Preparing to Operate and Survive in a Reformed Health Care Environment

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Session Outline

I. Examine the goals of health reform

II. Identify and define the new models of payment and care delivery

III. Explore what health care providers are doing relative to these initiatives and the strategies for implementation

IV. Discuss how organizations can prepare for what is needed to succeed in a reformed health system

V. Review and test various scenarios in a value-based payment and ACO environment

VI. Questions
The complexity and pace of change will bring opportunities and pose significant threats.
Key Trends

Drivers include local culture, customs, and care delivery patterns.

Successful strategic planning will require comprehensive understanding.
Themes of Health Reform

- Access to Care
  - *Wellness*
  - *Prevention*
  - *Chronic care management*

- Care Reform
  - *Wellness*
  - *Prevention*
  - *Chronic care management*

- Payment Reductions

- Payment Reform:
  - Reward and increase value

- Information
  - *Quality and EHR*
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 Delivered
- Center for Medicare and Medicaid Innovation
- Comparative effectiveness (evidence-based best practices)
- Multidisciplinary care teams across sites of service
- Electronic Health Records
- Care Transitions
- Improved coordination of care for dual eligibles

### How Care is Organized
- Accountable care organizations
- Medical homes
- Episodes of care
- Health information exchange
Payment reform will focus on quality and value.
Potential Implications to Providers

- Robust measurement systems
- Automated data collecting processes
- Significant cost of care reductions
- Changing gain-sharing payer expectations
- Better payer contracting data
Key Trends Impacting Providers

Referral Sources are instituting changes in preparation for different payment models (i.e. ACOs, VBPs, etc.).
Potential Implications to Providers

- Hospital and physician relationships
- New provider roles
- Integrated care delivery models
- Best practice protocols
- Community and post-acute setting care delivery
Key Trends Impacting Providers

#3

Hospitals will experience significant financial strains over the next 5 – 7 years.
Potential Implications to Providers

- More SNF and home care discharges
- Greater hospital integration
- Frail and clinically complex residents
- Preferred provider networks
- Faster response times
Future customer buying practices will likely not reflect historical patterns.
Potential Implications to Providers

- More focus on quality and value
- Desire choice and flexibility
- New marketing messages
- Short stay residents
- Patients staying in their own homes
Key Trends Impacting Providers

#5

Health Care Reform legislation will create opportunities for aging services providers.
Potential Implications to Providers

- Health information exchange
- Payment reform
- Quality and performance measurement
- SNF and Home Health payment reductions
- Shift to lower cost levels of care
- Growth in home and community based services
What Does All This Mean?
Our Overall Perspective: The Critical Issues

- Recessionary economy
- Access to capital
- Technology
- Health care reform
- Relationships
- Accountability for quality and value
Impact of Economic Recession

The “New Normal”

Economic downturn was both good and bad ...

What is the long-term impact?
Health Reform Will Drive Tremendous Change

Change is imminent.

- Greater financial risk
- Operational efficiency
- Collaboration
- Technology investments
- Increased quality
- Elevated regulatory risk
- Community-based services and care
- Post-Acute
Changing Technology Focus

**Past:** information management and monitoring

**Today and future:**
- Creating connectivity
- Improving staff productivity
- Using technologies as part of medical procedures
Business Relationship and Process Changes

1. Manage referral relationships.
2. Add value in the “care delivery” stream.
3. Implement sophisticated business processes.
4. Adapt management and governance activities.
Increasing Consumer and Payer Expectations

Demand for accountability and value

- Targeted under health reform
- Person-centered post-acute care
- Home and community based services
- A long range financing vehicle
- Living arrangements
- Expectation of “free!”
Regulatory Challenges
CMS Vision for Post-Acute Care

“The person-centered post-acute care system of the future will:

– Optimize choice and control of services;
– Ensure that placement decisions are based on patient needs;
– Provide coordinated, high quality care with seamless transitions between settings;
– Reward excellence by reflecting performance on quality measures in payment;
– Recognize the critical role of family care giving; and
– Utilize health information technology.”

The Field Of Aging Services Is Evolving

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
Value-Based Performance Payment

Value Based Performance Payment is a generic term for payments that: “improve beneficiary health outcomes and experience of care by using payment incentives and transparency to encourage higher quality, more efficient professional services.”

