Preparing for ACOs, VBR and Bundled Payments

An Aging Services Strategic Framework

Agenda

• The current state of health care…and where we may be headed

• Aging services industry influencers

• Adapting to new industry demands
  – Health Care Reform

• Strategies to succeed in the near-, mid- and long-term
“Leaders must emerge who regard themselves as defenders not of organizations but of the underlying purposes that have temporarily created those organizations in their current forms. Leaders will have to be willing to unmake the very organizations they hold in trust. That’s a big job. It requires a kind of courage that is rare among human beings, including organizational leaders.”

Don Berwick MD
“Seeking Systemness,”
Healthcare Forum Journal,
March/April 1992

Health Care Delivery: Today

Influencers:
- Family
- PCP
- Care Setting
- Care Provider
- Payer

Considerations:
- Residential Setting
- Older Adult
- Medical Needs
- Socialization

Providers:
- Home
- ILU
- AL
- SNF
- CCRC
- PCP
- Drugs
- HH
- HC
- DME
- Friends
- Family
- Living Arrangement
- Day Care

The system is complicated by the influencers, settings, multiple providers and payers

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Health Care Delivery: ACO Network

ACO Network

ACO Providers: Bonus-Eligible

- Primary Care Practitioners
- Hospitals

Non-ACO Preferred Providers

- "Value" Providers

Non-Preferred Providers

- Low Quality, High Cost Providers

ACO Configurations Will Vary: Continuum

ACO

The Integrated Continuum

- PCPs
- Hospitals

- Specialists
- Post Acute
What happens nationally and globally impacts aging service providers locally

Near-Term Challenges
- An unstable and unpredictable political environment
- Volatile stock market
- Size of National debt
- Consequences of recession
- Rising health care costs
- High unemployment rates
- State budget shortfalls

Unsustainable Health Expenditures

- National Health Expenditures (NHE) Are Unsustainable

<table>
<thead>
<tr>
<th>NHEs</th>
<th>2010</th>
<th>2019 (Projected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>As a % of GDP</td>
<td>17.5%</td>
<td>19.3%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$2.6T</td>
<td>$4.5T</td>
</tr>
</tbody>
</table>

- Individually, insurance premiums as a % of employee income
  - By 2016, estimated that half of U.S. households will need to spend more than 45% of their income on premiums.
- 16.7% of the population is uninsured

Looking to the future:
How will we address the Needs of an Aging Population

Life expectancy has risen over the last century, and both new and growing demand for aging services as this trend continues well into the 21st century will bring opportunities as well as challenges for senior living providers.

Changes in Consumer Needs and Preferences

- **Significant decline in housing values**
  - Assets typically used to fund health care and LTC in retirement
  - Inability to sell homes limits service choices for seniors. (More HCBS, less assisted living)

- **Net worth/assets**
  - Baby Boomers declined substantially and they don’t have enough years to recover losses
  - Adult children of seniors see their inheritance and their own investments declining, are now assessing needed LTC services differently.

- **Baby Boomers**
  - Many delaying retirement due to losses
  - Caught between the defined benefit and the defined contribution era – few have employer pensions to help pay health care costs.

**Implications**

- Long term it appears that when baby boomers need services they are most likely to finance that care through Medicaid.
- Baby boomers with parents needing care currently may decide to try to support parents in their homes because they don’t have the money to supplement.
Public Policy

U.S. Health Reform

• In March 2010, Congress passed and the President signed health reform in:
  – The Patient Protection and Affordable Care Act
   ◦ Increases access to health coverage (32 million)
   ◦ Aims to reduce costs via payment reductions and focus on wellness and prevention
   ◦ Seeks to reward “value-based” care delivery

• Since enactment, numerous additional laws have been passed amending portions of the original laws, and rules/guidance issued to assist in implementation.

