LeadingAge Oklahoma Annual Conference

Health Care Reform – Turning Theory Into Reality

March 12, 2013

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Our Discussion Today

- Where have we been and where are we going?
- Health insurance update
- Latest developments in payment reform and Industry Trends
- Taking on additional risk and What have/will providers do in response?
- Questions and Comments

Where have we been and where are we going?

What Happened in the Past?

- 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

Reform Summary Timeline (In the Past)

2010

- *High risk insurance pools established.*
- *Small business tax credits for offering employee health insurance established*
- *Insurers can no longer deny coverage to children for pre-existing conditions.*
- *New group and individual plans required to cover preventive services at 100%.*
- *Dependents coverage expanded to age 26.*
- *Annual review of insurance premium increases effective.*
- *Grandfathered plan notification requirements.*

2011

- *Increased penalty on non-medical distributions from HSAs.*
- *Insurance administrative simplification begins.*
- *Medical loss ratios become effective for small group and individual plans.*
- *New simple cafeteria plans available to small businesses*
- *Workplace wellness program grants available for small employers*
- *Annual fees assessed on pharmaceutical companies.*
- *Application of non-discrimination regulations to fully-insured plans.*
- *OTCs no longer reimbursable under various health spending accounts*

2012

- *CLASS Act: National voluntary LTC insurance program established. – ON HOLD*
- *Summary of Benefits and Coverage*
- *Health plans to pay per participant fee to pay for Comparative Effectiveness Research.*
- *Preventive health benefits covered without cost sharing.*

Reform Summary Timeline (Still to come)

2013

- *Large employers disclose health insurance benefits on W-2s*
- *Health insurers required to begin following administrative simplification regulations.*
- *Limits placed on flexible spending accounts.*
- *New 3.8% Medicare Tax for Unearned Income .*
- *Medicare Earned Income Tax Increases to 2.35% for higher income earners.*
- *Employer tax deduction for Part D subsidies eliminated.*
- *Insurance Exchange open enrollment begins*

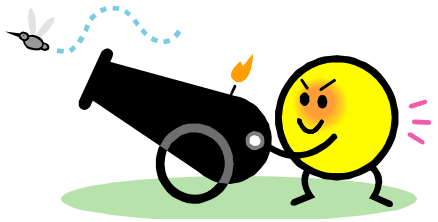
2014

- *State and federal insurance exchanges operational.*
- *Individual penalties imposed for failure to obtain health insurance coverage.*
- *Insurance industry pays fees based on market share.*
- *Insurers prohibited from restricting coverage and imposing benefit limits.*
- *Employer "shared responsibility" penalties imposed.*
- *Small employers to begin reporting health benefits on W2s.*
- *Large employers to begin auto-enrolling FT employees into health insurance plan.*
- *Insurers must guarantee issue and renew plans*

2015 - 2018

- *Large employers may be able to offer Exchange plan as employer-sponsored coverage (2017)*
- *Excise tax imposed on "Cadillac" health plans (2018)*

The Affordable Care Act (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

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 and in the future
- 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

Key Employee Notification Requirements

1. Notice of grandfathered health plan status
   - Must include a statement describing the health plan benefits and contact information for questions or complaints, as part of plan materials provided to participants (for plans in existence on 3/23/10)
2. Notice of key plan design changes (effective 1/1/11)
   - Annual and lifetime limit changes
   - Eligibility for dependent coverage of adult children
   - Primary care physician designation and OB/GYN self-referral change
3. Summary of medical benefits (starting 9/23/12)
4. Summary of material changes (effective 9/23/12)
5. **Notice of eligibility for health insurance exchange (effective 3/1/13)**

Summary of Benefits and Coverage (SBC) Notice to Employees

- **Effective for plan years after 9/23/12**
- Include with open enrollment materials
- Distribute to newly eligible employees, employees with special enrollment rights, and upon request
- A new SBC must be distributed at least 60 days prior to any mid-year plan changes affecting SBC.
- The Department of Labor six-page SBC template can be found at: http://www.dol.gov/ebsa/pdf/correctedsbctemplate.pdf

Tax Credit for Small Employer Health Premiums

Eligible small employer:

	Full Credit	Upper Limit
# of FTEs	≤10	25
Avg. annual payroll per FTE	≤$25,000	$50,000

- Employer contributes ≥50% of employee premium
- ***This will only benefit the smallest employers***

File for credit on Form 8941: http://www.irs.gov/pub/irs-pdf/f8941.pdf

Additional Health Plan Fees/Taxes

Comparative Effectiveness Research Plan Fee (2012)

- Effective for plan years beginning on or after 10/1/2012
- Requires health insurance and self-insured plans(employer) to pay a per participant fee
- **Fee**
  - Year 1: $1/participant
  - Year 2: $2/participant
  - Due by 7/31/2013
  - 2014: Inflation adjusted rate
  - 9/30/2019: Phased out

Final IRS Regulations issued December 6, 2012

Transitional Reinsurance Fee (2014)

- Third Party Administrators pay on behalf of the Plan
  - Remit annual contributions to support reinsurance payments to issuers
    - Estimated to be $63 per covered employee and their dependents
    - Will operate 2014-2016 with first quarterly payment due 1/15/14

Health Plan Fees/Taxes

Cadillac Plan Tax (2018)

- 40% excise tax assessed on health insurer or plan administrator offering "high-cost" health coverage
  - "High cost" = annual premium
    - > $10,200 single coverage
    - > $27,500 family coverage
- Tax would be on premiums above the thresholds
- Goal is to generate revenue to help pay for coverage for the uninsured and to make the most expensive plans less attractive.

