Welcome to TIM Talks: Business Acumen

April 12th, 2016
“This is a time of rapid and dramatic change in the way we approach healthcare in this country. That change brings great opportunity for community-based organizations that are the backbone of the aging and disability networks.”

- Kathy Greenlee, Assistant Secretary for Aging and Administrator, Administration for Community Living
TIM TALKS: Business Acumen and Comprehensive Joint Replacement Model

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Why is Business Acumen Important?

• The growth of the population of older adults and persons with disabilities is quickly outpacing the available funding to support them.

• Community Based Organizations that support older adults are increasingly finding that they do not have enough funding to meet the demands for services.

• Diversifying your organization’s revenue streams will provide opportunities to serve more people in your community.
Can Non-Profits make money?

• Non-profit status does not mean that your organization is not allowed to make revenue over expenses (margin)
• Non-profits are often mission oriented
• The greater the margin, the more capacity your organization will have to achieve your mission

• Example:
  – DSMP Title III funding allows us to provide four classes per year serving approximately 50 people
  – Billing for DSMT will allow us to provide 15 classes per year serving 180 people per year
Federal Funding Trends: 2004 – 2014 (Billions)

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<td>2014 Budget</td>
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Healthcare Landscape Changes Have Arrived

• The Patient Protection and Affordable Care Act
  – Health Reform. Commonly called the Affordable Care Act or ACA
  – Signed into law by President Obama on March 23, 2010
  – On June 28, 2012, the Supreme Court rendered a final decision to uphold the law

• MACRA: Medicare Access and CHIP Reconciliation Act
The Evolution of the System

- Understanding the changes coming to the health care delivery system requires understanding how the current system evolved.
- You have to understand the financial incentives in the market to track where there are opportunities.
Shift Toward Value-Based Purchasing

- The current system is changing from Fee-For-Service to payment for outcomes.
- A Value-Based Purchasing system provides financial incentives for outcomes (Value)
- MACRA legislation provides direct incentives to Physicians and Hospitals to move towards a system that pays for outcomes
- In the past, there were real financial incentives to providers, when complications occur
Target Population

• The target population of many of the current changes in Healthcare are Medicare Eligible Beneficiaries
• The healthcare change mandates are dramatically impacting the actions of providers that serve Medicare beneficiaries
• Medicare Eligible Beneficiaries include the following:
  – People 65 or Older
  – People under 65 with certain disabilities
  – People of ANY age with End-Stage Renal Disease
    • Permanent kidney failure requiring dialysis or a kidney transplant
Where are there costs in the system?

• A system that pays for value will focus on where the highest cost drivers are
  – Reduction in Institutional Care
  – Readmissions
  – Nursing Home Placement
  – Preventable Primary Admissions
Emphasis on Duals

• The term “Dual” generally refers to beneficiaries that qualify for both Medicare AND Medicaid

• Duals make up the population that is most vulnerable to cost increases

• Eligibility generally requires
  – Aged (65+) or;
  – Disabled AND
  – Meets means testing for Poverty status

• Many Reforms impact both Public Payers
  – Medicare + Medicaid
What is the Role of Medicaid for Duals?

- Medicare is the primary payer for Healthcare services for Duals
- Medicaid becomes the secondary payer
  - Operates in a manner as the Medigap policy
- When a Dual has both
  - Medicare pays for health services
  - Medicaid pays supplemental costs
  - *Medicare is most often the primary
How do we prepare for the market?

- Now that we have a better understanding about the dynamic healthcare market, what do we do next?
- It is important to prepare and know your market before seeking contracts
- Know who your customer is
  - Customer is the entity that buys your services
  - Beneficiary is the recipient of the services that are paid for by your customer
  - BOTH the Customer and Beneficiary needs must be met
Know Your Market

• Medicare population
• Those at-risk for Institutional Care
• Target services to those impacted by change
• Define how your services will lead to cost reduction and improve health outcomes.
• Drive value and continually document the ROI that your organization can provide.
What is your competitive advantage?

- You have to mobilize quickly
- The window of opportunity will not remain open indefinitely
- SOMEONE will fill the need
- No one should be able to mobilize faster in your community than YOU
Customer Vs. Consumer

• The new marketplace requires that you meet the needs of the customer and the consumer

• Customer – Managed Care Plan

• Consumer – Beneficiary receiving services paid for by the Managed Care Plan
What does the Customer need?