Impact of the Act:
• Cost: = $940 billion/ 10 yrs
• Coverage = 32+ million by 2019

Public Policy

Estimated Deficit Reduction Over Next Ten Years

The following are the Congressional Budget Office’s estimates of deficit reduction impacting providers. These estimates are based on a number of provisions in the health care reform act:

- Hospital Cuts - Total $148.7B
  ◦ Medicare market basket reductions $112.6B
  ◦ Medicare DSH $ 22.1B
  ◦ Medicaid DSH $ 14.0B
  **While Critical Access Hospitals will be cut, much of payment reform does not apply to them.

- Home Health market basket reductions – Total $ 39.7B
- Hospice market basket reductions – Total $  6.8B
- SNF market basket reductions – Total ~$15 B
- Medicare Advantage reductions – Total $ 132B

Source: HFMA webinar “Health Care Reform: A Conversation with HFMA’s Dick Clark, CEO,” April, 2010

There are several hundred demonstrations, pilots, and research grants included in the health care reform laws, which allow for changes in current delivery and payment systems.
Projected Spending by Sector: Medicare & Medicaid

Despite the impact of deficit reduction resulting from decreases in Market Basket updates from 2010-2020, spending in Medicare & Medicaid is expected to continue to increase.

<table>
<thead>
<tr>
<th>Sector</th>
<th>Medicare</th>
<th>% Change</th>
<th>Medicaid</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital</strong></td>
<td>2010</td>
<td>$229.3</td>
<td>81.3%</td>
<td>$150.7</td>
</tr>
<tr>
<td></td>
<td>2020</td>
<td>$415.7</td>
<td></td>
<td>$324.4</td>
</tr>
<tr>
<td><strong>Physician</strong></td>
<td>2010</td>
<td>$113.7</td>
<td>48.1%</td>
<td>$42.5</td>
</tr>
<tr>
<td></td>
<td>2020</td>
<td>$168.4</td>
<td></td>
<td>$121.2</td>
</tr>
<tr>
<td><strong>Home Health</strong></td>
<td>2010</td>
<td>$31.5</td>
<td>61.0%</td>
<td>$25.6</td>
</tr>
<tr>
<td></td>
<td>2020</td>
<td>$50.7</td>
<td></td>
<td>$63.6</td>
</tr>
<tr>
<td><strong>Prescription Drug</strong></td>
<td>2010</td>
<td>$58.2</td>
<td>124.6%</td>
<td>$19.9</td>
</tr>
<tr>
<td></td>
<td>2020</td>
<td>$130.7</td>
<td></td>
<td>$55.9</td>
</tr>
<tr>
<td><strong>Nursing Facility</strong></td>
<td>2010</td>
<td>$29.6</td>
<td>84.1%</td>
<td>$44.6</td>
</tr>
<tr>
<td></td>
<td>2020</td>
<td>$54.5</td>
<td></td>
<td>$65.6</td>
</tr>
</tbody>
</table>

* Amount in Billions of Dollars

Source: Centers for Medicare & Medicaid Services, Office of the Actuary

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National Health Expenditures: Projected

