Reforming Health Reform: After the Election, What Happens Now?

LeadingAge Indiana
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Objectives

- Update current status of ACA
- Ongoing impacts of ACA on employers
- Discuss opportunities for older adult service providers
- Review threats for older adult service providers
What Happened?

- In March 2010, Congress passed and the President signed health reform in:
  - **The Patient Protection and Affordable Care Act**
  - **The Health Care and Education Affordability Reconciliation Act of 2010**
    - Increases **access** to health coverage
    - Aims to **reduce costs** via payment reductions and focus on wellness and prevention
    - Seeks to reward “**value-based**” care delivery

- Since passage, numerous additional laws have been passed amending portions of original laws, and rules/guidance issued

Impact of the Act:
- Cost: = $940 billion/10 years
- Coverage = 32+ million by 2019
The ACA

- Is the law of the land today
- Applies to all businesses in the US, including governments
- Requires almost all individuals to obtain health insurance coverage or pay a penalty
- Establishes health insurance exchanges (state or federal)
- Employers with 50+ FTE employees may have to pay a penalty if they don’t offer full-time employees affordable, minimum level health insurance after 1/1/2014
- Implementation details continue to be outlined through the issuance of new regulations, guidance, and FAQ documents from IRS, HHS, DOL
Supreme Court Examines Constitutionality

U.S. Supreme Court Ruling: June 28, 2012

- Individual Mandate - Constitutional
- Entire Affordable Care Act - Stands
- Medicaid Expansion - State Option
Variables Effecting Costs for Employers

- State where business is operated & employee resides
  - State vs. Federal Exchange
  - Medicaid Expansion
- Employer premium deductibility vs. non-deductible penalty
- Offer vs. don’t offer health insurance today
- Number of Full-time employees
- % of FT employees who enroll vs. don’t enroll in employer coverage
- Wages of workers
- Employer contribution, if any, toward employee premiums
Implications of State Decisions for Employers

Medicaid Expansion State

Medicaid Eligibility
Up to 138% FPL

Exchange Subsidy
139 – 400% FPL

No Subsidy
400% + FPL

No Medicaid Expansion State

Medicaid Eligibility
Varies by state
Ex. 35% FPL

Exchange Subsidy
100 – 400%

No Subsidy
400% + FPL
2014: Potential Large Employer Penalties

Law does NOT require employers to offer health insurance

- Large employers subject to one of two “shared responsibility” penalties if any FT employee receives Exchange subsidies
  - For employers that own multiple companies, the 50 + employees is determined by control group or affiliated service group

Large employer = 50 or more full-time employee + FTEs

FT employee = avg. 30 or more hours of service per week

FT equivalents = Hours worked in a month by all PT employees divided by 120

Employer “shared responsibility” penalties

Penalty only assessed if a FT employee receives Exchange subsidies. Employees ineligible for subsidies if employer coverage affordable

No Insurance Coverage Penalty

**Amount** = $2000 x each full-time employee (after first 30 employees)

Unaffordable Employer Coverage Penalty If employer fails to offer coverage that is:

1. **Minimum essential coverage** -- minimum 60% actuarial value -- **offered to employees and their children under age 26.**

2. **Affordable** = Employee premium cost for single coverage < 9.5% of household income.

**Amount** = $3000 x # of full-time employees who receive exchange subsidies

“**Affordable**” = the employee premium contribution for single coverage is **less than** 9.5% of their MAGI household income, or one of three employer safe harbor options exist. (e.g., W-2 wages)

**Maximum penalty** = no insurance penalty

**Inflationary adjustments** to penalties begin in 2015

Employer pays **no penalty for Medicaid** eligible employees
Supreme Court Action Irrelevant: The market is driving reform not PPACA

- According to a Dec. 2011 Payor Market Survey conducted by HealthEdge, of the 100 payors responding:
  - 48% plan on leveraging value-based benefit design plans
  - 51% plan on utilizing pay-for-performance models
  - 55% plan on participating in accountable care organizations

Examples

- Cigna has set a goal of 1.4 million enrolled in ACOs by 2014 (currently have 17 ACO arrangements covering 100,000 lives)

- UnitedHealth Group has new value-based contracts for hospitals and physicians based upon quality and efficient care metrics. Payments are withheld if certain standards aren’t met.

