March 14, 2013

Good afternoon

In an effort to assist with implementation of the Affordable Care Act, the IHS Director convened a team that consists of IHS, Tribal and Urban participants to develop a ACA business plan template. The ACA Business Plan is attached for your review and consideration. The template is intended to serve as a tool or guide as IHS, Tribal and Urban health programs determine the best business approach to consider.

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Director, Office of Tribal and Service Unit Operations

Portland Area IHS

Affordable Care Act Business Plan Template

In January 2013, a workgroup was established to develop a plan and template for Indian Health Service (IHS) facilities to assist in the preparation for implementation of the Health Care Marketplaces (Exchanges) and the Medicaid Expansion as a part of the Affordable Care Act (ACA) scheduled for 2014. As a result, more IHS eligible patients are likely to have insurance and Medicaid coverage and more choices on where they receive their healthcare services.

IHS facilities are expected to conduct business planning this year with the template as a guide with three important outcomes in mind: 1) Ensuring that the number of patients receiving services from IHS health care facilities remains stable or increases; 2) Ensuring that third party revenues remain stable or increase each year; and 3) Ensure priority customer service and quality of care, as well as an Indian health care system which continues to improve over time.

RADM Richie K. Grinnell, Area Director, Albuquerque Area Indian Health Service was assigned as Chairman of the workgroup which was composed of representatives from IHS Headquarters, Area Offices and IHS, Tribal health and Urban Indian program staff to ensure a broad range of experience in both operations and policy among the membership.

The workgroup developed the attached Affordable Care Act Business Plan Template to provide local guidance to I/T/U facilities in assessing and preparing for implementation of the ACA. This template is outlined in seven (7) primary sections which also list available reference resources to assist facilities with their business plan development. Listed are the seven sections of the template with a brief narrative statement describing the sections content and purpose:

Section 1 . -- Assess Local Environment for Health Insurance Marketplace (Exchanges and Medicaid Expansion). This section is intended to provide facility management with guidance for establishing a local Subject Matter Expert (SME) to assist management with assessing local, state and national factors which will influence and affect local ACA implementation at the local facility. This would include but is not limited to: health insurance market (state-based exchanges), Medicaid expansion, potential competition, contractual requirements/efficiencies, referral process analysis and current patient input/feedback. The SME could also serve as the POC for all approved ACA education and outreach materials and information to be used locally.

Section 2. – Assess Patient Workload and Revenue Impact (+ and -). This section is intended to provide guidance for establishing critical baselines for a particular location's active patient user population. Baselines should include, but are not limited to: current 3rd party coverage (Medicaid, Medicare and P.I.); current user population; current number of 3rd party claims; current monthly collections and projecting revenue growth potential for all identified categories.

Section 3 . – Assess current staffing and workload levels, along with facility space based on outcome of assessments from sections 1 and 2, then developing strategies to handle possible workload changes. This section provides guidance for assessing current staffing within the facility relative to workload changes (+ and -) affected by ACA implementation. Business Office, CHS, Finance, Patient Registration and Benefits Coordination are areas to consider. Clinical provider staffing needs should also be assessed if patient population increases are

projected and/or expanded access to care is considered. Best practices for improving efficiencies and utilization of technology should be researched and implemented where appropriate.

Section 4. – Referrals and Prior Authorizations. This section includes assessment of each facility's referral processes and how that could change with ACA implementation. CHS, MCO, VA, County Indigent Programs, etc. should all be reviewed and changes implemented to ensure the Agency as "payer of last resort" and that referral processes are adequate to meet the payee's requirements. Expenditures for services previously covered by CHS may now be covered under insurance plans through either the Exchanges or Medicaid expansion. This could result in the re-evaluation of CHS budgets and priorities and could possibly include payments for additional priorities including clinical preventive measures.

Section 5 –Eligibility Process for Medicaid Expansion and Health Insurance Exchanges. This section is important for maximizing enrollment in alternate resources. One process to assist with this is continual monitoring of future patient appointment rosters as to alternate resource status. Availability and requirements for presumptive eligibility and electronic application processes (state by state) should also be reviewed and understood. Processes to insure maximum alternate resource coverage should be implemented.

Section 6 – Assess Data Reporting Requirements. This section reminds all facilities to research and be aware of data reporting requirements and any changes implemented within our current systems (RPMS, UFMS, etc.) to address changes in billing and reporting related to the ACA. This may include DHHS, IHS, State or contractual data/reporting requirements for reimbursements.

Section 7 – Marketing. This section provides guidance for marketing the Indian Health Care system as a medical home model to ensure we maintain and expand our current patient user populations. This section outlines key points for effective marketing both internally and externally. Current patient care initiatives, with a focus/ priority on quality of care and customer service, should always be emphasized. Approved ACA community education and outreach materials should always be utilized to ensure consistent and accurate information is being disseminated. Marketing plans and strategies should also include the private sector contractors and MCO's.

