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White paper

Addressing the six key challenges to starting a provider-owned ISNP

An eye-opening realization for a nursing facility executive came during the Centers for Medicare & Medicaid Services (CMS) audit process. He admitted that his team went into its first (of three) audits with a cavalier attitude, not expecting much more than an informal review. Instead, CMS delivered a sobering reminder that, as a distributer of taxpayer dollars, the owner of the ISNP plan — not its partner — had the ultimate responsibility for residents' lives. The auditors also made it clear that the owner of the ISNP plan was expected to be intimately aware of, and involved in, managing clinical and financial operations, and to be prepared to answer the auditors' questions about compliance with CMS rules.

Introduction

The health care landscape is evolving rapidly, and senior care is no exception. As the United States population continues to age, Medicare Advantage health plans are proliferating. A record 3,148 Medicare Advantage plans are available nationwide this year, up 15% from last year.[1] Today, one in three Medicare beneficiaries are enrolled in these plans, with that share projected to rise to nearly half by the end of the decade.[2]

At the same time, the number of Institutional Special Needs Plans (ISNPs), a type of Medicare Advantage plan for individuals requiring an institutional level of care, is also increasing significantly. This year, 99,114 Medicare beneficiaries are enrolled in 150 ISNPs,[3] more than double the 69 plans in 2016.[4]

The growth in ISNPs is being driven, in part, by senior housing operators. Looking to offset revenue losses from Medicaid, Medicare Advantage and accountable care organizations, and achieve greater financial and operational control, some skilled nursing facility owners are taking on the dual role of provider and insurer. Between 2016 and 2018, the number of provider-sponsored ISNPs doubled, and enrollment more than doubled.[5]

ISNPs defined

ISNPs, a type of Medicare Advantage plan, restrict enrollment to Medicare beneficiaries who require or are expected to need the level of services provided by long-term care facilities such as a skilled nursing facility for 90 days or longer.

The ISNP challenge

Provider-owned ISNPs face many challenges when assuming full risk. Wearing both a provider and payer hat involves significant clinical, financial and compliance responsibilities. First and foremost, they must adjust to the rapid shift in the Medicare environment from fee-for-service to a value-based care model, with its emphasis on cost-efficient, quality outcomes.

Some nursing homes are entering the market by forming partnerships with venture capital investors or private equity companies who fund the plans and manage the insurance part of the business. As the Centers for Medicare and Medicaid Services (CMS) has made clear, however, the owner of the ISNP plan — not its back-office insurance partner — is fully accountable for all aspects of plan management and operations.

This paper explores — and offers solutions to — six key challenges that providers may struggle with in launching an ISNP:

- Demonstrating quality
- Coding accurately
- Developing models of care
- Reorienting physician relationships
- Adhering to marketing guidelines
- Complying with regulations

1. CHALLENGE: DEMONSTRATING QUALITY

Like other Medicare Advantage plans, ISNPs are responsible for demonstrating their quality credentials on an ongoing basis. CMS annually publishes its Star ratings for Medicare Advantage plans based on plan quality and beneficiary surveys. The ratings system is intended to help Medicare beneficiaries and their families compare performance among Medicare Advantage plans they are considering.

The ratings range from five (highest) to one (lowest). Plans scoring four or higher receive a 5% bonus from CMS. The rating program is complex and consistently earning four stars or higher is a steep challenge.

Solution

Attaining a high rating requires a combination of:

- Enterprise-wide dedication to providing a high-level customer experience
- Commitment to continuous quality improvement
- Robust data analytics platform that collects and assesses patient medical, behavioral and pharmaceutical claims data from the plan's electronic medical records system to identify care gaps and appropriate interventions

CMS continually reassess its methodology and may add new measures or retire old measures on an annual basis. A dedicated quality team can help monitor these changes to ensure the plan is on track to achieving a high-performing score.