2013: Contribution Limits on Flexible Spending Accounts

- Places an annual limit on employee's FSA contributions to $2,500.
  - Current law imposes no limit.
  - The limit will be indexed for inflation beginning in 2013.

- This contribution limit does not impact Dependent Care FSAs. Contributions to Dependent Care FSAs will continue to be subject to a $5,000 per year limit.

2013:
Increased Medicare Tax - Earned Income

Current Law

- Employee FICA payroll tax: 6.2% on first $106,800
- Medicare Tax = 1.45% on all earnings

New Law

- Medicare tax increases 0.9% to 2.35% for higher income earners:
  - Single earned income over $200,000
  - Joint earned income over $250,000
  - Assessed on employee share only, but employer withholds
  - If withholding is inadequate, must be remitted in 1040

2013: Medicare Surtax - Unearned Income

Net investment income

- Interest, dividends, annuities, royalties, rents
- Passive income
- Trading in financial instruments/commodities
- Capital gains and other property disposition gains

New Law

- 3.8% Medicare surtax on unearned income
- Lesser of:
  - Net investment income, or
  - Modified AGI in excess of $200,000 single ; $250,000 MFJ
- Applies to estates and trusts, too
- Exceptions: Active business income; IRA and retirement plan withdrawals; all SE income; tax-exempt income

Reporting Requirements in 2014

Insurers must file IRS information returns for coverage provided to full-time employees on or after 1/1/2014

- First returns filed in 2015
- Include information on who is covered and when, if plan is on the health insurance Exchange, plus additional information
- Report information for each covered individual
- Provide written statements that information reported to IRS must be given to each participant
- The Employer could include information along with W-2's issued

2014: Individual Mandate

- **Individual mandate to obtain health coverage:** Beginning in 2014, most individuals must obtain a minimum-level of health insurance coverage or pay a penalty

- **Minimum essential coverage includes:**
  - Medicare, Medicaid, TRICARE
  - Insurance purchased through an Exchange, or the individual market
  - Employer-sponsored coverage that is affordable & provides minimum value
  - Grandfathered plans (group plan in effect on 3/23/2010)

- **Penalties for failure to obtain coverage:**
  - In 2014: greater of $95 or 1.0% of income
  - In 2015: greater of $325 or 2.0% of income
  - In 2016: greater of $695 or 2.5% of income
  - Penalty is capped at three times the per person amount for a family
  - Assessed penalty for dependents is half the individual rate

Hardship exemption
Premium cost for lowest cost plan > 8% of Household Income

2014: Government assistance to help some individuals obtain coverage

- **Medicaid expansion:** Expands eligibility to individuals and families up to 133 % of the federal poverty level (FPL) or Modified Adjusted Gross Income(MAGI) of138% of FPL
  - If cost effective, states can opt to subsidize employer-sponsored premiums for this group

138% FPL
Individual = $15,414
Family of 4 = $31,809

- **Premium and cost share assistance:**
  - Individuals and families with household income of 100 - 400 % FPL may be eligible for sliding-scale assistance, such as:
    - ◊ Tax credits to help pay premiums; and
    - ◊ Out-of-pocket reductions to help with cost sharing (e.g., co-payments and co-insurance)

400% FPL:
Individual= $44,680
Family of 4= $92,200

2014: State Health Insurance Exchanges

What is an exchange?

A marketplace for individuals and small businesses to shop for insurance.

- Offer a choice of health plans
- Standardize health plan options
- Allow consumers to compare plans based upon price
- Intended to provide a more competitive market
- Provides consumers with a neutral party to assist with plan enrollment, information and eligibility determination for any subsidies

Who can participate?

- **In 2014, small employers** can offer an Exchange plan as their employer health plan
- **Individuals:** Includes self-employed or unemployed individuals (2014)
- In 2017, states can allow l**arge employers** to participate

- Each state must establish a health insurance **exchange**
- HHS Secretary to establish the rules around exchanges

2014: Exchange Plans

Types of exchange plans to be offered by insurers

- **Bronze** = 60% actuarial value
- **Silver** = 70% actuarial value
- **Gold** = 80% actuarial value
- **Platinum** = 90% actuarial value
- **Catastrophic plan**
  - ◊ Only available to individuals < 30 years old, or those exempted from the individual mandate due to unaffordability or hardship.
  - ◊ Plan must cover:
    - "minimum essential benefits"
    - a minimum of three primary care visits per year
- All exchange "metal" plans must cover essential health benefits, limit cost-sharing and have a specified actuarial value

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

For "minimum essential coverage", see IRS Notice 2012-31 at: http://www.irs.gov/pub/irs-drop/n-12-31.pdf