- Data
- Data
- More Data
- Integrated Care Organizations have performance goals to meet
  - Financial and Quality Risks
- How do you contribute to improving quality and reducing financial risk?
  - If you are not, why should they contract with you?
Bundled Payments for Care Improvement Initiative

- Initiative first awards were announced January 31, 2013
- Under this initiative, organizations enter into payment arrangements that include financial and performance accountability for episodes of care
- Episode of Care
  - Key component of the initiative
  - All services rendered are bundled into one payment for an episode of care
  - Provides a financial incentive for the org to keep costs down
Is there a BPCI Near You?

Source: Centers for Medicare & Medicaid Services
CJR Model Overview

• Bundled Payment for Lower Extremity Joint Replacement (LEJR) for designated hospitals
  – Start Date: April 1, 2016
• Final Rule established November 16, 2015
• Link to the Final Rule:
Participating Hospitals

• Hospitals geographically located within 67 Metropolitan Statistical Areas (MSAs) are included

• Proposed rule listed 75 MSAs. This number was reduced to 67 in the final rule

• Approximately 800 hospitals participating
  – An Excel file listing all participating hospitals will be provided
Episode Description

- **Episode:** Hospitalization + 90 days post discharge
- The day of discharge is counted as the first day of the 90 day post discharge period
- The model establishes a target price for each participating hospital
- The participating hospital & “Collaborators” must work together to keep included Medicare costs at or below the target price
Inclusion Criteria

- Medicare eligible beneficiaries enrolled in Original Medicare
- MS-DRG 469
  - Major Joint Replacement or Reattachment of Lower Extremity with MCC
- MS-DRG 470
  - Major Joint Replacement or Reattachment of Lower Extremity without MCC
- *MCC – Major Complications or Comorbidities
• Medicare Severity Diagnosis Related Groups (MS-DRG)
• 2007 - Implemented as part of the Inpatient Prospective Payment System for Acute Care Inpatient Hospital Stays
• One DRG is assigned to each inpatient hospital stay
Exclusion Criteria

- Medicare Beneficiary eligible for Medicare due to End-Stage Renal Disease (ESRD)
- Beneficiary enrolled in Medicare Advantage (MA)
- Beneficiary enrolled in a Special Needs Plan (SNP)
Included Services

- Physician Services
- Inpatient hospitalizations
- Hospital readmissions
- SNF
- Home Health
- DME
- Hospice
- Outpatient therapy
- Clinical laboratory
Excluded Services

• Acute or Chronic conditions that are not related or affected by the LEJR procedure or post-surgical care

• Example 1: 67 Year old with Breast CA undergoes a knee replacement and then gets admitted for chemotherapy during the 90 day post acute period

• Example 2: 67 Year old with Diabetes develops a surgical wound infection contributed by her non-adherence to her diabetes regimen
Payment Model

- Two-sided risk model
- Actual spending during the episode is aggregated and compared to the target price
- When the target price is above the aggregate spending there is a Gain
- When the target price is below the aggregate spending there is a Loss
How is the Target Price set?

- Initially there will be a target price set for each individual facility.
- Target price is established based on historical trends.
- Gov. includes a 3% discount, based on projected spending.
Gain Limits (Stop-Gain)

• Gain sharing begins immediately
• There is a limit to the amount of gains that a facility can receive. This is referred to as the “Stop-Gain”
• Stop-Gain
  – Years 1 and 2: Capped at 5%
  – Year 3: Capped at 10%
  – Years 4 – 5: Capped at 20%
• There is a cap to the total amount of losses a facility can incur
• This cap is losses is referred to as the “Stop-Loss”
• Stop-Loss
  – Year 1: No responsibility to repay Medicare
  – Year 2: Capped at 5% of target price
  – Year 3: Capped at 10% of target price
  – Years 4 – 5: Capped at 20% of target price
What about Rural Hospitals in the MSA?

