Atkins: Oh, I'm the presenter? Can you give me the mouse control rather than making me the presenter or is it...

Lauren Solkowski: Yes...

Sandy Atkins: ...all or nothing?

((Crosstalk))

Lauren Solkowski: No, no I can. Let's see...

Sandy Atkins: Because I don't have it queued up. I could but...

Lauren Solkowski: Okay let me take it back and then I'm going to make - there.

Sandy Atkins: So the idea is that we have a basic model where we enter information by program by contract, change our assumptions if necessary and then come up with the pricing. Let me see if that's going to work.

Is a getting big enough for you guys to see?

Lauren Solkowski: It looks big to me. Yes.

Sandy Atkins: Okay. So I think this is so interesting.

Okay so the first thing on this model pricing model the green is where you enter data.

So for example whatever you pay your social workers you're going to put in that number. And again it depends on your contract. If you're required to have MSWs it's going to be one salary level. If you can have bachelors level or coaches or community health workers it's going to be something else.

So you would put in all the positions that you need here. And you can do it just by adding, you know, inserting lines and then copying formulas across and things like that.

So then I just divided it by 2080 to get the hourly cost and I entered in our benefit rate. We enter - I had, you know, how much are we spending on handouts so I put those in.

The first month we're doing the advanced directive and some brochures. The second one people are asking questions and we print off some stuff from the

net. Whatever the mileage rate you're going to enter there and then whatever your margin is you would enter there.

So then moving down here's where I have the assumptions. So this is our sort of short-term case management model. So that in month one we do an initial screening and assessment by a social worker. So we figured four hours including time in transit, time in the home and then creating the care plan out of the assessment, doing case conferencing and communication was another two hours.

And then we said that, you know, with this model we're having a case aid, more of a bachelors level person do the establishing services with the vendors you don't - you know, because it's not as high a level.

So the philosophy is everybody operate at the top of their skill set or license or whatever. So try to keep people doing the things that they need their qualifications to do and no more than that or no less that really, you know, no typing and stuff like that if you have to.

And, you know, again the efficiency I talked about we want to make sure that they're not doing a lot of data entry. So then we entered the for the subsequent months the home visit is shorter because they don't have to do the full assessment. They just touch - doing a touch base. And there's less communication, less documentation for the subsequent visits.

For our care transitions we used a high number of the total amount of time it takes to do it. And then we calculated the average round-trip for our interventions.

So all of those things feed into formulas at the top so you'll see that all of these things if you can see in the bar up here they all relate back to the lines for the salary and the lines where we put the assumptions of how much time it takes to do things.

So if, you know, for example if I change the salary here that would be great salary wouldn't it, $50 a year. And then you can see that it just changes all of the numbers all the way through so all of those are calculated.

You could use it just exactly as it is and just change your assumptions or you can use this as a basis for, you know, how do I do a model, here's one way to do it.

This last time this is our second year of one of our contracts. And we were griping to them about how we don't - there's not enough volume for us to bring the price down for them.

So they said, "Well how about if we give you 500 cases or more?" And now this is they're saying for a statewide contract where, you know, even a large county like San Diego might have 28 cases in a year so there's no possibility of stepping up.

So what we did is say okay the only place where there's a volume discount is in what we're doing as the NSO. So we brought the MSO fee down because we can't take away from the network partners who are going out to the homes.

And we based all of the direct costs off of our own experience because we are a member of the network as well as the network office just because we happen to be the ones who had contacts to make the contracts and just sort of inherited the role.

So then also in this model what I did was enable us to enter a monthly volume assumption and then with that calculate what our FTEs would have to be.

So, you know, there's in a month 173 hours is one FTE. So if I put in here that we're actually going to get 35 cases a month instead of 20 cases a month then it recalculated here.

So now we have 1.2 FTEs and a half time case aid. So that's just how you kind of figure out what you're staffing is going to look like. And that helps you figure out how much supervision time. It's just going to be a big impact on our supervisors.

And then down here we've got what's in our other assumptions so again if you look - sorry if I'm skipping around. I get carsick when people do this and I have to watch the screen.

But included in the rates that the network member is getting for a direct service provision there's an administrative rate which is those direct fixed costs and allocation of 15%. Then we had an allocation of 15% for indirect.

And so I - that comes down from this little model down here where we say what we need is - and this is 7% of the cost of the intervention here.

And it - you have to evolve this because like what I was saying before most of us haven't really done a good job of allocating real expenses exactly where the effort goes. So this will have to evolve over time. This was just, you know, our initial experience and we are adjusting this.

And then the indirect so it should have your rent, insurance, your communication department, finance staff, IT staff, contract, legal -- all that kind of stuff.

And so those all went into the pricing for the network member and then the MSO whoops, sorry.

The MSO was, you know, we have to train all the network members. We're providing or will be providing software for all of them to use, you know, when they're doing the interventions under contract.