The Field Of Aging Services Is Evolving

Today’s Spectrum of Services

Want driven
Preventative
Need driven
Long-term care
Hospital

Active adult communities
Continuing care retirement communities/multi-level campus

Source: Adapted from previous Greystone and LarsonAllen LLP presentations
Threads of Reform

• Reduce hospital readmissions
• Patient-centered care/experience
• Improved care transitions
• Health information sharing/exchange
• Prevention/wellness
• Chronic care management
• Total cost of care
• Integrated, coordinated, seamless care
• Higher quality, cost effective care
• Value-based payment to replace FFS
• Targeting high-cost, high-risk patients
Reformed Health System – Service Delivery

Primary Care
- Home care
- SNF
- Assisted Living
- Hospital
- Physician office
- Group visits
- Self management
- RN, Care Coach
- Online/social networking (e.g. diabetes group)
- Telehealth monitoring

Chronic Care
- Hospital
- SNF
- At Home
- Telehealth

Wellness
- Health risk assessment
- Independent senior housing
- Adult day programs
- Community clinic for vaccines
- Local fitness center
- Smoking cessation program
- Weight loss program
- Personal wellness coach
- Senior Center
- Online social networking groups/tools
- Labs, diagnostics

Acute Care
The Triple Aim Goals

• Better Care
  – Improve/maintain quality and patient outcomes
  – Eliminate avoidable re/admissions
  – Eliminate potentially preventable conditions (e.g., never events)

• Better Health
  – Primary Care Driven
  – Focus on Prevention & Wellness

• Reduce Cost
  – Reduce/eliminate duplication
  – Improved coordination
Array of Payment Options

Spectrum of Payment Models for Health Plans and Providers

- **Fee-for-service**: Negotiated payment based on volume of service
- **Performance-based, fee-for-service**: Negotiated payment for volume plus additional incentives for managing costs, quality, and patient experience
- **Shared savings**: Shared savings if interim costs are less than target
- **Risk sharing**: Shared savings and shared losses
- **Full capitation**: All savings/losses are assumed by provider
Accountable Care Organizations

General Definition
A group of health care providers working together to manage and coordinate care for a defined population, that share in the risk and reward relative to the total cost of care and patient outcomes.

Medicare ACO Programs
- Medicare Shared Savings Program
- Pioneer ACOs
- Advanced Payment Initiative
Indiana ACOs

- Awarded one Pioneer ACO, four MSSP ACOs, & one Advance Payment ACO Model as of January 2013.

- Pioneer ACO
  - Franciscan Alliance (Indianapolis & Central IN)

- MSSP ACOs
  - Indiana Care Organization LLC (IN)
  - Indiana Lakes ACO (IN)
  - KentuckyOne Health Partners, LLC (IN & KY)
  - Owensboro ACO, LLC (IN & KY)

- Advance Payment ACO Model
  - American Health Network of OH Care Organization, LLC
Bundled Payments for Care Improvement Initiative

- Announced on August 23, 2011, the Centers for Medicare & Medicaid Services (CMS) announced its first bundled payment framework for testing out of the Center for Innovation
  - The Bundled Payments for Care Improvement Initiative
    - Tests four models of bundled payment related to an inpatient stay
      - Two models look only at the inpatient stay itself
      - Two models look at post-acute services
      - One model is prospective payment vs. the other three which are retrospective
      - Target price must be set based upon individual provider’s cost history.
    - Goal is to redesign care to deliver the Triple Aim
      - Gainsharing to align provider incentives will be permitted

- Applications submitted June 28, 2012

- Next round of models expected to be released soon
Four Bundled Payment Models

- **Model 1 – Acute Care Hospital Stay Only (Retrospective):** An episode is considered an acute inpatient hospital stay for all Medicare FFS beneficiaries regardless of assigned health condition (MS-DRG).