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

Three Employer Safe Harbors: Affordability of Coverage *IRS Notice 2012-58*

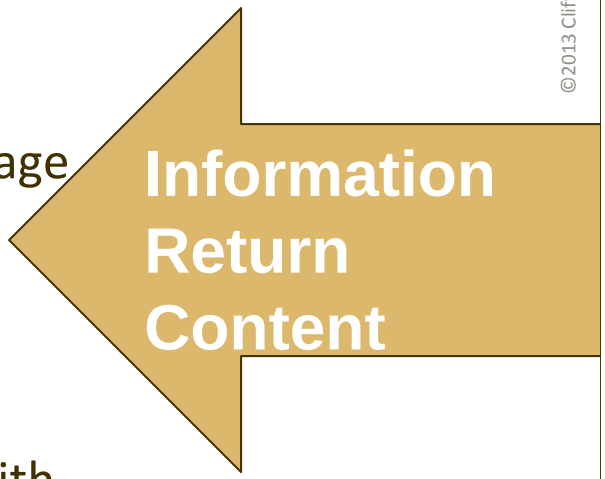
1. **Form W-2 Safe Harbor related to Affordability for Employee:** If employee's premium cost for self-only coverage is less than 9.5% of their W-2 wages for the employer, the health insurance is considered affordable AND
   - The employer will not pay a penalty for that employee
   - The employee may still be eligible for premium tax credits in the Exchange based upon Modified Adjusted Gross Income of Household.
   - Employer is not subject to penalty if employee receives tax credit but later employer-sponsored insurance is determined to be affordable.
   - **Affordability for related individuals**: Employers don't appear to need to make coverage affordable for dependents (e.g. family coverage, Employee+1)

Identifying full-time employees: 2013 & beyond

- Employee engaged in average of 30 “hours of service” per week or 130 hours in a month.
  - Uses common law definition of employee
    - ◊ Does not include: leased employees, sole proprietors, partners in partnership, 2% S-corp shareholder
  - Hours of service = hours worked and hours paid but for which no work was performed (e.g., PTO, FMLA, Deployment leaves, disability, etc.)
  - Salaried workers use actual hours, or 8 hours/day or 40 hours per week standard.
  - Special rules for employees of educational institutions
  - Seasonal workers: If 120 days or fewer; or 4 calendar months of work, then excluded from calculation of large employer

2014: Other Employer Requirements

- **Government reporting obligations**
  - Names of FT employees on the health plan
  - Employer contribution levels to employee coverage
  - Plan waiting period length
  - Whether employer-sponsored plan meets "minimum essential coverage" requirements



- **Large Employers to auto-enroll:** Employers with 200+ FT employees will be required to auto-enroll employees into their employer-sponsored health plan
  - Employees can opt out
  - Won't be effective until U.S. Dept. of Labor issues rules, which won't be effective by 2014.

Employer Health Insurance & Penalty (HIP) Costs

Impact of Employer Health Insurance Reforms		
Full-Time Employees	154	*(140 Insured / 14 Waived)*
Total Staffed	186	*(23 PT Insured/9 PT No ESI)*
2014 PPACA FTEs	170	

HEALTH REFORM KEY DRIVERS			
Today's Single Coverage Employer Premium Cost			
Average Single Employer Cost	$	4,972	
Employer Contribution %		*87%*	
Medicaid Eligible Employees			
Total FT Medicaid Enrollees		7	
Employer Estimated Cost Savings	$	64	*($000s)*
Employer Unaffordable Coverage Penalty			
Subsidy Eligible Full-Time Employees		48	
Subsidy ($3,000)	$	3	
Estimated Subsidy Penalty	$	144	*($000s)*
% Total Full-Time Employees		*31.2%*	
Employer No ESI Insurance Penalty			
Total Full-Time Employees		154	
Less: 30 Employees		(30)	
Adjusted Full-Time Employees		124	
No Insurance Penalty ($2,000)	$	2	
Estimated Subsidy Penalty	$	248	*($000s)*
2014 Pre Reform Projected HC Costs	*$*	*1,644*	*($000s)*
Estimated Net Savings	*$*	*1,396*	*($000s)*

HEALTH REFORM SUBSIDIES IMPACT ON HEALTH COSTS			
ORGANIZATION ($000s)	**Today's Cost**	**2014 Offer Coverage**	**2014 Drop/ Don't Offer**
Baseline Premium Cost	$ 1,384	$ 1,384	$ 1,384
2012-2014 Premium Increase (9.0% / Yr)	-	260	260
Pre-Reform Projected Premium Cost	1,384	1,644	1,644
Tax Adjusted Premium Costs	900	1,069	1,069
PLUS: Additional Reform Impact			
Previously Waived FT Employees	-	71	-
Transitional Exchange Fee	-	6	-
Penalty: Subsidy Eligibles & ESI	-	144	-
Health Reform Increased Cost	-	221	-
LESS: Previous Premium Liabilities			
Medicaid Employee ESI	-	(64)	-
Subsidy Eligible FT Employees ESI	-	(414)	-
Health Reform Decreased Cost	-	(478)	-
No Minimal Essential Coverage			
Less: 2014 Inflation Adjusted HC Cost	-	-	(1,644)
Plus: Subsidy Eligible Penalty	-	-	248
Health Reform No ESI Cost	-	-	(1,396)
Post Reform HC Costs	$ 1,384	$ 1,387	248
HC Cost Change to 2014 Projected		*$ (257)*	*$ (1,396)*
% HC Cost Change to 2014 Projected		*-16%*	*-85%*
Tax Adjusted HC Costs	$ 900	$ 948	248

