# 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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# Agenda

1. Business Acumen
2. Market Changes
3. Comprehensive Joint Replacement Model
4. Q & A

# Why is Business Acumen Important?

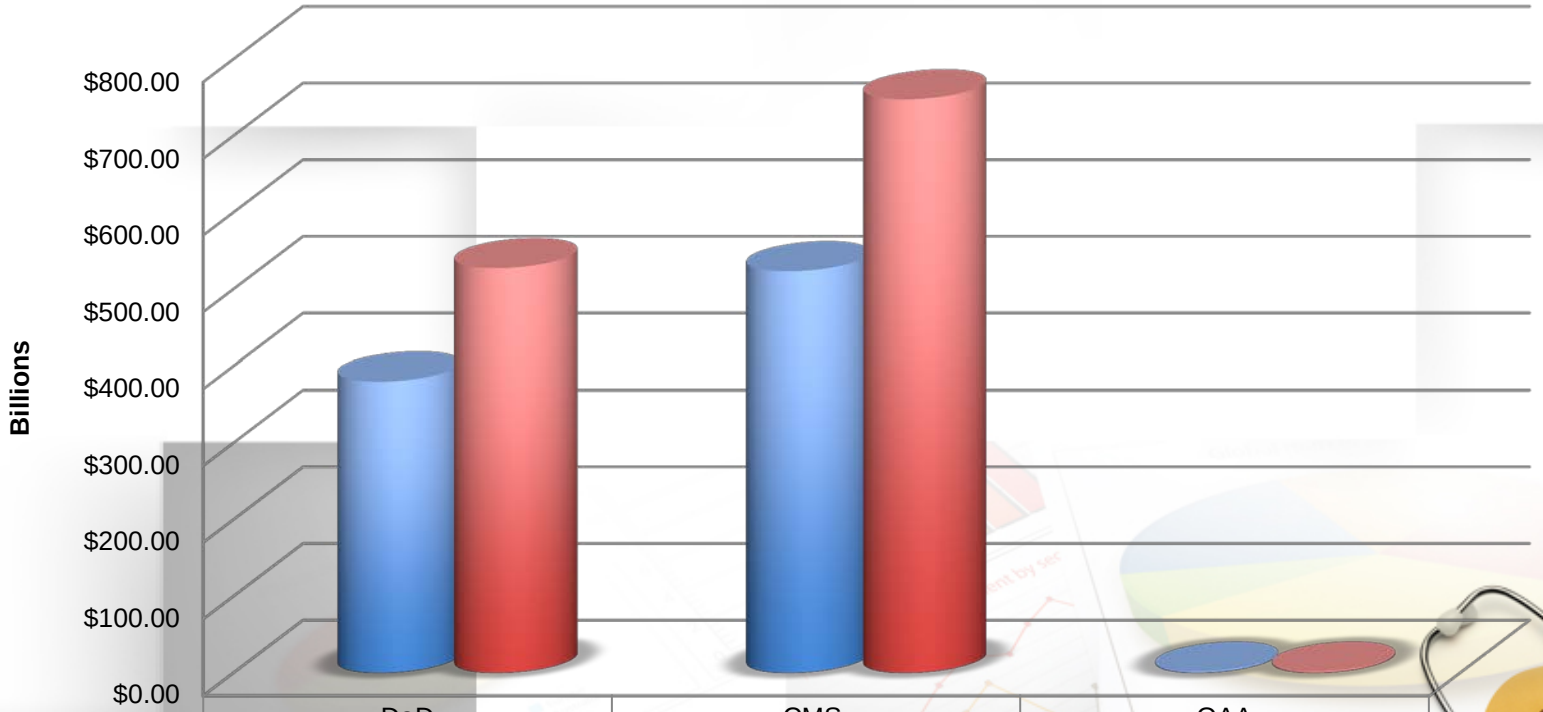
- The growth of the population of older adults and persons with disabilities is quickly outpacing the available funding to support them
- Community Based Organizations that support older adults are increasingly finding that they do not have enough funding to meet the demands for services
- Diversifying 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

# 50 Year Anniversary of the Older Americans Act (OAA)

## Federal Funding Trends: 2004 – 2014 (Billions)




| | DoD | CMS | OAA |
|---|---|---|---|
| 2004 Budget | $379.90 | $523.40 | $1.80 |
| 2014 Budget | $527.50 | $747.70 | $1.88 |

Sources: U.S. Department of Defense, Under Secretary of Defense Comptroller. CMS Research Statistics Data Reports. AARP Public Policy Institute.

