Navigating the Ever-changing Health Care Landscape

LeadingAge Iowa Spring Conference

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It’s Coming...

The Future
NEXT EXIT

Are you up to the challenge?
So, what does this mean for you?

You Are Not Alone
Reform at the Core: 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

Driving New Thinking for LTC and Senior Services

- **2011–2012**
  - Bundled payment initiative
  - ACOs
  - Hospital readmission penalties

- **2013**
  - More ACOs!
  - Medicaid to Managed Care
  - Dual-eligible program evaluations

- **2014**
  - Exchanges and coverage mandates
  - Dual program launches
  - Hospital VBP expands
  - SNF and HHA VBP likely

- **2018–2020**
  - Bundles outpace FFS
  - Population health management
Shifting from Volume to Value

*Tying payment to performance is the future*

If you can deliver **QUALITY** and help lower cost, you have a play in the game

But you must get IN the game!

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The Rise of the Post-Acute

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The BIG Picture

Skilled Nursing Facilities Key to Bending Cost

**Nursing homes can play an important role for health plans**

- Medicare Acute Hospital Discharges
  - 43% Sent to Post Acute

- Skilled Nursing 41%
- Home Health 37%
- Acute Rehab 10%
- Outpatient 9%
- LTACH 2%

With the bulk of post-hospital patients, skilled nursing represents a key setting for controlling total costs and managing outcomes.

Health systems often have limited control of costs and outcomes sent to non-affiliated post-acute settings.

Source: MedPAC, 2011

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“These transformational models are no longer isolated pilots. They [ACOs and bundled payment initiatives] are becoming the face of American medicine.”

Kathleen Sebelius, Former HHS Secretary, to the American Medical Association, February 12, 2013

2022 Goal: Minimum 50% of Total Medicare PAC Provider Payments Bundled

$0 $5 $10 $15 $20 $25 $30 $35 $40

Billions

2013 2015 2017 2018 2020 2022

Pilot began Oct. 1 Add new participants Jan. 1 All PAC providers

Reduce Spend by -2.85%

Source: Budget of the United States Government, FY 2016; http://www.whitehouse.gov/omb/budget
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FFS Versus Bundled Payment

Fee-for-Service
- Payor provides single payment intended to cover costs of entire episode of care

Bundled Payment
- Payor provides single payment intended to cover costs of entire episode of care

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Anesthesiologist</th>
<th>Consulting Hospitalist</th>
<th>Physician</th>
<th>Surgeon</th>
<th>Post-Acute Services</th>
</tr>
</thead>
</table>

Source: The Advisory Board, 2010

Bundled Payments for Care Improvement Initiative (BPCI)

CMS innovation demonstration project where participants enter an alternative payment arrangement

<table>
<thead>
<tr>
<th>Types of Services Included in Bundle</th>
<th>Model 1 Acute Hospital Stay Only</th>
<th>Model 2 Acute Hospital + Post-Acute</th>
<th>Model 3 Post-Acute Care Only</th>
<th>Model 4 Acute Hospital Stay + Readmissions</th>
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<tbody>
<tr>
<td>Inpatient hospital and physician services</td>
<td>✔</td>
<td>✔</td>
<td></td>
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<tr>
<td>Related post-acute care services</td>
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<td>Post-acute care services</td>
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<tr>
<td>Related readmissions</td>
<td></td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Other services defined in the bundle (Part A &amp; Part B)</td>
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<td>✔</td>
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</tbody>
</table>

Episode Initiators

|               | 15 | 2,077 | 4,558 | 17 |

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Nickel & Diming Yourself...

How much does it COST to care for a CHF patient in your subacute unit for 15 days?
Odds are, you don’t know

But you really need to know
When the hospital or the ACO or the MCO shifts to a bundled payment and comes calling

We need to learn patient-level cost accounting
Otherwise we can never take on risk
(And people who can manage risk get to sit at the grown-up table)

Bundled Payment
The Greatest Opportunity to Bend the Cost Curve

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

Estimated Cumulative Percentage Changes in National Health Care Expenditures, 2010 through 2019

Preferred or Select Provider Networks

Hospitals, emerging ACOs, and other payors recognize that post-acute care and aging services will play an important, if not pivotal, role in reducing costs and managing population health.

“We have made significant strides in improving care coordination, but there is still much work to be done. By working together, we can achieve better outcomes for our patients and reduce costs.”

—Rich Umbdenstock, President & CEO, AHA

Recognizing and integrating, however, are two very different things.

It’s Not What You Believe...

“We Provide Great Quality Care!”