We have to do an IT security audit and we have to provide IT support for the software. We're doing the billing. We have to do that sign off that I talked about.

We're providing a pharmacist for home meds or accreditation the contracting and legal expense. We have to do outside patient satisfaction surveys that we have to pay for. And then because this is the only part that we get of course that we always have to have our indirect so that goes into the rate.

So that's our basic pricing model. Any time you, you know, as I said oh, well this really isn't as much as I said it was. It's only 4%. Then it changed the MSO rates to 29% and then it comes back and it changes the pricing.

So that is my demo of the tool. And I think I had a couple other slides. I don't know if I'm - I probably covered them already but...

Lauren Solkowski: Let me go back.

Sandy Atkins: And so we've, you know, we've covered that so next slide.

And just one thing that we learned don't ever provide final pricing until you see that contract. Because we had - after we had given them a price we had to add insurance. We had to do an IT audit. We had to add license staff. We had to do the outside patient satisfaction survey so we ate all of that first year.

And also know how your pricing would respond to volume changes and understand how that's going to affect your pricing because it's going to be low at first.

And usually they're very often willing to negotiate, you know, a time-limited volume limited and then go from there.

Next slide, and what we really want is to aim toward being able to get into shared saving models and per member per month capitation.

But so far we don't know enough about the population. The health plans really haven't been transparent about the targeting criteria that they're using.

We're getting to know more about how much work it takes especially for the communication with the health plan. But so I'm hoping that by next year we can start getting into some shared savings or PM PM arrangements. But for now we just have case rates.

And we need to include and all our contracts that they're going to give us information about the return on investment and our outcomes so that we can continue to build this model because if we had the volume we could bring the cost down. You know, and it's one of those sort of like the commuter trains where it costs $25 a day so nobody rides. So they raise the price because they don't have the ridership.

Someplace in here we've got to get the volume so that we can get the prices down reasonable and try to keep them from hiring the national companies and building it themselves.

So that's about it I think. That's it.

Lauren Solkowski: Great. Thank you so much Sandy.

Okay so I think now we have some time left over. We'll open it up for some questions.

So operator if you could now provide instructions for asking a question through the phone.

Coordinator: Absolutely. We will now begin the question and answer session. To ask a question over the phone lines please press Star 1, un-mute your phone and record your name at the prompt.

To withdraw your question press Star 2. One moment please for incoming questions.

Lauren Solkowski: Great, thank you. So let me check the chat and see what questions that came in. Here is one question.

Sandy someone had asked if the cost worksheet that you were just using is that based off of the SCAN Foundation model?

Sandy Atkins: No.

Lauren Solkowski: Okay. So that was something that you all created?

Sandy Atkins: Yes.

Lauren Solkowski: Okay. And...

Sandy Atkins: Yes I'm a budget geek. I just love doing these things. I wouldn't give up my fun for - to not reinvent the wheel. I'm kidding.

Lauren Solkowski: Okay. And I know no one has asked this specifically but I know on other Webinars that we've done on this that they've - that we've gotten requests for that spreadsheet.

Sandy Atkins: Yes.

Lauren Solkowski: I don't remember.

Sandy Atkins: Yes I think I cleaned it up enough that it's shareable now and but, you know, it's not our actual pricing or actual cost or anything so I think they can...

Lauren Solkowski: Okay.

((Crosstalk))

Sandy Atkins: ...that, you know maybe somebody could check the formulas to make sure they're absolutely correct.

Lauren Solkowski: Sure, okay great.

Okay let me see, I'm not showing other questions in chat. Operator do we have any come in through the phone?

Coordinator: No. We don't have any questions on the phone lines.

Lauren Solkowski: Okay. I'll give it another minute or two just to see if anything else comes in before we hang up.

And again, if anyone does want access or wants these slides today you, you know, before that they're posted just feel free to email me and I'm happy to send you a copy of the slides.

So you almost sifted a very excellent presentation but nobody has any questions.

((Crosstalk))

Sandy Atkins: Just (unintelligible) sloppy after lunch.

Lauren Solkowski: Right. Okay operator I'll check one more time.

Coordinator: Okay. Once again if anyone has any questions please press Star 1 and record your name at the prompt.

Lauren Solkowski: Okay. Well I won't torture us any longer but I guess everyone is - but, you know, if something does pop in once we hang up please feel free to email it to me and I will definitely follow up with Sandy or Lisa to get it your questions answered.

Thank you again to Lisa and Sandy for joining us today. And again email me if you would like a copy of the slides or you have other questions. Okay thank you everyone.

Lisa Shugarman: Thank you.

Lauren Solkowski: Have a great day.

Sandy Atkins: Thanks for having me. Bye.

Coordinator: Thank you all for your participation in today's conference. You may now disconnect.

END