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Medicare &amp; Medicaid</th>
<th>Impact of Affordable Care Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>$2,584.20 $525.0 $400.7</td>
<td>$2,579.00 $519.6 $402.9 0.20% 1.04% -0.55%</td>
</tr>
<tr>
<td>2011</td>
<td>$2,708.40 $556.1 $428.1</td>
<td>$2,709.60 $553.2 $429.4 -0.04% 0.52% -0.30%</td>
</tr>
<tr>
<td>2012</td>
<td>$2,823.90 $565.6 $456.8</td>
<td>$2,831.00 $572.0 $456.0 -0.25% -1.12% 0.18%</td>
</tr>
<tr>
<td>2013</td>
<td>$2,980.40 $599.5 $487.8</td>
<td>$2,989.80 $614.3 $482.8 -0.31% -2.41% 1.04%</td>
</tr>
<tr>
<td>2014</td>
<td>$3,227.40 $636.8 $586.8</td>
<td>$3,163.20 $662.9 $511.3 2.03% -3.94% 14.77%</td>
</tr>
<tr>
<td>2015</td>
<td>$3,417.90 $668.1 $630.9</td>
<td>$3,341.50 $705.1 $542.7 2.29% -5.25% 16.25%</td>
</tr>
<tr>
<td>2016</td>
<td>$3,632.00 $707.4 $646.4</td>
<td>$3,545.90 $754.1 $578.1 2.43% -6.19% 18.42%</td>
</tr>
<tr>
<td>2017</td>
<td>$3,849.50 $751.2 $732.2</td>
<td>$3,770.60 $808.0 $618.4 2.09% -7.03% 18.40%</td>
</tr>
<tr>
<td>2018</td>
<td>$4,080.00 $801.3 $783.8</td>
<td>$4,015.20 $868.2 $664.1 1.61% -7.71% 18.02%</td>
</tr>
<tr>
<td>2019</td>
<td>$4,346.50 $857.4 $841.9</td>
<td>$4,280.30 $935.3 $713.9 1.55% -8.33% 17.93%</td>
</tr>
<tr>
<td>2020</td>
<td>$4,638.40 $922.0 $908.1</td>
<td>$4,564.30 $1,010.70 $766.9 1.62% -8.78% 18.41%</td>
</tr>
</tbody>
</table>

* Amount in Billions of Dollars

Source: Centers for Medicare & Medicaid Services, Office of the Actuary
Is Health Care Reform Here to Stay?

• The Supreme Court will hear arguments that will examine three fundamental areas of the law:
  – Is the individual mandate, which requires all individuals to have health insurance and imposes a penalty on non-compliant individuals who cannot demonstrate hardship, unconstitutional?
  – If the individual mandate is found to be unconstitutional, what portion of the rest of the law, if any, can stand?
  – Is it unconstitutional for the law to require states to pay 5 percent more into the Medicaid system by 2017 to cover the cost of new lives added to the program as part of the act’s expansion of health coverage to all individuals?

• A fourth question will also be examined
  – Is it premature to answer the above questions? Or, more simply stated, can the Supreme Court evaluate the constitutionality of a penalty that has not yet been imposed?

Yes, Reform will Continue

The consensus is that health care in the United States in its current form is unsustainable, and change will continue with or without the Affordable Care Act.

So, how can providers lead, react and prepare for change?
The Three Strategic Postures

Shape the future
Play a leadership role in establishing how the industry operates, for example:
• setting standards
• creating demand

Adapt to the future
Win through speed, agility, and flexibility in recognizing and capturing opportunities in existing markets

Reserve the right to play
Invest sufficiently to stay in the game but avoid premature commitments


Public Policy
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
Public Policy
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.”

Source: CMS Policy Council Document, 9/28/06 *Post-Acute Care Reform Plan; reviewed at MedPAC 1/07

New Business Models
The Patient Experience

• Health care delivery today is typically disjointed
  – Providers have difficulty communicating across the care continuum
    ◊ Patients end up with more expensive, less effective care

• Health care delivery in the United States is moving toward a patient-centric model
  – Providers will need to work together in a reformed, outcome driven and incented care delivery model
    ◊ Patients end up with less expensive, more effective care
  • Examples: Mayo Clinic and Cleveland Clinic Models
New Business Models

Putting the Patient First

Accountable Care that is Patient Centric will lead to improved clinical pathways, efficiencies and outcomes.

New Payment Models

Value-Based Performance Payment (VBP)

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
New Payment Models

Bundled Payments

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.

- 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
  - Bundled Payment Care Improvement Initiative 2011-2012
  - For hospitals, doctors and post-acute providers.
  - Aims to improve patient care and achieve savings.
  - Pilot can be expanded by 2016, if it appears to improve quality and reduce costs.

New Care Delivery Models

Accountable Care Organizations (ACOs)

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.