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Latest developments in payment reform and Industry Trends

Taking on additional risk

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Innovation and Dual Eligibles

- **Center for Medicare and Medicaid Innovation**
  - Established January 1, 2011
  - To research, develop, test, and expand innovative payment and delivery arrangements to improve quality of patient care and reduce costs to each program.

http://innovations.cms.gov/

- **Federal Coordinated Health Care Office**
- Housed within the Innovation Center
- Charged with:
  - Improving the effectiveness of integrating benefits for dual eligibles,
  - Improving federal and state coordination of Medicare and Medicaid benefits to ensure full access to services.

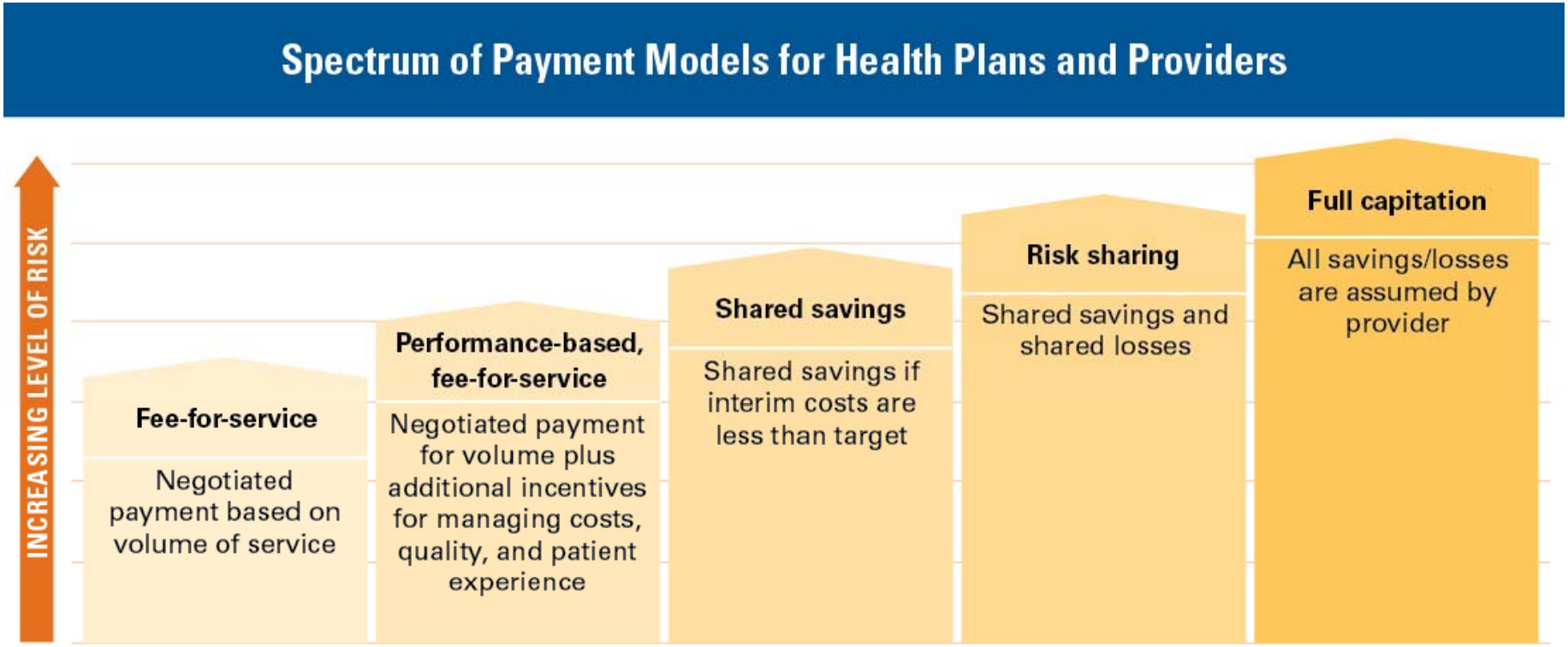
CMMI Overview

- Housed within CMS
  - ACA focus Medicare/Medicaid
- $10B appropriation for 10 years (through 2019)
- Budget neutrality requirement does not apply
- ACA allows CMMI to rapidly develop and deploy alternative payment models, like capitated PMPM payment
  - Described as a “License to play”

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



Quality Task Force within CMMI

- **Measure Applications Partnership Coordinating Committee (MAPCC)** influences CMS quality and evidence-based practices.
  - George Isham, Health Partners co-chairs this group and exerts much influence.
  - See MAP Coordinating Committee Background Materials document dated August 14, 2012 for more information on measures under consideration.