- **Model 2 – Acute Care Hospital Stay + Post Acute Care Episode (Retrospective):** Covers episodes that include both the inpatient hospital stay and the corresponding post-acute care services.

- **Model 3 – Post Acute Care Only (Retrospective):** Covers only post-acute care services (a minimum of 30 days) following an acute inpatient hospitalization and the related Part A and B services furnished during the post-acute period.

- **Model 4 – Acute Care Hospital Stay Only (Prospective):** Differs from Model 1 in that it provides a *prospective* payment for an acute inpatient hospital stay for *select* conditions (MS-DRGs).
Bundled Payments – Model 2

• Model 2: Acute + Post Acute Care Episodes
  – Episode of care includes inpatient stay in acute care hospital and all related services during episode (will end either 30, 60 or 90 days after hospital discharge)
  – Can select up to 48 different clinical condition episodes

• IN Selected Participant:
  – Saint Joseph Regional Medical Center-Mishawaka Campus
    ◊ 2 Episodes: Percutaneous coronary intervention, Major bowel
Bundled Payments – Model 3

• Model 3: Post Acute Care Only
  – Episode of care triggered by AC hospital stay and begins at initiation of PAC services with SNF, inpatient rehab facility, long-term care hospital or home health agency
  – Must begin within 30 days of discharge from inpatient stay and end last minimum of 30, 60, or 90 days after episode initiation
  – Can select up to 48 different clinical condition episodes

IN Selected Provider:

  – Amedisys Home Health of Jeffersonville
    ◊ 16 Episodes: including urinary tract infection, stroke, simple pneumonia and respiratory infections, percutaneous coronary intervention, other vascular surgery, other respiratory
Multi-payer Advanced Primary Care Practice Demonstration (MAPCP)

- CMS selected the following states to participate: Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota

- Advanced primary care (APC) practices = “patient-centered medical homes”
  - Utilize a team approach to care
  - Patient-centered care delivery
  - Emphasis on prevention, health information technology, care coordination and shared decision making among patients and their providers.

- Demo goal: To improve the quality and coordination of health care services.

- CMS will provide an enhanced payment to participating APC practices for their Medicare patients commensurate with other participating payers in exchange for providing continuous, comprehensive, coordinated, and patient-centered health care.
Federally Qualified Health Center Advanced Primary Care Practice Demonstration

- Started November 1, 2011
- 3-yr demonstration to evaluate patient-centered medical homes and reduce cost of care to Medicare beneficiaries
- Expected to achieve Level 3 patient-centered medical home recognition
- Paid a monthly care management fee ($6) for each eligible Medicare beneficiary receiving primary care services
Federally Qualified Health Center Advanced Primary Care Practice Demonstration

- IN Selected Participants:
  - Cass County Community Health Center, Logansport
  - Community Health Center of Jackson County, Seymour
  - HealthLinc, Inc., Valparaiso
  - Heart City Health Center, Elkhart
  - Indiana health Centers at Kokomo
  - Indiana Health Centers, Inc. at South Bend
  - Vermillion-Parke Community Health Center, Clinton
Health Care Innovation Awards: Indiana

- Trustees Of Indiana University – “Dissemination of the aging brain care program” (IN)
  - Funding Amount: $7,836,084
  - Estimated 3-Year Savings: $15,659,916
  - Improve care for Medicare beneficiaries with dementia or late-life depression in Marion County
  - Many of these beneficiaries are dually eligible for Medicare and Medicaid
Health Care Innovation Awards: Indiana

- NATIONAL COUNCIL OF YOUNG MEN'S CHRISTIAN ASSOCIATIONS OF THE UNITED STATES OF AMERICA (YMCA OF THE USA) – “Delivery on the promise of diabetes prevention programs” (AZ, DE, FL, IN, MN, NY, OH, TX)
  - Funding Amount: $11,885,134
  - Estimated 3-Year Savings: $4,273,807
  - Serve 10,000 pre-diabetic Medicare beneficiaries in 17 communities
  - Intervention focus on community-based diabetes prevention through a diabetes prevention lifestyle change program
Health Care Innovation Awards: Indiana