ACO “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
New Care Delivery Models: Medical Homes

1. Patients/citizens identifying a primary care practitioner and team
2. Routinely acting from a patient-centered, whole-person orientation
3. Aiming for population health outcomes
4. Through a practice team tailored to needs of each patient and situation
5. Carrying out practice-based care coordination
6. Coordinating with the healthcare neighborhood of other teams and community
7. With patients actively participating in quality improvement and practice development
8. Demonstrating capacity for continuous learning and improvement
9. Supported by a sustainable business model and leadership alignment
10. Accountable to achieving a set of clinical, experience and financial outcomes

Expected to be a component of many reform initiatives including ACOs.

Two key health reform demonstrations:

1. Multi-payer Advanced Primary Care Practice Initiative.
   Selected states: ME, VT, RI, NY, PA, NC, MI, and MN
2. Independence at Home

Source: “A Consensus Operational Definition of Patient-Centered Medical Home (PCMH) Also known as Health Care Home,” A joint product of the University of Minnesota and the Institute for Clinical Systems Improvement (ICSI) CJ Peek, PhD and Gary Oftedahl, MD, December 17, 2010

Value Based Reimbursement Payouts

Methodology may be similar for Home Health

Source: CMS 2/10/11 Open Data Forum: Hospital Value-Based Purchasing Proposed Rule Overview for Facilities, Providers & Suppliers, #16
Making the Transition to Performance Based Payment

- Shared Savings
- Bundled Payments
  - Negotiated Episode Price
  - Longitudinal Accountability
  - Risk based
- Value Based Reimbursement
  - New metrics
  - Best practices
  - Performance based
  - Uncertainty
  - Electronic communications
- Fee For Service
  - No risk payments
  - Common payments
  - Predictable

Significant Change

Implications of Reform:
How Do We Track and Communicate Performance?

How do we ensure proper information flow throughout the continuum so we are providing maximum Value?
Home Health Compare: Key Metrics for Reform

LOWER PERCENTAGES ARE BETTER

<table>
<thead>
<tr>
<th>Metric</th>
<th>25%</th>
<th>27%</th>
<th>29%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of patients who had to be admitted to the hospital</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of patients who need urgent, unplanned medical care</td>
<td>20%</td>
<td>23%</td>
<td>22%</td>
</tr>
<tr>
<td>NEW! Percentage of patients who need unplanned medical care related to a wound that is new, is worse, or has become infected</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

The Value Proposition

Each organization in *telling their story* will define the value proposition, but it should not be limited to the value of a Home Care visit or episode. The value of an aging services provider can include:

1. Greater knowledge and understanding of geriatric medicine and successful older adult care delivery models
2. Ability to impact health care utilization, i.e., ER use, readmissions, etc.
3. Longitudinal relationships with customers
4. Enhanced setting for patient education
5. Ability to assess and support capabilities of informal caregivers
6. Improved transitions to the community
7. Care coordination across settings and community based
8. Large customer base who require services
9. Other
Bend the Cost Curve

**Think Globally, Act Locally**

- Cost efficient care
- Eliminate duplication
- Reduce/eliminate unnecessary care
  - Hospital readmissions
  - Health care acquired conditions
  - Improve care transitions/ care coordination
- **Provision of same service but in lower cost setting**
- Consistent use of best practices
- Chronic care management

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Preparing 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
New Business Models

Developing New Competencies

Managing Change
End of Life Care
Chronic Disease Mgmt

The New “Value”

Customer Satisfaction
Wellness & Prevention

Geriatrics

Financially Savvy Strategies

Developing Capabilities:
- Serving wide range of payers with multiple payment structures
- Integration across sites of services
- Care coordination & health planning
- Scaling programs and services to build on infrastructure
- New services and/or lines of business
- Technology services and capabilities to substitute for other costs
- Increased focus on patient-centered, patient-engaged care

Implications of Reform Initiatives

Implication #1: LTC must forge new relationships with the C-suite in Acute Care

Implication #2: FFS is going away
- Value not volume
- Quality
- Cost effective

Implication #3: New purchasers of service
- ACOs
- Consumers (i.e., CLASS Act)
- Other providers

Implication #4: Providers will need more robust quality measurement system that collects, monitors, and reports process and outcome measures, including predictive modeling

Implication #5: Survival will depend on health information
- Tracking: quality, claims
- Care transitions
- Data mining & exchange
- Disease management
The complexity and pace of change will bring opportunities and pose significant threats.