- Establish a quality standard that every provider delivers
- Standard being developed will apply to:
  - All quality measures, Value-based payment, Readmissions, Patient Safety
- Quality metrics are based upon extensive evidence = very well vetted

Partnership for Patients Initiative

- Partnership for Patients is a public-private initiative across all 50 states charged to improve health care for all Americans in the domains of:
  - ◊ Safety
  - ◊ Quality
  - ◊ Affordability
- More than 7,700 partners already committed (as of 9/10/12)
  - – Over 3,300 direct care providers
    - ◊ Hospitals
    - ◊ Physicians
    - ◊ Nurses Groups
    - ◊ Consumer groups
    - ◊ Employers

Partnership for Patients (cont.)

- **Goals by 2013**
  - **Reduce hospital-acquired conditions by 40%, as compared to 2010**
    - ◊ Achieving this goal would:
      - Save 60,000 lives over 3 years
      - Prevent approximately 1.8 million injuries to patients
  - **Reduce the number of rehospitalizations within 30 days of discharge by 20%, as compared to 2010**
    - ◊ Achieving this goal would mean approximately 1.6 million patients would recover without a preventable complication
  - **Potential $35 billion industry savings in next 3 years**
    - ◊ $10 billion in Medicare savings

New Pilot: Initiative to Reduce Avoidable Hospitalizations among Nursing Facility Residents

- Four-year pilot to implement evidence-based interventions that reduce avoidable hospitalizations.
  - FFS duals who are long-stay nursing home residents
  - Enhanced care and coordination providers eligible receive to $5M to $30M each
  - Requirements:
    - ◊ Minimum of 15 nursing facilities with average census of 100 or more
    - ◊ Must have an on-site presence at NFs
    - ◊ Must obtain letter of support from state
    - ◊ Interventions must improve health outcomes of residents, smooth care transitions, and coordinate care

Timeline

- Notice of Intent due: 4/30/2012
- Applications due: 6/14/2012
- Awards: Aug. 24, 2012
- More info:
- http://www.innovations.cms.gov/initiatives/rahnfr/index.html

Community-Based Care Transitions

Establishes five-year community-care transitions program to assist Medicare beneficiaries at high risk of a hospital readmission with their transitions from inpatient to outpatient care

- Program began accepting applications April 12, 2011
- $500M available to be paid to:
  - Community-based organizations that provide care transition services OR
  - Hospitals with high readmission rates that partner with such entities.
- "High-risk Medicare beneficiaries" = one or more chronic conditions and not enrolled in a Medicare Advantage program
- HHS may expand the program if the program proves to lower spending without reducing quality.

Independence At Home Demonstration: 2012

- Establishes a shared savings program for physicians and nurse practitioners to test the use of home-based primary care teams for certain Medicare beneficiaries
- Eligible Medicare beneficiaries:
  - 2 or more chronic conditions
  - Medical condition in past 12 months with non-elective hospitalization OR
  - Received acute or sub-acute rehab within past 12 months
  - Needs assistance with 2+ ADLs
- Practitioners are paid for care coordination and must provide home-based care

Goals

- Reduce health care costs
- Reduce preventable hospitalizations, readmissions and ER visits
- Improve health outcomes
- Improve efficiency of care (i.e., reduced duplication of labs)
- Achieve beneficiary and family satisfaction

CMS Fact Sheet:

http://www.innovations.cms.gov/Files/fact-sheet/IAHfactsheet.pdf Updated August 2012

ACA Bundled payment pilots and demonstration projects

- **Medicaid episodes (Begins 2012)**
  - Pays bundled payment to acute care hospital to coordinate with physicians and post-acute services.
  - Demonstrations in up to 8 states
- **Medicaid Global Payment System Demonstration**
  - Would permit up to 5 states to pay safety net hospital systems or networks a global capitated payment instead of fee for service.
  - Demonstration to be coordinated with CMS Innovation Center
- **National Pilot Program on Payment Bundling**
  - CMS to establish a national, voluntary Medicare pilot by 2013
  - For hospitals, doctors and post-acute providers.
  - Aims to improve patient care and achieve savings through bundled payments.
  - Pilot can be expanded by 2016 if it appears to improve quality and reduce costs.

Definition:

A single, fixed per person payment paid to provider(s) for the provision of all services and expenses for an episode of care, management of a chronic condition or an individual.

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).

Pending Bundled Payment Models

- **Model 5 –Acute Care Hospital Stay + Post Acute Care Episode (Prospective):** Covers episodes that include both the inpatient hospital stay and the corresponding post-acute care services.
- **Model 6 – Post Acute Care Only (Prospective):** 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 7 – Chronic Care Management (Retrospective)**
- **Model 8 – Chronic Care Management (Prospective)**

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**

Medicare ACO Programs

Medicare Shared Savings Program (MSSP) = 115 ACOs

- Established January 1, 2012
- Program requires the participating providers to form an ACO
- 5,000 Medicare beneficiary minimum for participation
- Two tracks: Savings only, Savings/Losses
- Two 2012 start dates: 4/1/2012 & 7/1/2012

Pioneer ACO Program = 31 Pioneer

- For organizations with prior ACO-like experience
- Must enter into outcomes-based contracts with multiple payers.
- 15,000 Medicare beneficiaries minimum
- Model transitions to greater financial accountability(risk) faster.
- January 1, 2012 start

Medicare ACO Programs – Advanced Payment Initiative

- To be eligible, applicants for this initiative must apply for MSSP for an April or July 2012 start AND:
  - Not include any inpatient facilities AND have less than $50 million in total annual revenue. OR
  - Include only inpatient facilities that are critical access hospitals and/or Medicare low-volume rural hospitals AND have less than $80 million in total annual revenue.
- Application deadlines
  - For April 1, 2012 start date
    - Applications accepted between January 3 and February 1, 2012
  - For July 1, 2012 start date
    - Applications accepted between March 1 and March 30, 2012 (consistent with Shared Savings Program)

State Innovation Models Initiative

- $275M competitive funding for states to design and test multi-payer payment and delivery models that deliver high-quality health care and improve health system performance.