- TransforMED—“Multi-community partnership between TransforMED, hospitals in the VHA system and a technology/data analytics company to support transformation to PCMH of practices connected with the hospitals and development of “Medical Neighborhood” (AL, CT, FL, GA, IL, IN, KS, KY, MA, MI, MS, NE, OK, WV, WI)
  - Funding Amount: $20,750,000
  - Estimated 3-Year Savings: $52,824,000
  - Partners with 12 VHA-affiliated hospitals to support care coordination among Patient Centered Medical Homes, specialty practices & hospital and create “medical neighborhoods”
Health Care Innovation Awards: Indiana

- University of North Texas Health Science Center – “Brookdale Senior Living (BSL) Transitions of Care Program” (AL, AZ, CA, CO, CT, DE, FL, GA, ID, IL, IN, IA, KS, KY, LA, MA, MI, MN, MS, MO, NV, NJ, NM, NY, NC, OH, OK, OR, PA, SC, TN, TX, VA, WA, WI)
  - Funding Amount: $7,329,714
  - Estimated 3-Year Savings: $9,729,702
  - Expand and test the BSL Transitions of Care Program
    ◊ Evidence-based assessment tool called Interventions to Reduce Acute Care Transfers (INTERACT) for residents in independent living, assisted living and dementia facilities
Health Care Innovation grants

• No second round plans

• Proposals include:
  – Patient education/engagement
  – Personal Health Record
    ◊ Making information available
    ◊ ERs picking LTC
    ◊ Telemedicine
    ◊ Lack of patient medication – medication errors
  – Biggest cost of care last two years of life
    ◊ Prevented from talking about palliative care after “death panels”
Financial Alignment Initiative

- Goal is to test two payment models to better align care for dual eligibles.
- Serve up to 2 million duals through approved programs
  - Issued design grants to 15 states
  - 38 states submitted letters of intent to participate
  - 26 states submitted proposals
- Massachusetts is the only state as of 9/9/12 with a signed Memorandum of Understanding.
Financial Alignment Initiative: CMS Seeks to Test Two Payment Models for Dual Eligibles

**Capitated Integration Model**
- Three-way contract between state, CMS and health plans
- Plans paid prospective blended rate for all primary, AC, behavioral, and LTSS
- CMS and state share savings
- Passive enrollment of duals with opt out
- Simple, unified rules

**Managed FFS Model**
- State eligible for retrospective performance payment for achieving estimated level of Medicare savings
- Providers continue to get paid FFS by CMS & State
- Other state flexibility may be granted around benefits and to target duals in certain geographies.

38 States and Washington, DC submitted Letters of Intent to participate in these demonstrations
How can Senior Service Organizations Drive Reform?

- Focus on **demonstrating value** internally
  - Improve care transitions and lower readmissions
  - Explore LEAN practices to achieve value and efficiency
  - Develop, deploy, disseminate best practices in post-acute and long-term care
  - Focus on high cost, high risk populations

- **Transparency**: communicate this value to consumers and payors

- Harness health **information technology**
How can Senior Service Organizations Drive Reform? (continued)

• Explore opportunities to **test new models** of care and payment

• Explore/develop **partnerships, relationships** across the continuum

• **Examine ROI** - cost to outcome for treatments, interventions (*e.g.*, *Rx vs. alternative therapy*)

• **Think beyond the medical solution**
Update on Value Based Purchasing

• Medicare – nothing happening yet

• Indiana Medicaid – scheduled to start 7/1/13
  – Depend in part on performance with ISDH surveys and staffing measures
Threats to Older Adult Service Providers

• Staying competitive within the marketplace

• How to adapt to the rapid changes in payment structures and impact on referrals

• How to deal with changing consumer expectations
Thank you!

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