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

Successful navigation of "new normal" will require comprehensive understanding.

The Field of Aging Services is Evolving:
Where will YOU fit?

Spectrum of Services

Want driven
Preventative
Active adult communities

Continuing care retirement communities/multi-level campus

Need driven
Long-term care
Hospital

Source: Adapted from previous presentations
Overall Market Opportunity for Aging Services
Encompasses a Wide Range of Options

<table>
<thead>
<tr>
<th>Spectrum of Patients to be Served</th>
<th>Services to meet Patients’ Needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Those needing socialization and supportive services</td>
<td>• Independent/Assisted Living</td>
</tr>
<tr>
<td>• Those requiring rehabilitation services</td>
<td>• Home Health Care</td>
</tr>
<tr>
<td>• Those with long-term chronic needs</td>
<td>• Private-Duty Services</td>
</tr>
<tr>
<td>• Those with cognitive impairment</td>
<td>• Hospice Care</td>
</tr>
<tr>
<td>• Those nearing end-of-life</td>
<td>• Skilled Nursing</td>
</tr>
<tr>
<td></td>
<td>• Adult Day Health</td>
</tr>
<tr>
<td></td>
<td>• Care Management</td>
</tr>
<tr>
<td></td>
<td>• Multitude of Home and Community Based Service Options</td>
</tr>
</tbody>
</table>

*Where are YOUR strengths?*

Potential Aging Services Provider Strategies

- Develop a distinctive advantage through:
  - Integration across sites of service
  - Creating better customer experiences
  - Being the employer of choice
  - Demonstrated quality outcomes
- Build technology infrastructure to support workflow and quality measurement
- Integrate and/or offer community based services
- Quality initiatives should incorporate best practices and go beyond compliance
- Develop business process improvements that will increase efficiencies and effectiveness
- Influence and participate in the development of public policy
  - Certificate of Need/Moratorium Exception
  - Capacity analysis
  - Eligibility criteria and service coverage for governmental payers
  - Reimbursement models
  - Demonstration projects
- Understand the interrelationships of the various demand influencers
**So What Does All of This Mean?**

*While none of us has a perfect crystal ball, here are some of the expectations for the next few years:*

1. We expect a decline in hospitalizations by up to 30% over the next ten years.
2. More care will likely move to home care & SNF
3. As the public policy shifts to increase palliative care & hospice these services will increase
4. Personal home care service demand will be strong, but payment rates could be similar to Medicaid
5. ACOs will not have the authority to waive restrictive payment rules; Pioneer ACOs may have greater flexibility
6. Bundled payments will change models of care, reduce length of stay, increase integration before & after services & change relationships w/ physicians

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**Key Conclusions & Thoughts..**

Reimbursement changes will gradually expand and clinical, operational and financial performance will matter. Some potential impacts may include:

1. Performance will determine who is “in”
2. Payers will differentiate based on performance
3. Value will be “king” – but measured differently across the continuum
4. Clients/residents will define value as ease and service
5. Integration will lower overall costs, but may increase costs for PAC providers
6. Redefining Medicaid payments is critical
7. Process improvement may be the path to financial viability
Be the Provider of Choice

Low/no hospital readmissions

Meaningful Use of Electronic Health Record

Partner or provide services across care continuum

Demonstrated patient-centered approach to care

High Quality

• Top of Class in 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.

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
Thank you!

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