  1. Model Testing
     - ◊ Implementing new already developed models
     - ◊ Maximum 5 states
  2. Model Design
     - ◊ Funding and technical assistance for identifying type of system improvements to pursue
     - ◊ Maximum of 25 states awarded

- Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

State Grants to Integrate Care for Dual Eligibles

- Phase One: $1M each to 15 states to develop service delivery and payment models that integrate care for dual eligibles
  - States submitted initial proposals that are expected to evolve based upon stakeholder input during this design phase
  - Upon completion of Phase One, grant states submit proposed design that describe how they will structure, implement and evaluate an intervention to improve quality, coordination and cost-effective care for duals. CMS will evaluate & select which proposals move to the **implementation phase in 2012.**

States awarded development grants: CA, CO, CT, MA, MI, MN, NY, NC, OK, OR, SC, TN, VT, WA, and WI

What will providers do in response?

The CMMI Effect On the Horizon…

- CMMI Initiatives are driving care delivery and payment change
- CMMI flexibility allows it to expand upon successful pilots, demos and programs, which could result in a more rapid shift from FFS to value-based or risk-based payment (2-3 years)
- Initiatives are underway in urban and more rural areas throughout the country
- Many initiatives are more acute care focused even though they target a Medicare population
- Some resistance from provider groups on value-based payment

How can Senior Service Organizations Drive Reform?

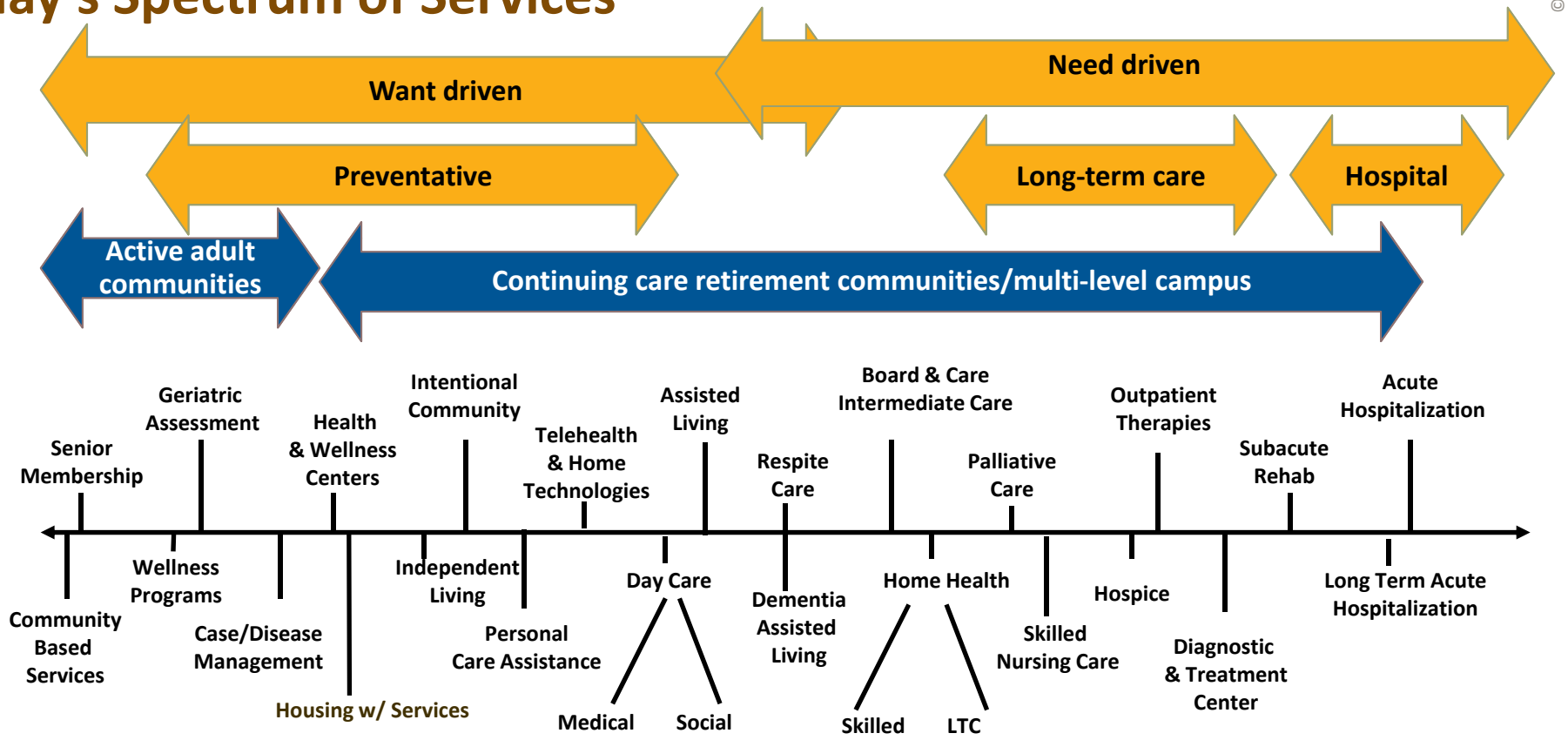
- Focus on **demonstrating value** internally
  - Improve care transitions and lower readmissions
  - Explore LEAN practices to achieve value and efficiency
  - Develop, deploy, disseminate best practices in post-acute and long-term care
  - Focus on high cost, high risk populations
- **Transparency**: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