More stars = more $

The Star rating dictates the level of quality bonus and the level of rebates. Plans with four stars or higher receive a 5% bonus on the Medicare Advantage benchmark and receive higher percentage rebate dollars. For example, a plan could potentially receive $30 to $60 more per enrollee per month for a 4-star or higher plan.

What CMS means by "quality"

The overall Star rating measures quality in six areas:

- **Staying healthy:** Whether members had access to preventive services such as various screening tests, vaccines and other checkups.
- **Managing chronic conditions:** How often members received recommended tests and treatments to manage their conditions.
- **Member experience:** How satisfied members are with the health plan.
- **Customer service:** How well the plan handles member calls and questions.
- **Member complaints and changes in the health plan's performance:** How often members had problems with the plan, and whether the plan's performance improved over time.
- **Drug safety and pricing:** How often members are prescribed drugs that are clinically safe and recommended, and how accurate drug pricing information is.

According to CMS, most areas of the United States have a Medicare Advantage plan and Part D coverage with a rating of four stars or higher.[6]

To date, however, very few provider-owned ISNP plans have achieved that threshold.[7] Low-performing plans risk losing out on significant revenues (potentially as much as hundreds of thousands of dollars) and restrictions on enrolling new customers. The potential final outcome for low, unimproved quality is full termination of the plan. Low quality ratings may also have negative business consequences: the stock prices of two large health plans fell following cuts in their Medicare Advantage plan ratings.[8]

2. CHALLENGE: CODING ACCURATELY

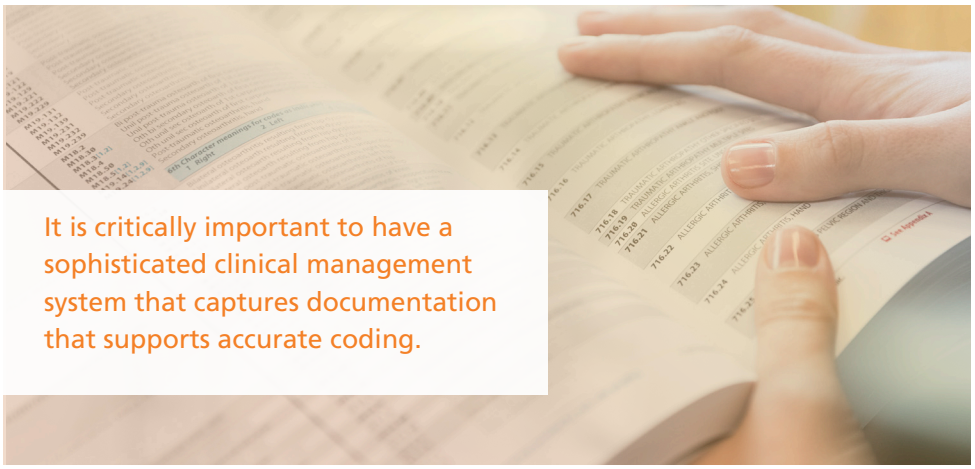
Medicare Advantage plans are reimbursed, to a greater or lesser extent, based on the level of disease burden present in the members who enroll and remain enrolled the following year. Plans are responsible for submitting accurate ICD-10 codes to CMS for every member. Thus, receiving the correct payment depends on precise coding.

Documenting diagnoses of nursing home residents, many of whom have multiple chronic conditions, is complex and time-consuming. Of course, failing to capture all of a member's chronic conditions may result not only in revenue losses, but also in gaps in the member's care plan, leading to suboptimal medical interventions and outcomes.

Solution

Hiring and training nurse practitioners and advanced practice clinicians with documentation and coding expertise in geriatric medicine is also key.

The key to coding accuracy is having a highly efficient support system behind the clinicians. That includes a team that conducts chart audits, monitors and ensures that every chronic condition is properly documented and submitted, and coaches and oversees the nurse practitioners. To avoid coding errors, ongoing education of the clinical staff is critical because codes are continually updated, modified and added.