Affordable Care Act Business Plan Template

Evaluate and address the following (as a minimum) as part of your operating units Business Plan. The expected outcome is a business plan targeted at: 1) Ensuring that the number of patients receiving services from IHS health care facilities remains stable or increases; 2) Ensuring that third party collections remain stable or increase each year; and 3) Ensure customer service and quality of care, as well as efficiency and effectiveness of the Indian health care system continues to improve over time.

1	Assess Local Environment for Health Insurance Marketplace (Exchanges and Medicaid Expansion) * Assign operating unit Subject Matter Expert (SME). * Assess premium payment possibilities. (Exchange, Part B, Part D) * Assess potential competition. (services offered, hours of operation, etc.) * Assess need for contracts with major payers / primary referral points for specialist. * Assess customer service levels. (patient satisfaction, wait times, etc.)	Resources NIHOE ACA Information[1]
2	Assess Patient Workload and Revenue Impact (+ and -) * Determine baseline for current 3rd party active users. (Medicaid, Medicare and Private Insurance) * Determine baseline user population. * Determine baseline for current claims. * Determine baseline for current collections. * Determine growth potential by reviewing local community demographics.	Resources U.S. Census Bureau[2] IHS Operational Summaries RPMS Period Summary Report UFMS Allowances

3	Assess current staffing and workload levels, along with facility space based on outcome of assessments and develop strategies to handle possible changes in workload.
	* Staffing - Consider possible changes in:
	  * Patient Benefit Coordinator (PBC) - coordinates with Health Insurance Marketplace Exchange Navigators and In-Person Assistors
	  * Billers
	  * Providers / support / ancillary staff - if increased hours are considered under #1 above.
	  * Voucher examiners (claim denials could increase due to IHCIA protections)
	  * Referral processor assistance for increased referral processing (not CHS).
	  * CHS staff (CHS staff normally get involved with approval processes, too, along with coordination of care)
	  * Finance staff (increased batching, reconciliations)
	  * Patient Registration (increased workload to identify new eligibles so screening may take longer – patient wait time for screening)
	  * Credentialing / Provider applications could increase if multiple contracts are signed.
	* Recognize and implement best practices for improving efficiencies.
	* Consider possible electronic verses manual processes due to possible increased volume.
		Resources
		RRM Module: Business Office
		IPC Green Book
		Revenues Operational Manual
		RRM Module: CHS

4	Referrals and Prior Authorizations * Assess Prior Authorization Referral Process. * Understand local contracts and pre-authorization requirements for both direct care and specialist referrals under the contracts and Qualified Health Plan (QHP) addendum. * Assess discharge and case coordination process. * Possible change in CHS priorities and budget. - Can prevention and priorities other than Priority One now be covered? (specialty clinics, preventive medicine, etc.)	
5	Eligibility Process for Medicaid Expansion and Health Insurance Exchanges * Daily review of future appointment rosters for third party status of all scheduled and admitted patients. * Prepare for electronic application process. * Consider presumptive eligibility process where available. * Assess RPMS Patient Benefit Coordinator note follow up process.	

6 Assess Data Reporting Requirements.

* Identify in RPMS any changes or system tracking identifiers/codes. Identify any state Medicaid requirements or National (Agency) requirements for tracking.
  * Determine State specific parameters for identifying expanded Medicaid programs.
  * Determine HQ/Area/Service Unit tracking requirements or required RPMS enhancements.
* UFMS - possible programming enhancements
* Quality performance measures required by contracts.

7 Marketing

Resources

RRM Module: Business Office
IPC Green Book
NIHOE ACA information[1]
Health Insurance Marketplace Navigators
Regional DHHS Offices

* Internal Marketing - Importance of customer service is to be stressed!
  * Staff education
  * Agency priorities updates
  * Internal improvements
    * Customer Service - "IHS Provider of Choice"
    * Staffing
    * Resource management
    * Patient care improvement initiatives
* External Marketing
  * Consumer Level Education
    * Difference in definition of Indian
    * Information on Indian specific provision (cost sharing)
  * Marketing Ourselves
    * Cultural competency
    * Wait times
    * Customer satisfaction
    * Quality of Care measures
    * Accreditation and Certification
  * Tribe/Community
    * Tribal consultation on local Business Plan development
    * Agency priorities
    * Medical home model
    * Keep websites updated
    * IPC initiatives
    * Affordable Care Act initiatives
    * Consider social media
    * Facilitate Tribal / State Communication
  * Private Sector Contractors and MCO's
    * CHS program and referral process
    * MCO Plans - IHCIA requirements to pay I/T/Us
    * Information on Indian specific provision (cost sharing)

[1] National Indian Health Outreach and Education (NIHOE) Materials are available at http://tribalhealthcare.org

[2] U.S. Census Bureau, 2006-2010 American Community Survey