The Field Of Aging Services Is Evolving

Today's Spectrum of Services



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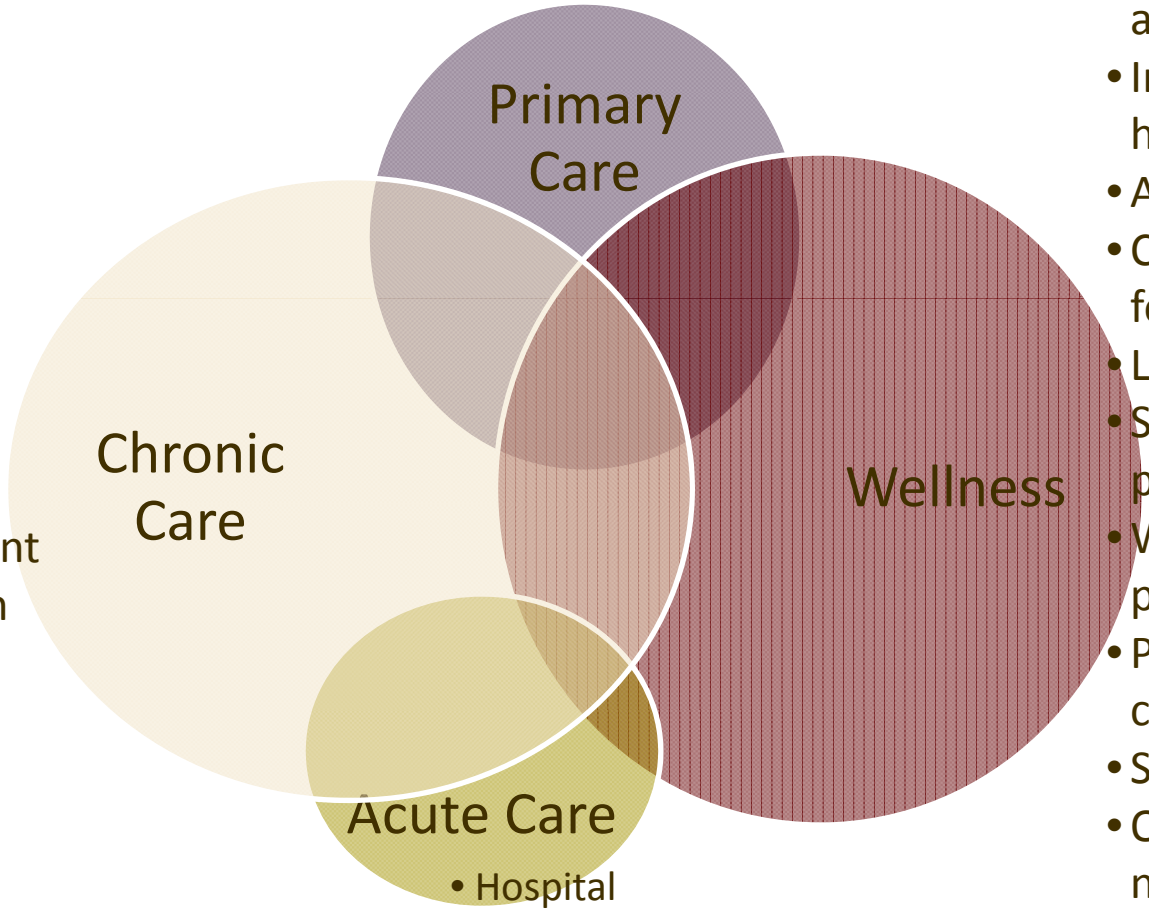
Reformed Health System – Service Delivery

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



- Hospital
- SNF
- At Home
- Telehealth

- 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

Overview: The Future Under Health Care Reform

Health care reform is designed to significantly alter:

How we Pay for Care

- Payment reductions
- Bundled payments
- Shared Savings
- Value-based payment
- Independent Payment Advisory Board

How Care is Organized

- Accountable care organizations
- Medical homes
- Episodes of care
- Health information exchange

How Care is Delivered

- Center for Medicare and Medicaid Innovation
- Comparative effectiveness
- Multidisciplinary care teams
- Electronic Health Records
- Care Transitions
- Improved coordination of care for dual eligibles

What's Next?