Key objectives:
1. Encourage use of evidence-based medicine
2. Reduce fragmentation, duplication and inappropriate use of services
3. Encourage effective management of chronic disease
4. Accelerate the adoption of health information exchange
5. Empower and engage consumers

Key assumptions:
1. Performance based payments will drive change
2. Different practice arrangements will be accommodated
3. Multidisciplinary team members will be recognized
4. Accountability will be across multiple levels and sites of services
5. Plan will be budget neutral
6. Focus will be to change FFS and there will be a short term and long term strategy

Source: Development of a Plan to Transition to a Medicare Value-Based Purchasing Program for Physicians and Other Professionals, Issue Paper, Public Listening Session, December 9, 2008; CMS
Array of Payment Options

Spectrum of Payment Models for Health Plans and Providers

1. **Fee-for-service**
   - Negotiated payment based on volume of service

2. **Performance-based, fee-for-service**
   - Negotiated payment for volume plus additional incentives for managing costs, quality, and patient experience

3. **Shared savings**
   - Shared savings if interim costs are less than target

4. **Risk sharing**
   - Shared savings and shared losses

5. **Full capitation**
   - All savings/losses are assumed by provider

Increasing level of risk
Four Bundled Payment Models

Timeline

- January – July 2013: No-risk prep period.
- July 2013: Risk Bearing Implementation Period

- Model 1 – Acute Care Hospital Stay Only (Retrospective): 3 participants representing 32 organizations
- Model 2 – Acute Care Hospital Stay + Post Acute Care Episode (Retrospective): 55 participants representing 192 organizations.
- Model 3 – Post Acute Care Only (Retrospective): 14 participants representing 165 organizations
- Model 4 – Acute Care Hospital Stay Only (Prospective): 37 participants representing 75 organizations
Accountable Care Organizations

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

**Pioneer ACO Program (32); started 1/1/12**
- Eligible organizations had prior ACO-like experience
- 15,000 Medicare beneficiaries minimum
- Must enter into outcomes-based contracts with multiple payers.
- Model transitions to greater financial accountability (risk) faster.

**Medicare Shared Savings Program (MSSP) (221)**
- Program requires the participating providers to form an ACO
- 5,000 Medicare beneficiary minimum for participation
- Two approaches: Savings only, Savings/Losses
- MSSP start dates: 4/1/2012, 7/1/2012, 1/1/2013

**Advanced Payment Initiative (35)**
- Must apply to be an MSSP ACO first
- Only smaller physician only practices OR rural health clinics or CAHs are eligible to participate
- Receive advance payment on their projected shared savings
Managed Care and the Dual Eligibles

Who are the “duals”? 9 million low-income seniors and disabled covered by both Medicare and Medicaid. Characteristics include:

- **High cost:** Represent 20% of Medicare population but 31% of costs.
- **Poorer health status**
- **Low income:** 86% of them have incomes below 150% FPL ($17,235 for individual)

- **Renewed federal and state focus on Managed Care for dual eligibles**
  - Federal Coordinated Health Care Office created
  - The Financial Alignment Initiative

- **Types of Managed Care:**
  - Medicare Advantage
  - Medicaid Managed Long Term Care
  - Managed Care for Duals/Financial Alignment Initiative
Financial Alignment Initiative

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.

26 States submitted proposals; As of 3/27/2013, CMS has approved five states: CA, WA, MA, IL, OH in these demonstrations
Illinois Integrated Care Program (ICP)

• Started in 2011

• **Population:** Non-duals Medicaid Managed Care for seniors and disabled

• **Geography:** Suburban Cook, DuPage, Kane, Kankakee, Lake, and Will counties only.

• **Services:** all Medicaid - acute care, behavioral health and long term services and supports (LTSS) ; Care coordination

• **Plans:** Aetna and IlliniCare

• Foundation for Medicare-Medicaid Alignment Initiative (MMAI)
Illinois Medicare-Medicaid Alignment Initiative (MMAI)

- **Population**: Full benefit duals, not DD
  - Passive enrollment with opt out – assigned plan if none selected but can change plans or opt out
- **Services**: Full array of Medicare and Medicaid services including pharmacy – medical, behavioral, pharmacy, and long term services and supports (both institutional and community-based)
- **Plans**: State reviewing plan responses to RFP now
  - October plan selection anticipated
- Blended capitation payment for MCOs with P4P incentive
- **Implementation date**: 4/1/2013
MMAI - Geography

• Phase I:
  – **Greater Chicago**: Cook, Lake, Kane, DuPage, Will, Kankakee counties
  – **Central Illinois**: Knox, Peoria, Tazewell, McLean, Logan, DeWitt, Sangamon, Macon, Christian, Piatt, Champaign, Vermilion, Ford, Menard, Stark counties

• Phase II: Year 2 of Demo
  – Rockford: Winnebago, Boone, and McHenry counties
  – East St. Louis: Madison, Clinton, and St. Clair counties
  – Quad Cities: Rock Island, Mercer, and Henry counties
MMAI State Expectations

- More care coordination for duals
- Increased health risk and behavioral health assessments
- More duals with care plans
- Greater access to HCBS waiver and support services
- Reduced hospital readmissions, inappropriate ER use, and non-emergent transportation costs (esp. for NH residents)
- Improved beneficiary satisfaction
What Do We Need to Do?
Preparing for Change ...