# 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 quality 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

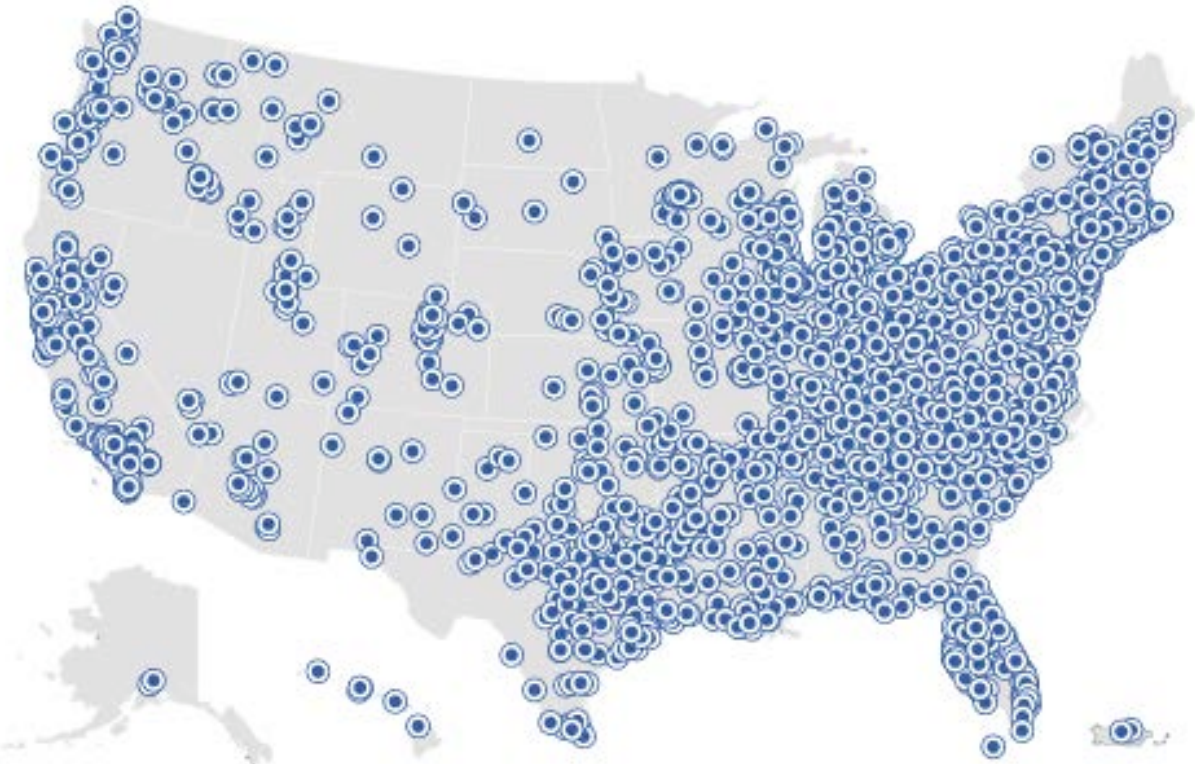
# What does the Customer need?

- 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: https://www.federalregister.gov/articles/2015/11/24/2015-29438/medicare-program-comprehensive-care-for-joint-replacement-payment-model-for-acute-care-hospitals

# 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

- 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

# MS-DRG

- 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

- 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%

# Repayment Ceiling (Stop-Loss)

- 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 LEJR 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

# Duals and Chronic Disease

- 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

# LTSS for Duals

- 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

# VD-HCBS?

- 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.

# HCBS Waiver Services?

- 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.

# OAA Services?

- 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