Of late, a lot of people seem to keep asking the same things:

"What's the next BIG thing in healthcare reform?"

or

"What should we be doing next?"

Focus on Quality

Outcomes and Measurement - <u>Here's why:</u>

As service providers, we received our business through either (a) the referral of others, or (b) consumers directly.

<u>BOTH</u> are intensely focused on quality and affordability.

Skilled Nursing Provider of Choice

Low/no hospital readmissions

Meaningful Use of Electronic Health Record

Past success partnering with other providers

High Quality

- Top of Class in Nursing Home or Home Health Compare
- High patient satisfaction
- Robust continuous quality improvement
- Innovative care delivery approaches
- Good community reputation

Demonstrated patient/ resident-centered approach to care

Cost of Care is lowest in comparison to peers with comparable quality.

Getting ready to respond
Strategies for Senior Living Providers

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Responding to Reform

The BIG Picture

Decide: lead, follow, resist

Prepare to assume risk

Use technology better

Align providers interests

Connect quality to value

Build new relationships

Evolving Tools to Track and Trend Data

- **To become value-based providers, we must develop platforms for both capturing and trending outcome data.**
  - Better surveillance tools to monitor readmission issues, identify high-risk patients and establish protocols for intervention
  - Effective surveys or consumer interfaces to gather real-time (or near-to-real-time) data about patient perceptions of care, patient satisfaction and quality

Consumer Perception IS Reality!

Growing Clinical and Patient Management Skill

- **For many of us, growing clinical skill will require new ways of thinking and clinical training.**
  - Developing more clinical pathways for common patient types, like CHF, COPD, Pneumonia, Stroke and other diagnoses.
  - Increasing or evolving current physician strategies to support around-the-clock coverage
  - Adopting or evolving evidence-based protocols to better manage high-acuity patients
  - Evolving to or partnering with others to provide post-discharge management: CareTransitions, Coaching or geriatric care management.

Continuum Management of Patients

- **Senior care in the future will be tied less to "locations" and more to "services".**
  - In effect, bricks-and-mortar providers will be looking to evolve beyond their real estate to extend their reach.
  - Evolving community continuums will emphasize home and community-based services to keep people health and independent at home.
  - Organizations are approaching continuum management through two general approaches:
    1. "Own" a continuum through internal development of services
    2. "Partner" a continuum through relationships with other, similar community-oriented organizations

Relationships Are Mandatory Going Forward

- **Growing new relationships sometimes poses a challenge for us, and you can't be an island in the future.**
  - What is the role and function of business development in your organization?
  - How well do you really KNOW your major referring organizations? Who really holds the relationships?
  - Are there other providers with whom you can collaborate or partner?
  - With whom are you willing to share risk?

Provider Know Thyself

Define Your Organization's Value Proposition

- Be vocal
- What is your quality?
  - ◊ Performance: NH or HH Compare
  - ◊ Star rating
  - ◊ Dashboards
- What is your model of care?
- What other services willing to provide if reimbursed?

  - Adult Day Care, Infusions

"Tell them your story"

Provider Know Thyself (continued)

2) How much risk are you willing/able to take?

3) What is your current payer mix?

- Medicaid dependence
- Special programs

4) What are your key referral sources and physician doing? Which providers see your residents?

- MCOs should want all of you in the network
- Possible partnerships → lower cost of care

Contracting Strategies

- **Approach**
  - Be proactive
  - Bring your org stats – plans often don't know
  - Propose alternative rates or additional services
  - Don't be defensive – plans will contract with the easy orgs first
  - Read the MCO/State contract

Be proactive → collaborate with the plan

Escalate → talk to plan CEO/COO if necessary

Cont'd

- **Rural vs. Urban**
  - Know the geographic limits / access standards of the plan
  - Leverage the situation

- **Being Part of the Solution**
  - Who are the MCOs problem cases? Situations?
  - Consider approaching the plans' foundations for grants to pilot certain services or care delivery redesigns

How can Senior Service Organizations Drive Reform?

- Focus on demonstrating value internally
- Transparency: communicate this value to consumers and payors
- Explore LEAN practices to achieve value and efficiency
- Develop, deploy, disseminate best practices in post-acute and long-term care
- Test new models of care and payment
  - Geriatric Urgent Care
  - Geriatric Nurse Line
  - New clinical pathways
  - Bundled payment for a post-acute episode
- Improve Care Transitions and Lower Readmissions
- Focus on high cost, high risk populations
- 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

Up to Your Knees, or Up to Your Neck?

Ask Yourself:

How Far Do You Want to Get In?

What is your current business strategy?

How much Medicare do you currently manage?

What is your level of diversification?

Do you have capacity to grow or expand?

Can you partner or affiliate with others?

Do you have **energy** to take it all on?

"Strawman" Strategic Priorities for Health Care Providers

1. In each market in which you operate, position your organization to be #1 or #2 for key referral sources and collaborative partners
2. Develop / coordinate / collaborate to create a full continuum of capabilities in each market
3. Continue to invest in technology and update physical plants to meet contemporary requirements
4. Improve operating performance and build balance sheet

***Overall focus**: assemble basic performance data – tighten pre- and post-acute network – focus on developing relationships with Providers that will ultimately control or influence flow of funds*

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