Key strategies

- Decide: lead, follow, resist
- Prepare to assume risk
- Use technology better
- Align providers' interests
- Connect quality to value
- Build new relationships
Provider of Choice

Low/no hospital readmissions

Meaningful Use of Electronic Health Record

Past success partnering with other providers

Demonstrated patient-centered approach to care

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

Cost of care is lowest in comparison to peers with comparable quality.
Prepare to Demonstrate Value

#1: Re-examine care delivery to reduce cost and improve quality

#2: Know your quality and value
   - Compared to your competitors
   - Measure, track, communicate, and improve it

#3: Build new provider relationships & collaborations

#4: Develop more robust quality measurement systems that include predictive modeling, process and outcome measures

#5: Survival will depend on health information
   - Tracking: quality, claims, cost
   - Care transitions
   - Data mining & exchange
   - Disease management
Implementation of Change

Seven steps for successfully implementing change:

1. Generate a sense of urgency
2. Build a coalition throughout the system
3. Create and share a vision for process and outcome improvement
4. Empower staff to identify & eliminate obstacles
5. Communicate and recognize short-term wins
6. Instigate PGP investment in the process by recognizing lessons learned and adding processes that may improve overall change
7. Sustain change by emphasizing new patient management techniques and treatments.
Skills Needed to be Successful

- Strong Visionary Leadership
- Change Management Capabilities
- Actuarial
- Financial Modeling/Health Informatics
- Patient Connectivity/EHR/Health Info. Exchange
- Quality Measurement
- Medical Home/Chronic Care Management
Group Exercises

• Readiness Assessment
• Value Proposition
Assessing Organizational Readiness

1. Do you track the rate of hospital readmissions of residents from your facility?

2. Do you know how you compare to other facilities in your area on readmissions?

3. Do you routinely review and compare your organization’s Nursing Home and/or Home Health Compare Metrics?

4. Do you evaluate your organization’s cost of care and know how you compare with peers with comparable quality?
Assessing Organizational Readiness

5. Does your organization have electronic health records?

6. Do you partner with other providers in the community?

7. Do you have a relationship with the hospital(s) in your area at the C-suite level?

8. Have you collaborated with your hospital(s) or primary care physicians on any programs or services?

9. Would you describe your organization as innovative and open to change?

10. Do you achieve high levels of resident satisfaction?
Assessing Readiness

Can you Demonstrate that You Deliver High Quality at a Lower Cost?

– Can you prove (through data) that your organization delivers value (high quality/lower cost)? (yes, no)

– Do you have quality dashboards that help identify trouble areas? (yes, no)

– Can you identify how your quality provides value/savings? (yes, no)
Discuss Readiness Assessment outcome

- Discuss
  - How many “no” answers did you have?
  - Of the items you answered “no” to, which will be the most challenging to address and why?
  - What significant changes must be made in your organization regarding quality measurement and data analysis?
Defining Your Organization’s Value Proposition

Element 1: Tell Your Story and Care Delivery

- **Tell your story:** Explain what services you provide, the type of resident and geography you serve currently.
  - Discuss the non-profit difference and demonstrate through metrics how your outcomes prove your non-profit value.

- **Care Delivery**
  - What is your model of care? Discuss your staffing model
  - What best practice protocols or evidence-based medicine do you employ in your organization?
  - Describe any innovative care or payment delivery models you have used in the past.
  - Describe your approach to providing person-centered care.
  - Describe any care coordination or care transition programs/services you provide today.
Defining Your Organization’s Value Proposition

Element II: Quality/Performance

- Continuous quality improvement: Describe your quality improvement processes
  - Do you conduct root cause analyses when you identify a problem?
  - How do you identify and resolve issues?
- Share your performance on key quality and performance metrics? May include:
  - Resident satisfaction scores
  - Readmission rate for residents to the hospital
  - Falls rate
  - Medical errors resulting in hospitalization
  - Occurrences of pressure ulcers, weight loss and infections
Element III: Costs and Reimbursements