- There were additional protections put in place for Rural Hospitals.
- Rural and Sole Community hospitals have the following stop-loss figures:
  - Year 2: 3% of target price
  - Years 3 – 5: 5% of target price
Gainsharing

• Participants have a waiver that allows for Gainsharing
• Hospitals can share in the gains and the losses with participating “Collaborators”
• Hospitals must execute an agreement for gainsharing
• Collaborator must be a Medicare provider
• Hospitals are free to pay directly for services to non-Medicare providers
Beneficiary Incentives

• Hospitals may provide in-kind patient engagement incentives to beneficiaries.
• Incentives are to be used to encourage positive behaviors
  – Examples:
    • Adherence to drug regimens,
    • Adherence to care plan,
    • Reduction in readmissions,
    • Management of chronic diseases that may affect the LEJIR procedure
Suggested Collaborators

- Collaborators can participate in Gainsharing
  - Collaborators must be Medicare providers
  - Physicians, Home Health, SNF, DSMT providers, DME providers, etc.

- Hospital is free to pay directly for services to support the beneficiary as part of the in-kind beneficiary incentive
  - Example: Two week home delivered meal service in the immediate post-acute period
  - Example: Participation in an evidence-based group exercise program targeting knee movement
What About Quality?

- Facilities will receive a composite quality score.
- The composite quality score is a hospital-level summary reflecting performance and improvement on two defined quality measures:
  - Complications measure
  - HCAHPS Survey measure
  - The composite score will factor into the payment reconciliation process
  - *Readmissions was removed as a contributing factor to the composite quality score in the Final Rule. However, the cost associated with a readmission are included in the price aggregation process.
Are Duals Included?

- Duals are included unless they are enrolled in a Medicare Advantage Plan or Special Needs Plan (SNP)
- A Dual that receives Managed Long-Term Services and Supports is also included
- A Dual on Medicaid Waiver for HCBS is included
- *Medicaid costs DO NOT attribute to the final aggregated costs. Therefore, a strategy of maximizing Medicaid spending to lower Medicare costs can have positive financial benefits (Gain)*
What are the characteristics of Duals?

- According to the CBO, in 2009, there were 9 million dual eligibles and they cost Federal and State governments more than $250 billion in healthcare benefits.
- Medicaid provides health care coverage to low-income people who meet requirements for income and assets.
- All Duals qualify for full Medicare benefits, but they differ on the Medicaid benefits they qualify for.
• Full duals are twice as likely as non-dual Medicare beneficiaries to have at least three chronic conditions

• Duals are nearly three times as likely to have been diagnosed with a mental illness, including chronic depression
  – Many more have undiagnosed or untreated chronic depression

• In 2009, total average healthcare spending:
  – Nonduals - $8,300 per year
  – Full Duals - $33,400 per year
• Less than 0.5% of partial duals are institutionalized
• 15% of full duals are institutionalized
• Partial duals often transition to a full dual after completing the spend down period after a SNF/nursing home admission.
• Full duals are five times as likely to use LTSS as non-duals
• Full duals are twice as likely to use LTSS as the non-dual ABD population
Can Other Programs Support Medicare Costs?

• Many of the reform initiatives focus on lowering Medicare costs
• If an organization can leverage services from non-Medicare sources to provide more support for the consumer, there can be a decrease in Medicare costs
• A Veteran that has Original Medicare and uses their Medicare benefit to obtain a LEJR in a target MSA is included

• If the Veteran uses VD-HCBS or VA Choice post discharge does this cost get included in the final cost aggregation? **NO.** The VA pays for these services and they are not included in the Medicare final cost aggregate.
Are beneficiaries receiving Medicaid HCBS Waiver Services included: Yes if they also have Medicare (Dual).

*A Dual receiving Medicaid HCBS will NOT have their Medicaid costs included in the final Medicare cost aggregation after 90 days

Maximizing HCBS to drive down Medicare costs can be a real strategy in a partnership.
• Are OAA Services included in the final price aggregation for the beneficiary – NO

• The aggregation of all expenses includes all Medicare Part A and Part B services. Therefore, OAA expenses are not included.
Alignment of Payment Incentives

• Incentives to reduce Medicare and Medicaid directly impacts providers that serve duals
• Reductions in Medicare costs and Medicaid costs can have a dramatic impact on the overall cost of care
• Medicare
• Medicaid (Medicare Supplemental Coverage)
• Managed Long-Term Services and Supports – Medicaid Waiver
Questions

• Time for Q & A