It is critically important to have a sophisticated clinical management system that captures documentation that supports accurate coding.

What not to do when coding

Suppose a clinician regularly monitors the blood sugar levels of a nursing home member with diabetes and documents her medications and adherence to medications. But the clinician doesn't code and document the member's peripheral artery disease (which is commonly associated with diabetes). Without adequate blood flow to her feet, the member may develop ulcers, putting her at risk for infection, gangrene and amputation.

If documented properly, the member's care plan should have included ongoing monitoring of her mobility, fall precaution planning, checking her pedal pulse, ensuring that her feet are elevated to enhance blood flow to her legs, engaging in physical therapy and determining if heel protectors are needed. Without documentation of the comorbid condition, these interventions may be omitted from the care plan, causing the member's condition to deteriorate.

By omitting the diabetic peripheral artery disease, the plan is underfunded for the care provided to the member. The difference between the code for diabetes and the code for diabetes with peripheral vascular disease may be substantial. And, since plans typically pass a portion of their reimbursement to the nursing home for the services it renders, ultimately the nursing home would receive less money than it should have. In short, the nursing home would be penalized for the plan's inadequate coding and documentation practices.

3. CHALLENGE: MAINTAINING MODEL OF CARE

Unique to ISNPs (and other types of Medicare Advantage Special Needs Plans) is the requirement to develop, submit and obtain CMS approval for a "model of care." Preparing and staying committed to the model requires a significant commitment of time and resources.

The model of care provides the basic framework by which the plan promotes quality, coordinates care and meets beneficiaries' needs. It "is a vital quality improvement tool and integral component for ensuring that the unique needs of each enrollee are identified by the SNP and addressed through the plan's care management practices," according to CMS.[9]

> "Until you are thoroughly vested in the CMS process as an actual Medicare managed care provider, you don't have a clue what it all means."
>
> — Nursing facility executive

The model of care consists of the following elements:

- Description of the ISNP population
- Care coordination
- Provider network
- Quality measurement and performance improvement

Solution

The model includes details on a wide variety of topics, including how medical care will be delivered to the residents, how to staff the nursing home, how many nurses will be assigned, how will the staff interface with the physicians, how a care plan will be developed for each resident and how to ensure ongoing compliance with CMS regulations.

It is important to note that a resident's care plan is not the same as the facility care plan. CMS and National Committee for Quality Assurance auditors emphasize the role of the special needs plan in care coordination and require an Interdisciplinary Care Plan for members.

The audit process is comprehensive. Every three years — and even annually if deficiencies are identified — face-to-face audits of health plans are conducted in which medical records are examined and auditors look to ensure that plans are adhering to the model of care they submitted to CMS.

The model of care should focus on relationships with key stakeholders in the skilled nursing facility (staff, primary care physician, administration), enhanced communication with members and their families about disease trajectory and the risks and benefits of interventions, and buy-in to a model centered on treatment in the right place at the right time. The care model should also utilize tools that enable staff to proactively identify deterioration in residents' conditions.

At the heart of the model of care is a commitment to using clinical resources efficiently and making the effort available to members when they are in need.

4. CHALLENGE: REORIENTING PHYSICIAN RELATIONSHIPS

Managing the clinical and financial risks of providing care is a major challenge for provider-owned ISNPs. They may assume that they know what levers to pull to encourage the physicians to accept the plan's care model — a key driver of plan success. After all, the plan may figure, these physicians are already treating its members in its skilled nursing home. But orienting physicians, who are accustomed to practicing in a fee-for-service environment, to a value-based care model may not be as easy as imagined.

In a fee-for-service model, the focus is typically on one condition per visit, creating a fractured approach that doesn't consider the whole person or the comorbidities in total. For many providers, adjusting to a value-based model, with its emphasis on evidence-based medicine, quality improvement and population health strategies, may be a significant cultural shift.