- Describe how your organization and the services it provides are cost effective alternative to a higher cost setting (e.g., if you’re a SNF, how are you a better value than a hospital; if an assisted living, how can you attain the same patient outcomes in your setting less expensively than a nursing home, etc.)
  - Explain what your current Medicaid rate is and typical services provided for that rate
  - Describe steps you’ve taken to provide cost effective care

- Describe services that you could provide that produce better outcomes for patients at a lower cost
  - Example: caregiver support following patient discharge from SNF to reduce rehospitalizations, or need for institutional level services
  - Example: Serving clinically complex patients. Would you be willing to add service/staff appropriately so these individuals could be maintained in your setting if paid a higher rate by the MCO?
  - Discuss additional services willing to provide to maintain the resident and negotiate different rate for that package of service
Element IV: Communication and Partnerships

- Does your organization have an electronic health record?
  - Share dashboards on quality outcomes to tell your story
  - If no EHR currently: talk to the plan to see if they have any resources that could help you invest in this important technology, which could help you improve care transitions and better manage patient populations.

- Discuss any current care transition processes to/from hospital or home that you have in place today. Inquire about their preferred approach and how they could help you establish these processes if there are no current protocols.

- Describe any current or past provider partnerships that you have participated in to improve care or outcomes for the people you serve.

- See if there are grants available through the MCO foundations or companies that support testing new approaches to care delivery in general or for targeted populations.
Defining Your Value Proposition

Scenario:
An MCO is meeting with area Senior Living providers to discuss contracts for the new Managed Medicaid Long Term Care program the state is rolling out. The state’s network requirements do not require MCOs participating in the MMLTC program to contract with all existing providers.

How does your organization prepare for this meeting?
1. Know the Rules

• What does the state proposal to CMS for managed care for duals say?

• What does the State’s Request for Proposal to the Managed Care Organizations say?

• What other information is available from the State agency administering the program about the program?

• What do the state contracts with MCOs require?
Know the Rules/Goals of Program

Example: State Expectations

- More care coordination for duals
- Increased health risk and behavioral health assessments
- More duals with care plans
- Greater access to HCBS waiver and support services
- Reduced hospital readmissions, inappropriate ER use, and non-emergent transportation costs (esp. for NH residents.
- Improved beneficiary satisfaction
Know the Rules/Goals of Program

Example: Reimbursement Requirements

• Plans must propose “creative payment plans that encourage a holistic approach to beneficiary care, quality outcomes, and evidence-based practice, such as bundled payments for episodic specialty care.”

• Medical home payments encouraged to combine capitation, FFS and P4P

• No language in state proposal about Medicaid rates as floor.
Know the Rules/Goals of Program

Example State MMLTC Quality Metrics

• For all populations:
  – ER utilization
  – Inpatient hospitalization
  – 30-day readmission rate
  – PCP follow up after ER or IP hospitalization
  – Assistance to enrollees accessing services outside Covered Services
  – Health Education provided
  – Coordination of primary and specialty care
  – Care coordination, care management, disease management
  – Individualized care plans
  – Utilization of dental benefits
  – Preventive health care for adults
Know the Rules/Goals of Program

State Monitoring and Chronic Conditions

Chronic Health Conditions

- Diabetes
- Asthma
- CHF
- CAD
- COPD
- Behavioral Health
- Individuals with one or more co-morbidities

Related Monitoring

- Appropriate treatment and follow up care
- On-going risk assessment
- Enrollee participation in treatment plan development
- Care coordination, care management and disease management
- Chronic Health Condition action plans
Discussion Questions

• What organizational features will you select to share with the MCO?

• Which metrics will they find most valuable? (e.g., readmissions)

• What format will you share this information in?
  – Do you have a quality scorecard?
  – How would you describe your quality improvement process?
Discussion Questions

• What is your value proposition for why this MCO should contract with your organization over another senior living provider?

• What information will you include in your value proposition document that will be different if you are an assisted living, home health agency vs. a Skilled Nursing Facility vs. CCRC?
Resources

• Information on the Financial Alignment initiative program and links to state proposals:
Our Advice.....

1. *Think big, but act small*....this can lead to greater engagement, clearer focus and higher outcomes.

2. *Go slow to go fast*.....plan the next few years out thinking about how you will create the “burning platform” for change in your organizations that will engage not only the minds but hearts of staff.

3. *Participation in the changes is not a choice*.....health care is going to change dramatically and we need to design the best transition plan for our organization and our constituents.

4. *To create better, connect more*.....connecting with referral and payer sources, wise souls and key community leaders may help identify the innovations that will lead to success.
Questions?
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