PROVE IT

From here on out, data (i.e., “evidence”) are the distinguishing feature from one provider to the next—especially for payors and should be among collaborative providers.
Increasing Intensity Around Measures

As the emphasis on quality goes up and reimbursement goes down, the intensity around measures will be profound

- Evolving “preferred” or “select” provider networks are creating complex evaluative criteria and clearly defined expectations about ongoing participation
- Managed care organizations (for Medicare Advantage and inevitably duals), while not on the record yet, have conceded that outcome performance over time will dictate many of their contracting and referring decisions
- In almost every network scenario, measurement plays a key role in determining if you are on the field or on the bench

Web of Health Care Reform
Emerging Opportunity: Community Partnerships
Case Study 1: Massachusetts’ Healthy Living Center of Excellence

- AAA + Senior Care Provider:
  - Elder Services of the Merrimack Valley, Inc.
  - Hebrew Senior Life
- Goal: to help seniors remain independent and in the community
- Chronic disease self-management is at program’s core

Case Study 1: Massachusetts’ Healthy Living Center of Excellence (continued)

- Outcomes to date:
  - $740 per person costs reduction (hospital and ER use)
  - Reduction in ER visits from 18% to 13%
  - Improved involvement in patients’ own care
  - Decreased depression
  - Significant improvements in sleep, pain management, and overall quality of life
Case Study 1: Massachusetts’ Healthy Living Center of Excellence (continued)

“The HLCE is in essence creating an integrated delivery system in which health care systems, community-based social services and older adults collaborate as partners to improve care and lower costs.”

-Jim Roosevelt, President /CEO
Tufts Health Plan Foundation /Tufts Health Plan

Case Study 2: Tandem 365
Grand Rapids, Michigan

- Integrated care model encompassing volunteers, community services, retirement communities, skilled nursing providers, and EMS
  - Sunset Retirement Communities and Services
  - Clark Retirement
  - Holland Home
  - Porter Hills
  - St. Ann’s
  - Pilgrim Manor
  - Life EMS Ambulance

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Case Study 2: Tandem 365
Grand Rapids, Michigan (continued)

• Goal: to help older adults navigate the complexities of health care while managing costs and enabling them to remain in their homes

• How does it work?
  – Provides services and supports in the community through a single point of contact
  – Care provided by team of medical and wellness experts
  – Model includes non-traditional services not commonly reimbursed by insurance (transportation, personal aides, adult day care, chore services)

Case Study 2: Tandem 365
Grand Rapids, Michigan (continued)

• Integrated care model based on intense case management:
  – Navigators include RNs and SWs
  – Interdisciplinary team provides a means of actively monitoring and evaluating each person’s care
  – Rapid response teams on call 24/7
  – Encompasses non-medical services such as meals, transportation, telehealth, personal care, and emergency response systems
Case Study 2: Tandem 365
Grand Rapids, Michigan (continued)

• Progress to date:
  – Prevention of ER visits
  – Diversion of hospital admissions
  – Return of elders to their homes
  – Enrollment increased from 26 participants to 70 participants within two-month span

• In progress:
  – Conversations with payor sources and health systems to expand the program

What Makes You So Special?

It's a Jungle out there! www.hengencartoons.com By Hagen

FRANKLY, YOU'RE NOT IMPRESSING US: WE CAN ALL DO THAT...

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Step 1: Defining Your Value Proposition

- What are our strongest programs/services?
- What services can we offer/sell?
- Do we have excess capacity?
- Who are we serving?
- Who else could we be serving?
- Who are our partners?
- Can we demonstrate our value via defined metrics and readily available data?
Step 2: Define the Potential

• What is the local/regional Affordable Care Act activity?
• Who are the leaders?
  – Hospitals, health systems, larger senior living providers
• What are the priorities of the leaders?
• Are there any care transitions discussions or collaborations occurring?
• Are there established metrics for performance?
• Are we at the right tables? If not, how do we get invited?
• Could we be leading the conversation?

Step 3: Strategic Evaluation

• Complete financial modeling of potential opportunities
• Define each target opportunity:
  – What is the target market area (expanded; constricted)
  – Who are the potential competitors?
  – Who are the potential partners? What are their motivators and goals?
  – What is our potential ROI?
  – Who will we be serving?
  – Can we leverage existing programs and services?
  – Does this support our mission?
• Prioritize opportunities
Step 4: Develop Business Plan

- Define the program
- Organizational structure
- Service offerings
- Competitor review
- Job descriptions
- Staff education plan
- Marketing plan
- Budget findings

Questions
Thank You!

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