Solution

The move to value-based care requires careful planning and a rigorous examination of market forces. Provider-owned ISNPs should research market dynamics, understand financial impacts, conceive a thoughtful physician network strategy and define the population needs of their service area. Building risk management capabilities, and the right rewards, into their business model is also important.

Plans may need to encourage the physicians to work more collaboratively with other clinicians, become more deeply involved with patients and their families in care decisions, write more detailed notes about patients, visit patients more frequently, and be more circumspect about sending patients to the emergency room in situations where a less intensive level of care may be warranted. To facilitate that change in outlook and drive greater physician engagement, plans should consider investing significant resources in leadership training and education for physicians and offering financial or other incentives.

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5. Challenge: Following marketing guidelines

CMS marketing guidelines are complex and a potential pitfall for unwary provider-owned ISNPs. *The Medicare Communications and Marketing Guidelines*, running approximately 80 pages, contain wide-ranging, highly detailed rules on marketing tactics, solicitation, steerage, telephone contact, sales brochures, websites, provider oversight and call centers. Their intent is clear: to protect vulnerable Medicare beneficiaries.

Consider, for example, the level of minutiae set forth in the guidelines for marketing and sales events:

- Plans must submit scripts and presentations to CMS prior to use, including those to be used by brokers.
- Sign-in sheets must clearly be labeled as optional.
- Health screenings that may be perceived as, or used for, "cherry picking" are prohibited.
- Attendees can't be required to provide contact information as a prerequisite for attending an event.

Solution

Provider-owned ISNPs will likely need the assistance of compliance or legal experts to interpret the guidelines. Consider, for example, the intricacies of just one guideline — Rule 60.4.1, which applies solely to ISNP plans. It states that if a nursing home resident does not request an appointment, any visit by an agent or broker is considered unsolicited door-to-door marketing, which is a violation.

The rule also notes that since ISNP long-term care facilities and staff can be viewed as both provider and plan, ISNPs "should put the necessary boundaries in place between clinical and sales staff to mitigate conflicts of interest."[10] Plans should carefully draw those boundaries, particularly since the nursing home holds protected health information about patients whom the plan could potentially market to.

A close call

Staffers in a skilled nursing facility helped several residents replace their prescription drug plan with another plan, thereby inadvertently terminating them from their Medicare Advantage plan. Upon termination, the residents' coverage automatically reverted to Original Medicare (Part A and B) with deductibles, coinsurance and other costs. Although the change in plans was perfectly innocent, it could have been interpreted as steerage in violation of CMS guidelines. Fortunately, the health plan and nursing facility were able to resolve the issue and restore the residents to the Medicare Advantage plan before CMS took punitive action.

6. CHALLENGE: COMPLYING WITH REGULATIONS

Becoming a health plan introduces significant regulatory complexity. ISNPs, like other plans, are subject not only to CMS rules but also to their state's department of health and department of insurance regulations.

Potential sanctions include notices of noncompliance, warning letters, corrective action plans, fines, suspension of marketing, enrollment and payment, and even Medicare contract termination.

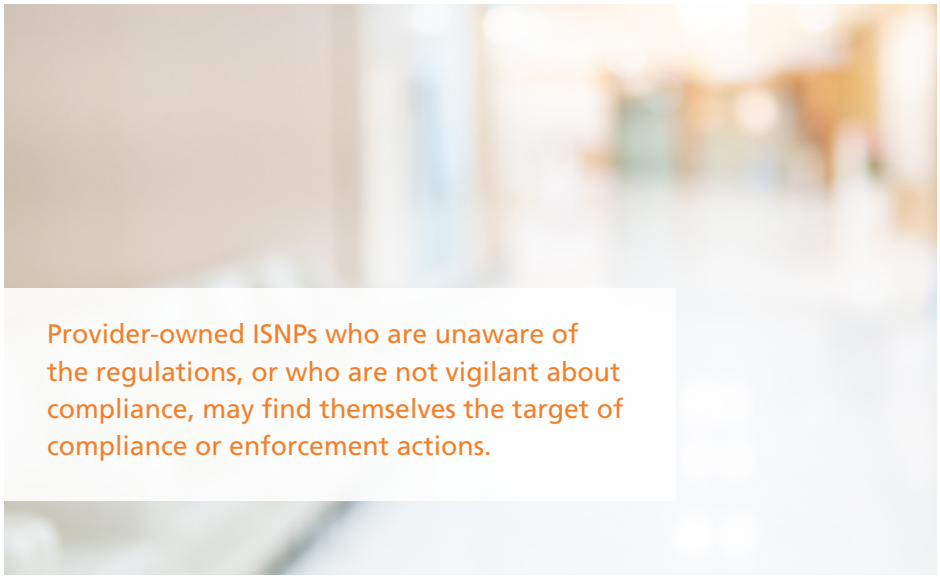
CMS has the authority to take enforcement actions when it determines that a Medicare plan sponsor:

- Substantially fails to comply with program or contract requirements
- Implements its CMS contract in a manner that is inconsistent with the efficient administration of Medicare Part C and Part D program requirements
- No longer substantially meets applicable conditions of Part C and D

Solution

With so many facets of the plan subject to regulation — model of care, provider networks, clinical operations, billing, marketing and sales, to name just a few — hiring a single compliance manager is likely to be insufficient. A better strategy is to hire several compliance officers, each with an expertise in a distinct discipline, such as legal, billing, and so forth.

As the plan, the provider-owned ISNP — not its joint venture partner — is responsible for oversight of all operations including compliance. Compliance staff should be familiar with the CMS requirement that Medicare Advantage plans implement and maintain an effective compliance program including compliance training.



Provider-owned ISNPs who are unaware of the regulations, or who are not vigilant about compliance, may find themselves the target of compliance or enforcement actions.

Fines add up

Following a CMS audit, a large health plan was fined more than $3 million for systemic failure to comply with Medicare Advantage requirements, resulting in enrollees experiencing delays or denials in receiving covered benefits.[11]

CMS notified a large health plan that it faced a fine in excess of $1 million because it ran afoul of Medicare requirements for providing enrollees with medical services and prescription drug benefits. According to CMS, enrollees were delayed or denied access to prescription drugs, or had to pay out-of-pocket to receive their drugs. CMS also determined that the plan violated coverage determination, appeal and grievance requirements, and notified the plan that further violations could result in contract termination.[12]

Optum works with skilled nursing facilities in various capacities, including bringing in partnering health plans to offer an ISNP. In this partnership role, Optum takes on the challenges of operating the ISNP.

A Southern long-term care facility brought in Optum — with its 30 years of experience as an innovator in enhancing the quality of care and outcomes — to help manage costs of the ISNP.

Optum helped improve the facility's outcomes through its:

- Sophisticated care model
- On-site clinical staff
- Accurate coding
- Management of treatment plans
- Strong physician relationships

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Before you start an ISNP, consider your options.

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A call to action

In this dynamic environment, with Medicare Advantage plans proliferating and new ownership models gaining a foothold, a critical mass of people, processes and systems is needed to effectively create, implement and manage an ISNP. If operated efficiently, ISNPs can provide quality care to members while returning a financial gain to the plan sponsor and skilled nursing facility.

Whether a skilled nursing facility aligns with an established partner to serve as the plan, or seeks a partner to help guide it to become a provider-owned ISNP, the keys to success include:

- Focus on patient-centered care
- Clinical team to manage utilization and avoid unnecessary hospitalizations
- Continuous quality improvement
- Efficient back-office operations
- Sophisticated data analytics to manage populations
- Family engagement and support of advance care planning
- Regulatory compliance expertise

When selecting a partner, consider its experience and track record in managing Medicare Advantage plans. Aligning with a partner that has a proven clinical infrastructure and operating model can help ensure success.

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11000 Optum Circle, Eden Prairie, MN 55344